



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Florida**

**Application for 2009
Annual Report for 2007**



Document Generation Date: Sunday, September 21, 2008

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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.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and certifications are on file in 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

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; expires May 31, 2009.

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.

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

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The needs assessment process in 2005 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. We are keeping this list for FY2009, as there have been no major changes over the past year that would compel us to change our priorities.

1. Improve preconception and interconception health and well-being.
2. Decrease racial disparities in maternal and child health outcomes.
3. Increase access to health care for the maternal and child health population, including children with special health care needs.
4. Decrease maternal, infant, and child morbidity.
5. Decrease maternal, infant, and child mortality.
6. Decrease risk factors associated with poor maternal and child health outcomes.
7. Decrease teen pregnancy.
8. Ensure consumer-friendly, culturally competent systems of care.
9. Increase statewide and local data and analysis capacity.
10. Increase awareness of public health preparedness issues unique to the maternal and child health population, including children with special health care needs.

The process for establishing priority needs included, but was not limited to: examination of data, coordination with partners to gain input from professionals and consumers, and collaboration with other agencies and other programs within the Department of Health. We began looking not only at outcomes, but at the risk factors that are associated with certain outcomes as well. This led to the attention on preconception and interconception health, which replaced a former issue related to maternal infections. The priorities also include a broader focus on racial disparities, where before the racial disparity issues were related only to infant mortality. This is in line with the Florida Department of Health's larger efforts to address racial disparities in all health outcomes.

Another priority area was added to address access to care with the provision of consumer-friendly, culturally competent systems of care. Attention to this area should decrease barriers to care, and increase capacity to reduce racial disparities. The list of priorities includes increased awareness of public health preparedness for the maternal and child health population. Another priority area was added to address access to care with the provision of consumer-friendly, culturally competent systems of care. Attention to this area should decrease barriers to care, and increase capacity to reduce racial disparities. The list of priorities includes increased awareness of public health preparedness for the maternal and child health population.

Selection of priority needs for this assessment included the consideration of quantitative and qualitative data. Although both have been considered in the past, there was substantially more

input from key stakeholders, direct service providers, and especially consumers with the addition of the survey performed by the Florida State University. As in previous years, staff from the Infant, Maternal, and Reproductive Health (IMRH) Unit employed a number of methods to assess the needs of the MCH population. Raw data was taken from many sources, and the data was analyzed to discern possible trends. Information was gathered from Healthy Start coalition service delivery plans, the Florida Youth Tobacco Survey, the Florida Medicaid Management Information System, the Florida County Health Department Clinic Management System, Fetal and Infant Mortality Review (FIMR) and Pregnancy Associated Mortality Review (PAMR) annual reports, vital statistics data, and Pregnancy Risk Assessment Monitoring System (PRAMS) data. Extensive information from the Florida's Community Health Assessment Resource Tool Set (CHARTS), which is maintained by the Department of Health's Office of Planning, Evaluation, and Data Analysis, was reviewed as well. The CHARTS system presents a wide variety of data in a very user-friendly format. Data from a variety of public health program offices in Florida were collected from the CHARTS system, including data on Healthy Start screening, substance-exposed newborns, WIC and nutrition, communicable disease (HIV/AIDS, TB, and STDs), vaccine preventable disease, and immunizations.

Additionally, 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 of preconception and interconception care, racial disparity, and access to care issues. After the advisory group provided recommendations, maternal and child health staff met for a final review of data, both quantitative and qualitative, and the recommendations from the advisory group. Staff members identified three additional areas of need for the list of priorities. This included the provision of consumer-friendly culturally competent care, the awareness of public health preparedness for the maternal and child health population, and the addition of reduction of teen pregnancy. Although the data shows a downward trend in teen pregnancy, the team felt that this is a state priority and was also identified in the survey data as a top priority for all three groups surveyed.

We have not made any major changes to the process we use to address needs, but we are beginning to readdress the process for the upcoming assessment in 2010.

III. State Overview

A. Overview

Florida is the fourth most populous state in the nation, and the diversity of its population creates unique challenges. According to the 2000 U.S. Census, the population in Florida was 15,982,378 in 2000. Females accounted for 51.2 percent of the total population. Children under 18 accounted for 22.8 percent, while 17.6 percent were 65 or older. Of the total population, 78 percent described themselves as white, 14.6 percent as black, 1.7 percent Asian, and 0.3 percent American Indian or Alaskan native, with the rest being some other race or races. Florida residents also reflect diverse ethnicities, as evidenced by the 16.8 percent who identified themselves as Hispanic. Of all residents over 5 years of age, 23.1 percent speak a language other than English at home.

Since 2000, the population of Florida has continued to grow at a rate of approximately 2 percent each year. The Florida Legislature's Office of Economic and Demographic Research estimates the population in Florida reached 17,613,368 in July 2004. By 2015, Florida is expected to surpass New York, becoming the third most populous state after California and Texas.

/2008/ By July 2007, the Office of Economic and Demographic Research estimates that the total population in Florida will have reached 18,824,412. Estimated racial breakdowns indicate that 80.5 percent of the population is white, 16.7 percent black, and 2.8 percent other. By July 2007, estimates project that 20 percent of the population is of Hispanic origin. This represents a 59.6 percent increase in the number of Hispanics over the last 10 years, from an estimated Hispanic population of 2,359,254 in 1997 to an estimated Hispanic population of 3,764,882 in 2007. //2008//

Florida is also a temporary home to over 20 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 2005 report by the Pew Hispanic Center, Florida is home to 850,000 illegal immigrants, following only California and Texas, and accounting for 9 percent of the total illegal immigrants in the nation.

Historically, many illegal immigrants have come to Florida seeking agricultural jobs, particularly in the citrus industry. 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. As the number of illegal immigrants willing to work for low wages increases, business and industry have an unending source of cheap, exploitable labor.

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 slightly more than \$10.5m in 1996 for 4,556 deliveries to undocumented aliens. By 2004, that amount increased to over \$65.3m for 16,281 deliveries. 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.

/2007/ In 2005, there were 17,648 reported births to undocumented aliens paid through Medicaid at a cost of over \$74.2m. //2007//

/2008/ In 2006, there were 20,099 reported births to undocumented aliens paid through Medicaid at a cost of over \$85.6m. This represents a 14 percent increase in the number of reported births

to undocumented aliens. //2008//

//2009/ In 2007, there were 20,657 reported births to undocumented aliens paid through Medicaid at a cost of over \$91.1m. This represents a 2.8 percent increase in the number of reported births to undocumented aliens and a 6.4 percent increase in Medicaid costs for these births compared to the previous year. //2009//

The geography of Florida can also create challenges in both the delivery of services and 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.

According to the 2000 U.S. Census, 33 of Florida's 67 counties are considered rural based on the statutory definition of "an area with a population density of less than 100 individuals per square mile or an area defined by the most recent United States Census as rural." In area, these 33 counties cover over 42 percent of the total land area. Portions of other counties also contain large, rural areas but are not classified as rural. Of the total population, 15.2 percent live in rural areas.

Poverty is also a major concern in Florida. According to the 2000 census, 12.5 percent of individuals and 9 percent of families are below the federal poverty level. Only 58.6 percent of the population age 16 or over is in the labor force, compared to 63.9 percent nationally, a figure that probably reflects the large number of retirees in the state. These data are also indicative of the overall economy and the abundance of service industry jobs that are typically low-paying.

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 and 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 governor has proposed allowing Medicaid recipients to join private HMOs. Changing the state Medicaid formulary to reduce the number of drugs covered is also under consideration to lower costs. The 2005 legislature declined to address major changes to Medicaid, but it remains an issue that may be addressed in coming sessions.

//2007/ A special session of the Florida Legislature resulted in passage of Medicaid reform legislation establishing a Medicaid managed care pilot program in two counties, Broward and Duval, beginning July 1, 2006. //2007//

//2008/ The Jessie Bell DuPont Fund commissioned Georgetown University's Health Policy Institute to assess the impact of Florida's Medicaid managed care pilot program. Their May 2007 report indicates that many physicians are reluctant to participate, and those that do are reporting declining Medicaid patient load, an indication that access to care in the pilot counties is worsening. The report further states that physicians are finding it harder to provide care to the Medicaid patients they do see, due to the complexity of the new system. However, this investigation is a snapshot based on surveys and focus groups and it may be too early in the reform effort to draw conclusions. The University of Florida, College of Public Health and Health Professions is also conducting a five year study to evaluate the Medicaid Reform pilot and it would be interesting to compare the two investigations. In addition, there are more choices for the Medicaid Reform beneficiaries as the number of the plans approved in the Medicaid Reform areas are as follows: Broward County - 10 HMOs, five Provider Service Networks; Duval County -- four HMOs, two PSNs. //208//

Bioterrorism has been a major issue in Florida since September 2001, and it continues to be an

important priority in the Department of Health. According to a report released in December 2004 by the Trust for America's Health, Florida was tied with North Carolina as the two states best prepared to respond to bioterrorist attacks and other health emergencies. The score for Florida was nine out of a possible 10, while over two-thirds of states scored less than six out of 10. The report also notes that Florida was among six states recognized as being adequately prepared to distribute vaccines and antidotes in an emergency. Florida is also one of five states with the ability to fully respond to a chemical terrorism threat, and is among the one-third of states that have sufficient bioterrorism lab response capabilities.

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.

//2007/ Partnering with other states and guided by the Centers for Disease Control and Prevention, Florida has developed a pandemic flu preparedness plan that addresses disease surveillance, emergency management, vaccine delivery, laboratory and communications activities and multi-agency response. Florida also has a very strong and robust surveillance system in place that is on alert to the potential for bird flu. Sentinel physicians report any unusual occurrences to the Florida Department of Health and the CDC. DOH laboratory facilities and staff have been increased, allowing for more timely diagnosis of avian flu should a case occur. The department also provides continuing education to EMS, hospital staff and private physicians, emphasizing the need to be alert for possible symptoms of bird flu coupled with overseas travel. Separate websites have been established offering information on avian flu for both health care professionals and the general public. //2007//

Another major priority for the department is reducing racial disparities in health outcomes. 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.

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.

Racial disparities were further addressed in 2004 when Florida was one of five states chosen to participate in an Action Learning Lab on Reducing Racial and Ethnic Disparities in Perinatal Health Outcomes sponsored by the Association of Maternal and Child Health Programs. The purpose of this action lab was to help participants develop goals and implement strategies intended to reduce racial disparity through lasting systems change.

Focusing on those populations with the poorest birth outcomes is important, but we also must

address the needs of the overall population as well. Improvements in infant mortality and low birth weight rates have been difficult to accomplish for all races and ages. Activities to identify the greatest periods of risk have shown the importance of addressing and improving the health of women before they become pregnant. The department has created the Office of Women's Health Strategy to address a life course approach to care, including better preconception and interconception care, and other issues that affect women's health. In addition, Florida is one of three states receiving grant funding through the Integrating Comprehensive Women's Health into State MCH Programs initiative.

/2009/ The Department of Health recently formed an Intraagency Work Group on Infant Mortality Prevention to address infant mortality rates in Florida. The work group will develop a departmental white paper on infant mortality prevention that: describes Florida's infant mortality problem, suggests effective public health approaches to reduce mortality, and identifies potential strategies that cut across departmental programs as well as engage external partner organizations. The paper will provide a brief overview of Florida's infant mortality problem, including recent trends, risk factors and contributors, and current issues and challenges. It will propose potential policy changes, current program opportunities, and new strategies. The paper will also identify current departmental and community efforts that could be enlisted to implement new strategies. //2009//

/2008/ In an effort to address racial disparities in birth outcomes, the 2007 Legislature passed legislation creating a black infant health practice initiative. The purpose of the initiative is 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 African-American infants, and to produce recommendations on how to address the factors identified by the reviews. However, as of June 5, the bill had not been sent to the governor for signature. //2008//

/2009/ Upon signature by the governor, House Bill 1269, now s. 383.2162, F.S., authorized the establishment of a practice collaborative to examine racial disparities in infant mortality. After development of an administrative rule (62F-21.001, Florida Administrative Code) in October 2007, the department began developing contracts with the Healthy Start coalitions representing the eight counties that fit the bill's criteria for study (Broward, Dade, Duval, Gadsden, Hillsborough, Orange, Palm Beach, and Putnam counties). In addition, we developed contracts with the University of South Florida and Florida A&M University to provide training and technical assistance throughout the initiative, as well as to develop the general research methodology. Contracts were executed January 1, 2008 with all of the above-mentioned entities, and work began immediately in the areas of qualitative and quantitative analyses of fetal and infant deaths, with race as the key focus, as well as strategies for community mobilization and engagement. The practice collaborative is running on schedule as of this date, and funding is set to end at the end of the 2007-2008 fiscal year, with the final report on findings and recommendations to the legislature due January 1, 2010. //2009//

/2008/ In the appropriations bill for the next state fiscal year, the 2007 Legislature approved a \$3 million increase in funding to Healthy Start coalitions. The additional funds will be used to increase the number of direct services provided through the Healthy Start program. //2008//

/2007/ The Department of Health was one of three states to be awarded a HRSA grant to integrate comprehensive women's health services in the maternal and child-health state programs. The goal of this initiative is to improve coordination and collaboration on women's health services to women of childbearing age within the department and across state agencies. This grant will also support the department's efforts to create a focal point for the coordination of women's health programs in Florida and help establish a sustainable infrastructure at the state and community levels for women's health. Grant-funded activities will help increase collaboration between programs and reduce the fragmentation that can occur when various initiatives provide services to similar populations. Objectives include developing a strategic plan for integrating

women's health services in Florida; increasing awareness about women's health status, available health services and related resources; and providing technical assistance and support to communities in the state to promote best practices at the local level. //2007//

/2007/ In May 2006, the Florida Department of Health's Women's Health Initiative hosted the first Governor's Conference on Women's Health in Orlando. The target audience of the conference included legislators, agency officials, health care providers, civic leaders, consumer representatives, and advocates who shape, implement, and assess women's health policies, programs and practices in Florida. The objectives of the conference were to help participants understand the factors that impact and affect women's health across their life-spans; understand the disparities in health outcomes for women in our diverse state, and recognize that health for women is not just physical health. Approximately 280 people attended this inaugural event. //2007//

/2008/ In May 2007, the department hosted the second annual Governor's Conference on Women's Health. This year's event included workshops on prevention and wellness, health disparities, women's health research, community collaboration, women's health in the workplace, and clinical practices. Approximately 320 people attended this event. The purpose of the Governor's Conference on Women's Health is to provide an educational forum for women's health stakeholders to discuss the major issues affecting women across the lifespan, including racial and ethnic disparities, perinatal care, and the needs of elder women. //2008//

/2008/ Jean Kline, R.N., B.S.N., M.P.H., was named as the new Officer for Women's Health Strategy in February 2007. Department staff continues with limited women's health efforts, even though the legislature did not provide funding for mandated women's health initiatives and projects in this year's budget. //2008//

/2009/ Like much of the nation, Florida has witnessed a downturn in the economy in recent years. State funding is dependent on sales tax revenue and corporate income tax, and property taxes fund public education and services at the county or city level. Declining consumer spending and slowdowns in the housing market significantly impact revenue sources at the state and local levels for public services, infrastructure needs, and education. Despite a growing population, a greater need for services, and higher costs to provide services, the state budget declined from \$71.9 billion in 2007 to \$66.2 billion in 2008.

Property taxes have become a major issue in Florida. The previously booming housing market caused property values to rise markedly, with a corresponding rise in property taxes as assessed values rose. Florida voters approved an amendment designed to decrease property taxes, despite fears that changes would affect the ability of local communities to fund schools or provide other services. Now the Florida legislature is considering further property tax reductions that will be somewhat offset by raising the sales tax rate, yet still result in less revenues for public education and other services.

Florida is very dependent on oil, and any rise in fuel costs can adversely affect the people in Florida in many ways. Natural gas is the source of much of the state's electric needs. Increased fuel costs also adversely affect tourism, as potential visitors may find it prohibitively expensive to drive or fly to our state. Airlines, cruise ships, rental car companies, tourist buses, and taxis must pass increased fuel costs onto their consumers. Florida citizens and visitors alike are very dependent on automobiles, as public transportation is often either underutilized or, particularly in rural areas, nonexistent.

Florida is home to over 3 million citizens 65 and older, and many of them are retirees on fixed incomes or they may be witnessing declining returns on retirement investments. As their costs for necessities such as food, housing, insurance, property taxes, and medical needs increase, even the fortunate ones have less to spend discretionally, reducing

spending that would contribute to sales tax revenues. Many have little or nothing left at the end of the month, and may find themselves in greater need of public services to meet their needs. //2009//

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.

//2009/ In an effort to provide technical assistance to the FIMR projects, we have established quarterly conference calls with all the funded FIMR projects in Florida. These calls address issues and opportunities identified by the local FIMR projects and allow the department to provide information and guidance to the projects. We held the first call in June 2007. These calls have been well received and are well attended. The FIMR project representatives share information and best practices with each other. In addition, the department hired an expert in the FIMR process who is available on the quarterly conference call and can provide technical assistance on an as needed basis. The Division of Family Health Services epidemiologist is also available to assist local FIMR projects on an as needed basis. Recently, a FIMR project notified the department of a spike in fetal deaths in their area, as a result, the epidemiologist has formed a team of experts to investigate the spike. //2009//

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 room staff persons provide more than 18 million services to Florida's 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 that 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; nursing assessment; 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.

Coordinating and strengthening the health care system for children is also an important focus of the overall strategic plan for maternal and child health. Infant and child health issues that will be targeted include: racial disparity in infant and child health outcomes, quality improvement, asthma, SIDS, fetal and infant mortality review, lead poisoning, shaken baby syndrome, school readiness/health component, day care, and immunizations.

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

/2008/ The Agency for Health Care Administration (AHCA) has approved the CMS Network (CMSN) to provide comprehensive services to special needs children as a provider service network in the Medicaid Reform Pilot Project in Broward County. CMSN anticipates approval in the near future to provide these services in Duval County as well. It is anticipated that the Medicaid Reform project will expand into Nassau, Clay and Baker counties, for which CMSN has already submitted letters of intent. //2008//

/2009/ AHCA has approved the CMSN to provide comprehensive services to special needs children as a provider service network in the Medicaid Reform Pilot Project in Duval and Broward Counties. It is anticipated the project will be expanded to Nassau, Clay and Baker counties, for which CMSN has already submitted letters of intent. //2009//

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

CMS 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 true medical home for the child and family. CMS has designed the Child Assessment and Plan (CAP), a web-based application, to document comprehensive care coordination services to all CMSN enrollees. CMS area office staff utilizes CAP to record patient assessments, care plans, and notes. The integration of the six National Goals into the CMS Program Goals, Performance Measures and CAP further enhances the care coordination activities by ensuring the provision of ongoing, coordinated, culturally competent, comprehensive care, within the context of a medical home.

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

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

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

Florida's Medical Foster Care (MFC) Program is a coordinated effort between the Florida Medicaid Program within the Agency for Health Care Administration, CMS and the Child Welfare and Community Based Care Program within the Department of Children and Families. The program provides family-based care for medically complex children in foster care who cannot safely receive care in their own homes. 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 650 children per year.

//2009/ In FY 2006-07, the Medical Foster Care Program served approximately 700 children. //2009//

The Infants and Toddlers Early Intervention Program continues to enhance the statewide service delivery system ensuring a focus on positive outcomes for families and children served by the program. In 2004, the program received a federal grant from the Office of Special Education Programs in Washington, D.C. to implement an evaluation of the early intervention system under Part C of the Individuals with Disabilities Education Act. The grant supported the program in developing outcome statements, indicators, evaluation questions, and measurement approaches to demonstrate that the service delivery system is effective. The grant also supported development of training materials to build the capacity of staff and providers in the collection and use of outcome data for program improvement.

//2007/ Florida's Infants and Toddlers Early Intervention Program (Early Steps) offers early intervention services to infants and toddlers (birth to 36 months) with developmental delays or established medical conditions that places them at risk of development delay. In Fiscal Year 2004-05 38,420 children and their families were served. Funding for the program is provided through Part C of the Individuals with Disabilities Education Act (IDEA). Federal funds are enhanced by state and local resources. Services are provided by 16 contracted local offices across the state to families to enhance their child's development. The goal of Early Step is to increase opportunities for infants and toddlers with disabilities to be integrated into their communities and to learn, play, and interact on a regular basis with children without disabilities. Many services and supports are available for eligible children and families. They receive an individualized family support plan that outlines services to enhance their child's development and integration into the community. Florida continues to move forward with the evaluation grant received from the Office of Special Education Programs in 2004 to develop measurement approaches to demonstrate our service delivery system is effective. The grant will also support training to build the capacity of staff and providers in the collection and use of the outcome data for system improvement. *//2007//*

Florida's Newborn Screening Program provides screening for all newborns for certain metabolic, congenital, and hereditary disorders prior to discharge from the birthing facility. In February 2005 Florida began screening using tandem mass spectrometry in the first hospital to begin the screening the disorders recommended by the American College of Medical Genetics and the Florida Genetics and Newborn Screening Advisory Council. Florida began statewide screening of 24 additional disorders on January 2006. The primary goals of the program are: (1) to ensure all newborns born in Florida are screened and testing is processed within two weeks of birth; (2) to ensure all affected newborns receive appropriate confirmatory testing, counseling, and treatment as soon as possible; and (3) to ensure all affected newborns are placed into a system of care in a timely fashion.

/2007/ On January 9, 2006 Florida began statewide screening for 26 additional disorders, including all of the disorders recommended by the American College of Medical Genetics and the Florida Genetics and Newborn Screening Advisory Council. //2007//

/2008/ On January 9, 2006, Florida began statewide newborn screening for 24 additional disorders, including all of the disorders recommended by the American College of Medical Genetics and the Florida Genetics and Newborn Screening Advisory Council. It is anticipated that statewide screening for cystic fibrosis will begin in the summer of 2006. //2008//

The CMS Early Hearing Loss Detection and Intervention (EHDI) program has resulted in improvement towards achieving the Healthy People 2010 goals of screening by 1 month, diagnosis by 3 months and receipt of intervention services by 6 months of age. Newborn hearing screening is mandated and will be fully integrated into screening and reporting procedures for metabolic and genetic disorders as of July 1, 2005. A component specific to serving families of children with hearing loss has been established in the Part C Early Steps program with ongoing emphasis on improving the number and quality of early intervention service providers.

/2007/ Newborn hearing screening is mandated and has been fully integrated into screening and reporting procedures for metabolic and genetic disorders as of December 2005. //2007//

The CMS Genetics Program provides genetic evaluation, diagnosis, and counseling for children with or at risk for having a genetic disorder. Services provided include initial and follow-up diagnostic and evaluation; genetic counseling; lab studies required for confirmation of genetic disorders; confirmatory testing for infants with abnormal test results for PKU and galactosemia; dietary consultation for treatment of PKU or galactosemia; and educational programs for CMS staff. The genetics telemedicine project enables a pediatrician and a University of Florida geneticist to communicate via two-way interactive video technology. This project has reduced the wait for a genetic screening consultation from one year to less than two months. In FY2003-04, 1,791 CMS eligible clients received services from the Genetics Program.

/2007/ A similar telemedicine project has been implemented at the University of Miami where the genetics team uses video conferencing to provide consultation for the Ft. Pierce and West Palm Beach CMS area offices. In Fiscal Year 2004-05, 1,423 CMS eligible clients received services from the Genetics Program. //2007//

/2008/ Telemedicine projects have been expanded by the University of Miami to Ft. Lauderdale and in Fiscal Year 2005-06 1,430 eligible clients received services from the Genetics Program. //2008//

/2009/ In Fiscal Year 2006-07, the Genetics Program provided services to 1,651 eligible clients. //2009//

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. As of December 31, 2004, 1,050 infants and children enrolled in the CMS Network were receiving services at a Pediatric HIV Referral Center or CMS HIV satellite clinic. The HIV Program at the University of South Florida conducts monthly pre-clinic chart reviews with CMS staff in Ft. Myers via two-way interactive video technology. This enables the HIV specialist to see more patients during the satellite clinics in Ft. Myers. A similar arrangement occurs between CMS staff in Pensacola and the HIV specialist from University of Florida prior to monthly satellite clinics.

/2007/ In fiscal year 2004-05, 1,018 infants and children enrolled in the CMSN received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic. //2007//

/2008/ In fiscal year 2005-06, 1,031 infants and children enrolled in the CMSN received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic. //2008//

/2009/ In fiscal year 2006-07, 1,111 infants and children enrolled in the CMSN received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic. //2009//

CMSN has partnered with the Agency for Health Care Administration (AHCA) and Florida Hospices and Palliative Care to develop and implement a pediatric palliative care (PIC) program for children with life-threatening conditions and their families. The program would provide palliative care from the time of diagnosis through the course of treatment. Palliative care services include pain and symptom management; patient and family counseling; expressive therapies; and respite, nursing and personal care. In May 2004, Florida received state plan approval to provide palliative care services to eligible CMSN children enrolled in the state's Title XXI program (KidCare). On March 1, 2005, the Agency for Health Care Administration submitted a revision to the CMSN component of the 1915(b) Managed Care Waiver, allowing palliative care services to be extended to children with Medicaid who have life-threatening conditions. In the first 10 months of the program, 16 children served by Title XXI with life threatening conditions have received or are pending PIC services. When approved, the waiver will allow up to 1,000 children with Medicaid to access services.

/2007/ In June of 2005, the approval of Florida's request represented the first Federal Medicaid waiver granted to provide this comprehensive service delivery system designed to enhance the quality of life for this vulnerable population. Florida implemented the program in July 2005. //2007//

/2009/ The program has served over 400 children through out Florida since July 2005. We anticipate that the program will be expanded to provide services to family's statewide in the coming years. //2009//

The Department of Health, Children's Medical Services, Division of Prevention and Intervention, promotes the safety and well being of Florida's children by providing specialized services to children with special health care needs associated with child abuse and neglect. The Division consists of three units: Child Protection Unit, Prevention Unit, and Special Technologies Unit.

The CMS Child Protection Team (CPT) Program is a medically led, multidisciplinary program based on the concept that child abuse and neglect involve complex issues and require the expertise of many professionals to protect children. CPTs supplement the assessment and protective supervision activities of the Department of Children and Families, local Sheriffs Offices child protective staff, and other community based care providers in reports of child abuse and neglect. There are 23 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 CMS Telehealth Program works with the CPTs to provide medical examinations of alleged child victims who are located in remote areas. A U.S. Department of Agriculture, Rural Utilities Services grant was awarded to CMS in 2004 to enhance capabilities at the current seven telemedicine sites and added two new remote sites in middle/north Florida. Another grant has been secured to support expansion of telemedicine services into the Florida Keys region. CPT Telemedicine capabilities are now available at 14 service sites. In FY 2005-06 the CPTs opened 25,716 cases involving child victims and their families; and provided 36,398 team assessments, 1,568 staffings, and 797 court testimonies.

/2009/ The CMS Telehealth Program works with the CPTs to provide medical examinations of alleged child victims who are located in remote areas. A U.S. Department of Agriculture, Rural Utilities Services grant was awarded to CMS in 2004 to enhance capabilities at the current seven telemedicine sites and added two new remote sites in middle/north Florida. A grant was secured to support expansion of telemedicine services into three locations in the Florida Keys region. CPT is now available at 14 services sites. In FY 2006-2007 the CPTs handled 27,470 cases involving child victims and their families; and provided 37,008 team assessments, 1,684 staffing, and 797 court testimonies. //2009//

The CMS Sexual Abuse Treatment Program (SATP) promotes the safety and well-being of Florida's children 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. One of the criteria for referral has been that the child must have been a victim of intrafamilial sexual abuse. However, since 2005, a grant through the federal Victims of Crime Act (VOCA) has allowed for expansion of SATP services to serve children who are victims of extra familial abuse, their siblings, and their non-offending caretakers. In FY 2005-06, services were begun or expanded in eight service areas, for a 50% increase in areas served. During FY 2005-06, the SATPs served 1,786 child victims, their siblings and families.

/2009/ Since 2005, the number of SATP providers has expanded from 11 to 18; with all areas of the state having an area provider. During the fiscal year 2006-07, the SATP served 2,283 child victims, their siblings and families. //2009//

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

Other CMS telehealth and telemedicine initiatives include: a partnership with the Institute for Child Health Policy, 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 University of Miami (UM) to develop teledermatology clinics as well. The CPT continue to expand their telemedicine network expanding from 7 sites to 14 sites.

/2009/ UM physicians and dieticians provide nutritional, neurological, genetics, dermatology, and orthopedic telemedicine consults for CMS enrollees in Ft. Pierce, West Palm Beach, and Ft. Lauderdale. UM dermatologist is working with Pensacola and Panama City area offices to initiate tele-dermatology clinics. A UF geneticist provides genetic screenings with infants in the Sacred Heart Hospital Newborn Intensive Care Unit, in Pensacola and coordinates follow-up care with the area office. A pilot project with a neurologist provides neurological consults and medical services to children who live in St. Lucie, Broward, and West Palm Beach counties .//2009//

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 FY 03-04 the three centers began receiving HRSA bioterrorism funds to develop systems for more rapid response to bioterrorism threats. During Fiscal Year 2005-06 the three centers received additional federal HRSA bioterrorism funds to continue to

develop and refine systems for rapid response to bioterrorism threats and natural disasters. During FY 2005-06 the Network handled 173,856 calls, provided 2,389 critical consultations, provided 1,474 community educational programs for over 64,952 participants, and distributed over 399,109 pieces of information materials. They also participated in 262 health fairs/special events and provided 392 educational programs for health professionals.

/2009/ Poison prevention and management information is provided 24 hours a day 7 days a week through a toll-free number. During FY 2006-07, centers received additional HRSA bioterrorism funds. During FY 2006-07, the Network handled 180,792 calls, provided 5,103 critical consultations, provided 1,532 community educational programs for over 133,202 participants, distributed over 818,536 pieces of information materials, participated in 554 health fairs/special events, and provided 302 educational programs to health professionals. //2009//

CMS has responsibility for the Shaken Baby Syndrome (SBS) information program. In FY 2005-06, over 278,000 "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. A new three-part initiative has begun aimed at reducing the most common cause of SBS -- caregivers' reaction to babies crying. The initiative includes developing and conducting training for hospital nurses to provide "Coping with Crying" information and coping strategies to new parents prior to discharge; conducting a pilot poster awareness program aimed at young men; and a collaboration with the Florida Pediatric Society to increase educational information provided by the pediatrician to new parents at the first post-discharge visit to the doctor.

/2007/ CMS continues to contract with the Mailman Center for Child Development at the University of Miami for education and training at the university, in Miami/Dade County communities, and over the Internet. The contract includes web-based instruction for CMS staff statewide on topics that have included: the use of psychotropic medications for CSHCN, adherence issues for families of CSHCN, and newborn screening. //2007//

/2009/ In FY 2006-07, over 283,000 "Coping with Crying" brochures were distributed to birthing facilities. Training for hospital nurses to provide "Coping with Crying" information to new parents was provided for 29 facilities. The collaboration with the Florida Pediatric Society and the Florida Academy of Family Physicians to increase educational information provided by the physician to new parents at the baby's first doctors visit continues. A Distance-Learning satellite broadcast, "Coping with Crying-Shaken Baby Syndrome Prevention," was presented reaching over 600 participants statewide. //2009//

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 Secretary, who is also the State Health Officer. The Secretary answers directly to the Governor. The Secretary is responsible for overall leadership and policy direction of the department. The Secretary is assisted by a Deputy Secretary for CMS, a Deputy State Health Officer, a Deputy Secretary responsible for administrative bureaus, and a Deputy Secretary for Health who also oversees the Office of Women's Health Strategy. The Deputy State Health Officer is responsible for the Division of Family Health Services.

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 directions 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; Child and Adolescent Health; and Adult and Community Health. Programs within Adult and Community Health include the Sexual Violence Prevention Program, the Breast and Cervical Cancer Early Detection Program, Domestic Violence, and the Strengthening Families Initiative. Programs within Child and Adolescent Health include Abstinence Education, School Health, and Osteoporosis Prevention.

/2007/ In January 2006, the Breast and Cervical Cancer Early Detection Program moved under the Bureau of Chronic Disease and Health Promotion, another bureau within the Division of Family Health Services. //2007//

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. In July 2003, the Family Planning Program merged with the Office of Maternal and Child Health to form the Infant, Maternal, and Reproductive Health Unit. The purpose of this merger was to fully integrate women's health care through the preconception, prenatal, and interconception periods, to promote optimal health prior to and between pregnancies in order to help ensure positive birth outcomes.

/2007/ Integration of family planning and maternal and child health staff into the new Infant, Maternal, and Reproductive Health Unit was fully accomplished in May 2006 with a physical move that placed all staff in even closer physical proximity, sharing offices in the same wing of the building. More importantly, a plan is in place to begin coordinated site visits to county health departments, which will further emphasize the integration of our efforts. //2007//

/2008/ The IMRH unit has begun conducting coordinated site visits, with MCH and family planning staff traveling together to county health departments for their onsite evaluations. Prior to the visit, staff conduct advance planning meetings where data are reviewed and ideas or problems are discussed. Onsite, they conduct coordinated entrance and exit reviews with county health department staff. The coordinated site visits allow for more efficient monitoring of actives and more effective follow-up to meet technical assistance needs. //2008//

D. Other MCH Capacity

/2008/ Ana M. Viamonte Ros M.D., MPH, was named Secretary of the Florida Department of Health by Governor Charlie Crist in January 2007. She is the first woman and the first Cuban American to hold this position. 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. In May 2007, the governor signed a new law changing the title of her position to State Surgeon General. //2008//

/2008/ In May 2007, Paul Metts became the Deputy Secretary for Administration. He comes to the Department of Health with a vast array of health and business experiences, including public practice as a CPA, a Masters degree in Hospital Administration from the University of Minnesota and 20 years experience at Shands HealthCare, the last 10 of which were as the CEO. //2008//

/2008/ In June 2007, Lillian Rivera, R.N., M.S.N. became the Deputy State Health Officer. She has worked at the Miami-Dade County Health Department for the past 16 years serving in various capacities, including Executive Community Health Nursing Director and Acting Executive Administrator. Since July of 2003 she served as the Administrator, responsible for the oversight and supervision of public health programs throughout Miami-Dade County //2008//

/2009/ Ms. Rivera left the state health office in November 2007 to return to the position of

administrator of the Miami-Dade County Health Department. //2009//

/2009/ In January 2008, Thomas Arnold was named the new Deputy State Health Officer. His nearly 30 years of experience includes serving as the Deputy Secretary for Medicaid at the Florida Agency for Health Care Administration (AHCA) and as a Deputy Secretary for the Department of Health. //2009//

The Title V programs are distributed among the Division of Family Health Services and the Division of CMS. As of May 2005, there were 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 32 Healthy Start coalitions covering 66 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 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.

/2008/ In April 2007, Amy Cober, B.S., R.D., L.D., M.P.H., joined the division as the new Assistant Division Director for Family Health Services. Her background includes serving as the Nutrition Program Director for the Highlands County Health Department before taking on leadership positions in the Office of Minority Health. In her new role, Ms. Cober's duties will include a focus on nutrition services, health equity, minority health, and cultural competency within the division. //2008//

/2008/ Katherine Kamiya joined the division as the new Assistant Director for Organizational Vitality and Legislative Affairs in February 2007. She brings over 25 years of experience in direct services, administration, and executive leadership with organizations addressing the needs of at-risk children and families. In her new role, Ms. Kamiya will coordinate orientation, training and professional development activities and legislative bill tracking for the Division of Family Health Services. //2008//

Terrye Bradley came to the Department of Health in 2002. Ms. Bradley worked briefly in the Department of Juvenile Justice, where she was the Chief of Volunteer Services. Prior to her work with the Department of Juvenile Justice, Ms. Bradley was 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.

Betsy Wood has served as the Executive Community Health Nursing Director of Infant, Maternal and Reproductive Health since 2002. Prior to that, Ms. Wood worked with the Division of Children's Medical Services for 17 years and the Bureau of HIV/AIDS for three years.

/2009/ In January 2008, Ms. Wood became the Bureau Chief of the Bureau of Chronic Disease Prevention and Health Promotion within the Division of Family Health Services. //2009//

/2009/ In April 2008, Kris-Tena Albers, ARNP, CNM, MN, CQIA, accepted the position of Executive Community Health Nursing Director in the Infant, Maternal, and Reproductive Health Unit. Ms. Albers experience includes work within the department in the Office of Public Health Preparedness and in Public Health Nursing. She has also served in the private sector as a certified nurse midwife, an adjunct instructor for nursing students, and in nursing positions focused on women's health. //2009//

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

Carol Graham, PH.D., serves as the leader of the Data and Evaluation Team, and has worked in Family Health Services since 1994.

/2007/ In February 2006, Ms. Graham became Director of the Adult and Community Health Unit within the bureau, and also serves as the Deputy Bureau Chief and overseeing special projects. Half of the staff positions within the Data and Evaluation Team remained under the Infant, Maternal, and Reproductive Health Unit. The remaining positions joined the Office of Surveillance, Evaluation and Epidemiology. //2007//

/2008/ Ms. Graham left the department in March 2007. In June 2007, Christina Canty became Director of the Adult and Community Health Unit within the bureau, and also serves as the Deputy Bureau Chief and overseeing special projects. //2008//

Laura Levine, R.N., B.S.N., serves as the leader of the Quality Improvement Team, and has worked in Family Health Services since 2003.

Mike Mason, B.S., and Marie Melton, R.N., B.S.N., serve as co-leaders of the Healthy Start contracts team, and have worked in Family Health Services since 1997.

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

/2007/ Ms. Alexander resigned from the department in April 2006. As the Family Planning unit is now fully integrated under the Infant, Maternal and Reproductive Health Unit, this position will be filled by a person who will serve as a leader of a quality improvement team. //2007//

/2008/ Janet Temkin, R.N., B.S.N., joined the Infant, Maternal, and Reproductive Health Unit in September 2006, and serves as the lead for Family Planning and co-leader of the Quality Improvement Team. Her experience includes eight years with Children's Medical Services, seven years in county health departments, and 13 years in the AHCA/Florida Medicaid headquarters office. //2008//

/2007/ Following the placement of a CDC medical epidemiologist in 2003, the Department of Health hired Dr. William Sappenfield in 2005 to serve as the State MCH Epidemiologist. Before retiring from the Centers for Disease Control and Prevention after 20 years, he led national efforts to develop maternal and child health epidemiology capacity in state and local public health agencies. In his new role, Dr. Sappenfield is leading the planning efforts of the Division of Family Health Services to develop the agency's MCH epidemiology and evaluation capacity and has formed the new Office of Surveillance, Evaluation and Epidemiology with a six person staff. //2007//

/2007/ A partnership with the Council of State and Territorial Epidemiologists (CSTE) placed Dave Goodman, a doctoral level MCH epidemiology fellow, with the Department of Health under the mentorship of Annette Phelps and Bill Sappenfield, beginning in November 2005. This two year fellowship addresses short term capacity building through fellowship-specified projects that address agency priorities, as well as long term capacity building through the potential integration

of the fellow into the agency at the end of the fellowship. //2007//

As of May 2006, there were approximately 96 central office staff members in the Division of Children's Medical Services (CMS) Program who perform duties for Title V funded programs. There were approximately 655 out-stationed staff members in the 22 CMS area offices located throughout the state. The senior level management employees include: Joseph Chiaro, M.D. Deputy, Secretary for CMS; Phyllis Sloyer, R.N., Ph.D., Division Director for CMS Network and Related Programs; Michael Haney, Ph.D., Division Director for CMS Prevention and Early Interventions Programs, Vicki Posner, M.H.S.A., 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 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.

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 President Elect of AMCHP. She serves on the Florida Developmental Disabilities Council.

Michael L. Haney, Ph.D., CCISM, NCC, LMHC, has served as the Division Director for Prevention and Intervention since 1998. Previously, Dr. Haney worked with the Department of Children and Families as Bureau Chief for Family Safety and Preservation, Children's Home Society as Coordinator for Family Preservation Services, as a mental health consultant, trainer and hostage negotiator, as a Clinical Supervisor for mental health services, and as an adjunct instructor in general and adolescent psychology at St. Johns River Community College and in the School of Social Work at Florida State University.

Vicki Posner, M.H.S.A., has served as Chief for CMS Network Operations Bureau since coming to the Department of Health in 2000. Prior to working for DOH, Ms. Posner directed clinical services departments in medical tertiary care centers and rural community hospitals for a number of years. Ms. Posner is involved in several workgroups representing children with special health care needs and is a member of the Governor's Interagency Services Committee for Youth and Young Adults with Disabilities.

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

Susan Redmon, R.N., M.P.H., is a member of the Specialty Programs Unit and has worked in the CMS Network since 1997. She serves as the CMS Network statewide youth transition champion and has been instrumental in interagency and community collaborations to include health care in youth transition activities. She also serves as the CMS telemedicine liaison for the CMS Network.

/2009/ Charlotte Curtis, R.N., B.S.N., C.P.M., has worked with the Department of Health since 1998. Prior to joining CMS in January 2006, as the Executive Community Health

Nursing Director 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. 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. //2009//

E. State Agency Coordination

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.

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

Coordination with WIC includes collaboration regarding breastfeeding initiatives, early entry into prenatal care, coordination with Healthy Start, addressing nutrition issues such as folic acid to

prevent neural tube defects, and the development of general nutrition guidelines for inclusion in the Healthy Start standards. Coordination with other grant programs administered outside of the Department of Health includes working with Florida's Federal Healthy Start projects in selected counties, and other MCH-funded projects, including the Pediatric Pulmonary Project at the University of Florida, the MCH program of the College of Public Health at the University of South Florida, the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, the Florida State University Center for Prevention and Early Intervention, and CISS grants related to reproductive health and child abuse and neglect prevention.

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

The Department of Health and the Department of Children and Families continue coordinated efforts to prevent substance abuse during pregnancy and to reduce the impact of children affected. An IMRH staff person serves on the Florida Substance Abuse Prevention Advisory Council, Mrs. Bush's Changing Alcohol Norms Workgroup, 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. 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 order for Florida to effectively respond to the challenges presented by Fetal Alcohol Spectrum Disorders, state agencies providing services to individuals with FASD and their families have been working together to reduce the number of children prenatally exposed to alcohol and to insure those with FASD have the resources needed for optimal outcomes. To that end, the Florida Fetal Alcohol Spectrum Disorder Interagency Action Group was established in September 2000 to improve the system of care for individuals with Fetal Alcohol Spectrum Disorder and their families. The action group is comprised of representatives from a variety of public and private disciplines including the Florida Departments of Health, Children and Families (Substance Abuse Program and Family Safety Office), Education, and Law Enforcement; Florida State University; the Governors Drug Policy Office; and families with children with FASD. This action group has been meeting quarterly since 2000 to strategically and systemically address Florida's FASD needs. During the last year the action group has made great progress addressing issues surrounding fetal alcohol spectrum disorders.

//2007/ During the 2005 Florida legislative session, \$280,000 was appropriated for an Integrated System of Care for Children and Families with Fetal Alcohol Spectrum Disorder, establishing Florida's first FASD Diagnostic and Intervention Clinic. The Florida Center for Child and Family Development in Sarasota is implementing the pilot project, which seeks to improve functioning of young children with FASD and their families, prevent the development of secondary disabilities, and provide training to community professionals on FASD. //2007//

The Interagency Methamphetamine Workgroup was established in 2005 to review the issue of public environmental health concerns at clandestine methamphetamine labs (homes, apartments, motels, businesses, automobiles, etc.) and ways to reduce the impact on children involved. Agencies participating in this work group include the Department of Business and Professional Regulation, the Department of Environmental Protection, the Department of Children and Families, Department of Health, and law enforcement agencies.

The Department of Health partnered with the March of Dimes Florida Chapter to distribute multivitamins containing folic acid and provide preconception education to underserved women of childbearing age that includes messages about the importance of folic acid. This was made possible when the Florida Attorney General's office received money through a class action lawsuit against vitamin companies for price fixing, and subsequently awarded a grant to the Florida March of Dimes for a vitamin distribution project for at-risk women. The Florida chapter placed their Vitamin Settlement Project Coordinator within our Division of Family Health Services, enabling the coordinator to work within existing infrastructures to reach underserved populations, such as clients being served through county health departments and Florida's Healthy Start coalitions. As a result of this partnership, March of Dimes staff members, located throughout the state, are providing interconception training to county health department and Healthy Start staff. Additionally, the March of Dimes is working with the Department of Health to develop interconception health awareness materials that will promote greater awareness of health issues between pregnancies that impact maternal and infant outcomes.

/2009/ The VitaGrant project ended in December 2007. The project distributed over 565,000 bottles of multivitamins, and provided folic acid education and preconception health education materials to both providers and consumers. Evaluation results indicate the public health delivery model of the VitaGrant project was effective in reaching the population at highest risk for neural tube defects. They also indicate VitaGrant was a successful model for influencing vitamin consumption behavior, ultimately resulting in better birth outcomes and fewer neural tube defects among babies born to women in Florida. //2009//

/2008/ The Department of Health sponsored nine two-day trainings around the state utilizing the "Promoting Maternal Health During Pregnancy" curriculum developed by Dr. JoAnne Solchany from the University of Washington. The "Promoting Maternal Mental Health During Pregnancy" curriculum was specifically designed to provide clinicians and home visitors with a series of relationship-based interventions that support the emotional and psychological course of pregnancy. Topics included the typical course of pregnancy, high risk pregnancies, domestic violence, pregnant women with unresolved grief or loss, and those women experiencing depression or other mental health disruptions. The curriculum also covered issues critical to the development of the early mother-child relationship. //2008//

/2009/ In an effort to ensure that we continue to employ best practices to help reduce infant mortality, the Department of Health and the Florida Association of Healthy Start Coalitions have assembled a statewide Research to Practice workgroup. The purpose of the workgroup is to review existing and ongoing research to ensure the continued effectiveness of the Healthy Start model. The workgroup will employ evidence-based practices to evaluate the Healthy Start program at the state and local levels, providing program improvements through the identification, implementation, and evaluation of best practices across the state. //2009//

Interagency coordination continues to be further enhanced by TEAM Florida. TEAM Florida was created in 1994 to address the coordination needed to implement the Family Preservation and Support Services Act. TEAM Florida members include individuals from the Department of Children and Families, the Department of Health, the Department of Education, the Department of Juvenile Justice, the Agency for Health Care Administration, the Department of Labor, and the

Department of Community Affairs. Additional TEAM Florida members represent Healthy Families Florida, United Way of Florida's Success by Six, the state association for the prevention of child abuse and neglect, and Healthy Start coalitions.

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 28 community health centers in Florida and 128 clinic locations, though not every clinic provides a full-range of services. Centers are located in 35 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.

/2007/ The Department of Health includes programs that address many of the leading causes of death for women including the Heart Disease and Stroke Prevention Program, the Comprehensive Cancer Control Program, the Breast and Cervical Cancer Program, and the Diabetes Prevention and Control Program. //2007//

/2007/ The Heart Disease and Stroke Prevention Program (HDSPP) was developed to prevent and reduce the burden of cardiovascular disease in Florida. This program's priority strategies focus on controlling high blood pressure and cholesterol, recognizing signs and symptoms of heart attack and stroke, the importance of calling 911 in an emergency, improving emergency response, improving quality of care, and eliminating health disparities between population groups. The HDSPP provides support and staff for the Florida Cardiovascular Health Council (FCHC) and brings together diverse public and private organizations to coordinate resources and collaborate to improve the overall cardiovascular health in Florida. The program provides technical assistance and contract management to 12 Chronic Disease Health Promotion and Education (CDHPE) projects and eight cardiovascular Closing the Gap projects. Program activities are implemented at both the community and statewide level. This program is funded by the Centers for Disease Control and Prevention (CDC). //2007//

/2007/ The Florida Comprehensive Cancer Control Program (CCC) works to reduce the burden of cancer in Florida on individuals, families, and communities by improving communication, coordination, and collaboration among public and private organizations at local, regional, and state levels. The CCC Program serves as the convener to the Florida Cancer Plan Council, which is comprised of statewide representatives who assist with the implementation of the Florida Cancer Plan 2003-2006. This program is also funded by the CDC. //2007//

/2007/ To address breast and cervical cancer disparities, the Breast and Cervical Cancer Program (BCCP) provides free or low-cost screening tests (Pap smears, clinical breast exams, and mammograms) and some diagnostic tests to uninsured/underinsured women. Eligibility includes women between the ages of 50 and 64 years of age, who are at or below 200 percent of the federal poverty level. Funds for treatment for women screened through the Florida BCCP are available through the state and federally funded Breast and Cervical Cancer Treatment Act (treatment monies are available through the Agency for Health Care Administration). The Florida

Breast and Cervical Cancer Program is also funded through CDC. //2007//

/2008/ The department awarded 16 grants to community-based organizations and county health departments for innovative demonstration projects aimed to improve breast cancer awareness, mammography utilization, and coordination of breast cancer treatment services. Projects target women ages 40-49 as well as racial and ethnic minorities affected disproportionately by breast cancer. //2008//

/2007/ The Diabetes Prevention and Control Program (DPCP) was created to reduce the burden of diabetes and the health-related complications of Floridians with diabetes by improving the access to, and quality of, diabetes care. This program has implemented strategies for increasing patient advocacy, promoted medical practice guidelines to improve healthcare standards, implemented awareness campaigns with statewide partners, and provided technical assistance to all county health departments on diabetes issues. The program administers the Insulin Distribution Program, and manages contracts for the Alpha One Project, the Diabetes Research Institute Foundation, and eight diabetes-related Closing the Gap grants. //2007//

/2007/ A statewide grassroots partnership, the Florida Alliance for Diabetes Prevention and Care, assists the DPCP in facilitating health-system improvement activities. The Diabetes Advisory Council develops recommendations to the DPCP, the Department of Health Secretary, and the Governor of Florida on statewide issues affecting individuals with diabetes. The program implements the CDC National Diabetes Education Program for increasing diabetes prevention activities, awareness of the disease, and the long-term benefits of disease management. This program is also funded through The Centers for Disease Control and Prevention (CDC). //2007//

/2007/ The Florida Department of Health is conducting a study of the logistics, costs, and policy concerns involved in implementing a teledentistry program in DOH facilities to further promote oral healthcare. Teledentistry could provide isolated populations with examination, consultation, and referral services for both basic and specialized oral healthcare. Moreover, teledentistry could allow a remote-based dental hygienist to perform educational services, cleanings, apply fluoride varnish treatments, and possibly place sealants without a dentist needing to be physically present. The main goal of the project is to improve access to oral health care services for isolated populations (e.g. rural populations, homebound or institutionalized populations, etc.), thus, extending the reach of the department's workforce by taking the workforce into the community, rather than have the community come to the facilities. //2007//

/2009/ The Florida Department of Health Public Health Dental Program is coordinating a teledentistry program in two counties - Nassau and Wakulla counties. The intent of the Florida DOH Teledentistry program is to extend the department's reach as an oral health safety-net provider for disadvantaged and isolated populations. The Nassau County teledentistry pilot program, which became operational in September 2007, has a fixed remote-site that will link via live two-way interactive videoconferencing to their fixed facility. The Wakulla County teledentistry program will utilize a mobile dental van, which became operational in April 2008, as a remote site that will link back to a fixed facility. //2009//

/2007/ Florida utilizes funding from HRSA through the State Systems Development Initiative Grant Program (SSDI) to enhance and improve statewide data capacity. Over the last three years, 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, the new Office of Surveillance, Evaluation and Epidemiology, and other

departmental efforts 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. //2007//

F. Health Systems Capacity Indicators

Introduction

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 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	62.9	54.9	40.9	37.1	32.3
Numerator	6417	5789	5307	4910	4344
Denominator	1019790	1054829	1298296	1323696	1343980
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 rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -- 493.9) per 10,000 children less than five years of age is calculated with inpatient hospital discharge data from the Florida Agency for Health Care Administration (AHCA) and population data for children 0 -- 5 from Florida Community Health Assessment Resource Tool Set (CHARTS) - <http://www.floridacharts.com/charts/PopQuery.aspx>.

There were a number of efforts in FY 2007 to reduce early childhood asthma included: The Healthy Start program assesses pregnant and parenting mothers for issues related to household indoor air quality, such as use of tobacco products, appropriate removal of dust and animal dander, and other allergens. Additionally, the Infant, Maternal, and Reproductive Health Unit works to reduce the prenatal smoking rate that includes education to pregnant mothers on the relationship between secondhand smoke sudden infant death syndrome, lung problems, ear infections, and more severe asthma. Mothers or their infants and children are referred for medical specialty care if asthma is suspected.

The Department of Health, Division of Environmental Health inspects daycare and pre-kindergarten facilities. The state asthma data workgroup tracks the relationships between environmental asthma triggers and rates of asthma hospitalization and student asthma. The rate of hospital discharges per 10,000 among children 0 to 5 years decreased from 37.1 in 2006 to 32.3 in 2007. Although the above activities may have contributed to this decrease, the increased availability of new and effective asthma treatments for use in young children may have contributed substantially.

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 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	80.2	81.7	81.7	100.0	
Numerator	123780	137071	143510	139614	
Denominator	154276	167705	175700	139614	
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 - 2007

Data for 2007 are not yet available.

Notes - 2006

For 2006, the actual number for this indicator is 107.8 percent and the actual numerator is 150,503, as reported by AHCA. The reason for the >100 percent participation ratio is due the fact that the # of eligible were based on their age as of 09/30/06. But, they count the eligible who had a CHCUP based on their age at the time of the CHCUP.

Notes - 2005

FY2005 data for indicator and denominator are estimated. Actual number of Medicaid enrollees is an estimate, derived by using actual number of infants screened and assuming rate stayed the same as last year.

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 ensures the public understands families may apply for and have their eligible children enrolled in Medicaid at any time. In addition, the Robert Wood Johnson Foundation Covering Kids Coalition is working to ensure that all eligible low-income children apply for Medicaid coverage through KidCare through collaboration with community, regional, and state organizations and 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 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0.0	0.0	0.0	62.4	67.3
Numerator	0	0	0	965	1189
Denominator	1	1	1	1546	1768
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
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Notes - 2006

In Florida, infants whose family income is <200% of poverty are eligible for Medicaid, so data on all infants are included in HSCI#02.

Notes - 2005

In Florida, infants whose family income is <200% of poverty are eligible for Medicaid, so data on all infants are included in HSCI#02.

Narrative:

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

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	72.3	63.6	72.8	72.0	70.2
Numerator	153538	138579	143758	151987	149916
Denominator	212243	218045	197525	211215	213490
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 - 2005

Starting in 2004, trimester prenatal care began is calculated as the time elapsed from the date of the last menstrual period to the date of the first prenatal care visit. Prior to 2004, these data were obtained by direct question that noted the trimester the mother began prenatal care. Consequently, these data are not comparable to data from prior years.

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 worked through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	94.1	99.9	90.8	97.2	80.7
Numerator	1495721	1582969	1577873	1415867	1121499
Denominator	1589640	1583850	1737630	1456033	1390019
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 Florida KidCare partners continue to work with community-based organizations, health care providers, and others to ensure people understand the Medicaid program availability. The 2005 Florida Legislature approved continuous open enrollment for the Florida KidCare program; and although Medicaid eligible children always had access to coverage at any time during the year, the Title XXI eligible children currently have year-round access as well. In addition, the Robert Wood Johnson Foundation funded Covering Kids and Families project 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 enabling services are targeted towards providing easy-to-understand, accurate information about the programs, and preventing loss of coverage among eligible children in the state.

The CMS program will ensure that families with Medicaid-eligible children with special health care needs are aware of the benefits of choosing the CMS Network as their child's health care provider. CMS arranged with the Department of Children and Families to include special needs questions in the initial Medicaid eligibility determination process and for eligibility redetermination. The goal is to identify early Medicaid-eligible children with special health care needs to inform their families about the CMS Network and the specialized health benefits it offers. If Medicaid eligible children with special health care needs are identified early and select the CMS Network before being subject to mandatory assignment, it can prevent breaks in continuity of care and ensure the children are enrolled in a coordinated system of care that uses pediatric providers and specialists.

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 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	29.2	33.0	42.5	38.3	36.6

Numerator	89409	102116	103907	98114	94167
Denominator	305762	309420	244304	256216	257000
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 - 2005

A significant increase is noted in the percentage of those receiving dental services in FY 2005. This increase is due to a notable decrease in the number of EPSDT eligible children aged six through nine years of age. That number though is questionable although the data were received from Medicaid's fiscal agent. The Public Health Dental Program is asking for verification of those numbers from the Medicaid Program's data section. Therefore, until we are certain we have accurate data the number of EPSDT eligible children, the data for FY 2005 remains provisional.

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. Currently the capacity is increasing around 10 percent yearly. The majority of the persons served through our programs are Medicaid-enrolled children. A state oral health improvement plan for disadvantaged persons has been finalized through broad-based input to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors. A major strategy of the plan is to address improvements in the Medicaid program to improve utilization. The state plan development has been facilitated through the HRSA MCH-B Oral Health Collaborative Systems grant.

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 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	21.8	15.9	16.3	10.4	11.2
Numerator	15740	11605	11940	7745	8390
Denominator	72137	72822	73181	74488	74846
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:

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 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	matching data files	9.7	7.7	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 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2005	matching data files	7.5	4.7	6.8

Notes - 2009

Infant Mortality Rate (IMR) as reported in the Florida Medicaid Maternal and Child Health Status Indicators Report 2002-2006 is the number of infants per 1,000 live births who die within one year of birth. This method provides an estimate of mortality risk for the 2006 birth cohort in which individuals may die during 2006 or 2007. This IMR differs from that reported by the Florida Department of Health (DOH) because DOH refers to all deaths occurring within a calendar year to children under one year of age regardless of the year the child was born. Also, the Indicators Report uses preliminary vital statistics data, whereas DOH uses a final dataset.

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	YEAR	DATA SOURCE	POPULATION
---------------	------	-------------	------------

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	59.7	80.8	69.6

Notes - 2009

First trimester entry into prenatal care is a combination of new and old birth certificate elements. Only 1% of values were missing from the old birth certificate, while 11.8% of values were missing from the new birth certificate in 2004. Similarly in 2005, 11.0% of values were missing and 9.3% of values were missing in 2006. These missing values are partially responsible for the decrease in the rate of first trimester entry into prenatal care. Furthermore, total deliveries is usually the denominator used for each Indicator table. However, total deliveries includes women whose date of entry into prenatal care was not known. Since calculation of first trimester entry into prenatal care was calculated starting in year 2004 using information only on women for whom entry into prenatal care was known, total deliveries is not an appropriate denominator for this Indicator. The denominator for first trimester entry into prenatal care deletes 20,888 women from total deliveries in 2004, 24,308 women from total deliveries in 2005, and 21,665 women from total deliveries in 2006 for whom data on first trimester entry into prenatal care was unknown.

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])	2006	matching data files	56.1	72.9	64

Notes - 2009

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)	2007	200
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)	2007	

Notes - 2009

In Florida, Medicaid covers infants up to 200 percent of poverty.

Narrative:

Infants 0-1 whose family income is 200 percent of the Federal Poverty level and below are covered by 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)	2007	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)	2007	200 200

Narrative:

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

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	2007	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	2003	

Notes - 2009

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

Narrative:

Pregnant women whose family income is 185 percent of the Federal Poverty level and below are covered by 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)
<u>ANNUAL DATA LINKAGES</u> 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
<u>REGISTRIES AND SURVEYS</u> 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 - 2009

Direct access to deidentified data with eligibility flag.

Direct access to deidentified data.

Direct access to deidentified data with eligibility flag.

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 Office of Planning, Evaluation, and Data Analysis; the University of South Florida Lawton and Rhea Chiles Center for Healthy Mothers and Healthy Babies; and the University of Florida's Maternal Child Health and Education Research and Data Center (MCHERDC). The actual linkage is completed by the MCHERDC and provides the information on Medicaid participation identified above. The project produces annually a Medicaid MCH Indicator Report. The University of Florida is also using this and other data to evaluate Florida's 1915(B) Healthy Start Medicaid Waiver.

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

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

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

Birth Defects Registry: SSDI staff continues to work closely with Birth Defects Registry staff to develop further data linking and utilization strategies. Increased awareness of Birth Defects Registry availability and access was achieved through convening a meeting of local and regional public health leaders, lead by SSDI staff. Plans are underway to develop a birth defects research data files that will allow this data to be more readily analyzed by internal and external partners including SSDI staff.

Pregnancy Risk Assessment Monitoring System (PRAMS): Access to this dataset is available to SSDI staff, including PRAMS files merged with birth files for the years 2000-2005. During the reporting period, SSDI staff worked in collaboration with PRAMS staff to identify new collaborative projects, and to secure the deposit of PRAMS data into the newly created data linkage library.

Youth Risk Behavior Survey (YRBS): Staff continues to work in collaboration with the School Health program and Department of Education to facilitate access to state specific YRBS data.

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 - 2009

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. We can access the results of the surveys, but the MCH program does not have direct access to the survey databases for analysis.

IV. Priorities, Performance and Program Activities

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 10 state priorities for Florida.

1. Improve preconceptional and interconceptional health and well-being.
2. Decrease racial disparities in maternal and child health outcomes.
3. Increase access to health care for the maternal and child health population, including children with special health care needs.
4. Decrease maternal, infant, and child morbidity.
5. Decrease maternal, infant, and child mortality.
6. Decrease risk factors associated with poor maternal and child health outcomes.
7. Decrease teen pregnancy.
8. Ensure consumer-friendly, culturally competent systems of care.
9. Increase statewide and local data and analysis capacity.
10. Increase awareness of public health preparedness issues unique to the maternal and child health population, including children with special health care needs.

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	2003	2004	2005	2006	2007
Annual Performance Objective	99	100	99	100	100
Annual Indicator	99.0	99.0	99.0	100.0	100.0
Numerator	208917	215864	222763	646	1181
Denominator	211027	218045	225013	646	1181

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
	2008	2009	2010	2011	2012
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 of refusing the test, almost all babies are tested. It is estimated that less than 1 percent of parents refuse to have their newborns participate in the statewide screening program. This is a population-based service. All of the MCH population groups are served by this measure. Follow-up activities include contracts with genetic specialty centers for referral of patients with abnormal test results, and contracts with endocrine and hematology/oncology specialty centers. Specialty referral centers provide confirmatory testing and treatment to patients identified through the Florida Newborn Screening Program. Genetic counseling, follow-up and nutritional counseling activities related to treatment and dietary management are included. Educational materials are distributed to all birthing facilities regarding the five disorders that are tested in the newborn metabolic screening.

In 2006, testing identified 646 babies with presumptive positive screening results. After confirmatory testing, 309 were found to have one of the 34 disorders. Of the 309 confirmed cases, all of them received timely follow-up and treatment. Data for 2007 is not yet available.

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

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. Specialty referral centers provide confirmatory testing and treatment to patients identified through the screening program. Genetic counseling, follow-up and nutritional counseling activities (treatment and dietary management) are included.			X	
5. Educational materials are distributed to all birthing facilities			X	

regarding the 34 disorders that are tested in the newborn metabolic screening.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Florida Newborn Screening Program expanded the number of disorders screened to 34. Beginning on January 9, 2006, all babies born in Florida were screened for 28 of the 29 disorders recommended by the American College of Medical Genetics plus five more recommended by the 2002 Florida Infant Screening Task Force. Florida began screening for cystic fibrosis on September 17, 2007. Entities that submit specimens for testing are responsible for forwarding the lab results to the newborn's primary care physician to ensure that the medical home is informed of the results. Beginning December 2005, hearing screening results are included on the lab report. All newborns identified through the Newborn Screening Program are medically eligible for the Children's Medical Services Network Program. These are population-based services.

c. Plan for the Coming Year

There are plans to begin screening for cystic fibrosis on July 1, 2007. Florida is currently developing a Web-based Internet program for physicians to access for newborn screening results. The website will also provide other important information for physicians and other health care providers who care for newborns. There are currently two hospitals testing electronic birth certificate software that will eventually link with the newborn screening program for auto-population of the specimen card information that will provide more accurate demographic information and linking subsequent specimens received. CMS will continue to contract with specialty centers for appropriate referrals; provide genetic counseling, follow-up and nutritional counseling activities; and continue distributing educational materials to all birthing facilities.

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	2003	2004	2005	2006	2007
Annual Performance Objective	47	49	51	53	55
Annual Indicator	45.4	45.4	45.4	50.2	50.2
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	52	54	56	58	60

Notes - 2007

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

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

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

A. % Families reporting satisfaction with the quality of primary care, obtaining referrals, needed services, and coordination among providers.

B. % Title XXI families reporting satisfaction with the quality of primary care, obtaining referrals, needed services, and coordination among providers.

C. % Complaints and grievances (# complaints/#eligible clients within the quarter).

D. % Families reporting satisfaction with CMS Area Office operations and staff (# positive response surveys/# surveys completed within the quarter).

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

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

In state fiscal year 2006-2007, the perception of quality care was 86.1 percent statewide from parents of CMS enrollees.

Satisfaction surveys for parents of children enrolled in CMS Programs were conducted through a CMS contract with the Institute for Child Health Policy (ICHP), University of Florida. Surveys conducted for the 2006-2007 fiscal year indicated that 95 percent of parents responded that they were satisfied with CMSN benefits. About three-fourths of parents indicated that their nurse care coordinator is available and helpful.

The CMS Network (CMSN) continued to contract with the Florida Resource Coalition, Inc. (FRC) for family-centered care. CMS families were included in the development of policy, training, and in-service education, an enabling service activity. The FRC subcontracted the family involvement, family centered care quality assurance, and liaison responsibilities to Family Health Partners (FHPs). FHPs worked with the families of children enrolled in CMS to understand relevant issues, available resources, resolve conflicts, navigate the system of care, and worked in partnership with CMS staff and providers to ensure a family-centered environment in all CMS area offices.

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-		X		

service education.				
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

ICHHP 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 CMSN.

In addition, CMS continues to collect data from each of the 22 area offices for this and the other five national performance measures.

The Florida Resource Coalition, Inc. (FRC) has developed a PowerPoint presentation on the topic of family-centered care and each Family Health Partner will provide a presentation to the 22 CMS Area Offices during the third quarter of this fiscal year to elicit dialogue on what is working and what CMS staff can do to improve the family-centered care it provides.

c. Plan for the Coming Year

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

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

CMS will renew its three-year contract to ensure family centered care and family-to-family support. The current contract with the FRC is scheduled to end June 30, 2008. CMS will work with the FRC to include a follow-up survey to the cultural and linguistic competency survey and presentation from last fiscal year.

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	2003	2004	2005	2006	2007
Annual Performance Objective	47	49	51	53	55
Annual Indicator	46.8	46.8	39.5	41.9	41.9
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	45	47	49	51	53

Notes - 2007

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

In partnership with a statewide task force, the Florida Institute for Family Involvement (FIFI) is developing a set of technical assistance and resource materials that communities can use to guide the development of local CSHCN-systems of care. FIFI has forged a partnership with MCHB-funded National Resources Centers, secured the services of four nationally recognized experts, and formed a task force comprised of individuals with expertise in the medical home and family-professional partnerships. These consultants, along with members of the task force and the staff of FIFI, will provide ongoing consultation and support to four implementation communities.

CMS has been allocated \$300,000 in MCH block grant funds to improve Medical Home Spread in Florida. The statewide Medical Home Workgroup decided to offer each of the CMS Primary Care programs a \$25,000 mini-grant to support their efforts in at least two of the Medical Home components. The statewide Medical Home Workgroup has allowed Primary Care sites to use mini-grant funds to send local pediatricians, resident, nurses, social workers, and interested families to the AAP Medical Home Conference in Orlando.

Data collection from each of the CMS 22 area offices for the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs is ongoing. Over time, as these reports are analyzed, CMS will be able to better identify strengths and challenges of meeting this and other national performance measures. Using the new measurement system, CMS area offices continue to gather data and compile reports that identify children at risk for and with special health care needs, utilize quality of care measures, and track health expenditures and costs of services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Demonstrate the importance of a medical home to the health and well being of children with special health care needs through data collection, satisfaction surveys, and performance measures.				X
2. Support initiatives in telehealth, and other innovative delivery				X

systems, that are built on the CMS medical home.				
3. Identify potential or approved providers that serve CMS children with special health care needs and their families.			X	
4. Assist families to understand the uses of telehealth.		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

CMS continues to strive for excellence in its Medical Home Spread with continued education and oversight of current medical homes through a variety of strategies in Florida's communities. CMS is collaborating with many community-based programs to provide a mult-level strategy for implementing the Medical Home concept. These strategies include the following areas: the CMS area offices, CMS Primary Care Programs, and collaborations within other state agencies.

CMS area offices strategies include: a research project working together with the University of Florida and the Duval County Health Department; presenting at different county health departments, conferences, and universities; and issuing public information fact sheets on the medical home concept.

CMS Primary Care Programs have initiated home visits for Medical Home clients, expansion of research into private practices, and have placed CMS Care Coordinators in Federally Qualified Health Centers.

Collaborations with other State agencies and the community partners include: working with the Early Childhood Comprehensive System for developmental screening initiative to be fully implemented in fiscal year 2007-2008, a newborn screenings grant with NICHQ, and with Healthy Start for a developmental and maternal depression screening initiative to be fully implemented in 2007-2008.

c. Plan for the Coming Year

At this time all of the "Medical Homeness" that exists within CMS has not been specifically identified as Medical Home, however many projects and programs have many elements of the medical home model. In an effort to unify and standardize the term Medical Home and what it means to CMS and CMS families, the following activities are planned for the next year:

- CMS Organizational Assessment: Determine the functions necessary to operate an effective managed system of care, analyze current functions and recommend staffing changes, and develop a comprehensive training program.
- Care Coordination: Revise care coordination guidelines and develop disease management guidelines and duties as well as any associated forms. Develop Web-based training modules and evaluation criteria for care coordination and disease management.
- Contracts and Monitoring: Continue the assessment of contract language and make corrections that will improve the accountability of the contract process. Review current monitoring and quality improvement functions and identify areas that are business critical which require monitoring. Develop an accountable and comprehensive administrative claiming process and a comprehensive system of payment accuracy review for the CMS regions.
- Decision Support and Information Technology: Develop a comprehensive information system and determine the critical decision support functions and reports.
- Communications: Develop comprehensive communication system/methods that provides

for optimal exchange of information between central office, regions, and contractors.

- Outreach: Develop and implement a comprehensive outreach plan and educational materials to include in age appropriate enrollment packets.
- Eligibility Process: Refine the clinical eligibility process for CMS and complete the NICA process authorized in law.
- Medical Services: Improve our clinical services through the development of clinic standards, the development of medical homes throughout the state, newborn screening expansion, and enhancement of the Early Steps Program.

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 Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	47	49	55	59	93
Annual Indicator	54.4	54.4	58	58	58
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	62	64	66	68	70

Notes - 2007

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

2005 data source: HRSA National Survey of Children with Special Health Care Needs-2004.

a. Last Year's Accomplishments

As of September 2007, the Children's Medical Services (CMS) Network for children with special health care needs provided coverage to 41,148 Title XIX-funded children and 13,537 Title XXI-funded children. In addition, 7,465 children received "Safety Net" services, state-funded services designed to provide limited wraparound services to children ineligible for Title XIX or Title XXI coverage, or whose private health insurance coverage is insufficient to meet the child's needs. These numbers are unduplicated for the Federal Fiscal Year ending September 30, 2007.

Adequate coverage and access to services for special needs children is a major goal for CMS. As part of performance improvement and measurement initiative, the CMS program developed measures to identify and document unmet need. The measures were piloted in mid-2004 with statewide implementation delayed until December 2004 due to several hurricanes that hit Florida that year. Much of calendar year 2005 was spent providing technical assistance to the 22 CMS area offices on how to efficiently and accurately capture the data.

The 2008 Florida Health Insurance Study reports approximately 548,000 uninsured children. It is estimated that about 72 percent of Florida's uninsured children are eligible for Florida KidCare coverage and of these, about 3 percent may have a special health care need that would qualify them for the CMS Network.

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 statutorily created Florida KidCare Coordinating Council, section 409.818(2)(b), Florida Statutes, includes a diverse membership that makes recommendations to the Governor and the Legislature to improve the implementation and operation of the Florida KidCare program. Some of the council recommendations from the January 2008 report include: restore and fund Florida KidCare community outreach and marketing, and fully fund the Florida KidCare Program.

The 2007 Florida Legislature allocated \$1 million in non-recurring tobacco funds to the Florida Healthy Kids Corporation for a Florida KidCare community based marketing and outreach matching grants program. In addition, the Legislature provided an increase in Title XXI funding for Florida KidCare to provide coverage to approximately 257,350 children.

c. Plan for the Coming Year

Governor Crist continues to prioritize the welfare of Florida's children, and state legislators have introduced several pieces of proposed legislation aimed at further streamlining and simplifying the Florida KidCare program. The changes set forth in the bills, if passed, would take effect on July 1, 2008. Children's Medical Services is monitoring these bills closely and will address the results in next year's report.

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	2003	2004	2005	2006	2007
Annual Performance Objective	67	69	71	73	75
Annual Indicator	69.4	69.4	69.4	85.9	85.9
Numerator					
Denominator					

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
	2008	2009	2010	2011	2012
Annual Performance Objective	87	88	89	90	91

Notes - 2007

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The Family Resource Coalition, Inc. (FRC) contracts with the CMSN to provide family-centered care and family involvement with a Family Health Partner (FHPs) in each CMS area office providing information, resources, and contact for families of CYSHCN. The FRC worked with the Georgetown University's National Center on Cultural Competence to identify educational tools for CMS staff and FHPs will provide training, using those tools, to CMS staff statewide in late spring of 2007. The FRC conducted a statewide educational conference in March 2007 to bring families, CYSHCN, and professionals together to learn about relevant issues. Evaluations indicated that all attendees thought it was a very positive and useful conference.

The University of Florida's Florida Initiative for Telemedicine and Education (FITE) Diabetes Project, under contract with CMSN, provided telemedicine clinics for children and youth with diabetes enrolled in the Daytona Beach CMS Area Office with a University of Florida endocrinologist. CMS telemedicine pilots included nutritional, orthopedic, neurology, dermatology, and genetic consults.

The Family Resource Coalition, Inc. (FRC) conducted a Cultural and Linguistic Competence survey with all CMS staff statewide, based on a survey that was revised by CMS and the Georgetown University's National Center on Cultural Competence. The FRC used the results to develop training for all CMS staff on cultural and linguistic competence.

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			X	

families of children at risk for and with special health care needs in effective partnerships.				
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

CMS and the Agency for Health Care Administration received a Medicaid Waiver that allows Medicaid reimbursement to specialty physicians with CMS telemedicine pilot projects for telemedicine services.

The CMS goals include the six key systems outcomes of the Maternal and Child Health Bureau, Division of Services for Children with Special Health Needs. Ongoing activities that are conducted to increase the number of CMS programs are to support: caregivers and partners; children, teens, and young adults, family leadership programs; family organizations and initiatives and to promote the use of telemedicine. These activities provide direct health care, enabling, population-based, and infrastructure building services.

The fifth goal states that CMS Offices will identify culturally competent, comprehensive community-based service systems for all children and families enrolled in the CMSN programs. The two performance measures and indicators are: Measure 1: Each child enrolled in CMSN will have access to comprehensive, community-based service systems. Measure 2: Decrease the amount of time required for approval of CMS physicians.

The ICHP conducts annual satisfaction surveys from randomly selected parents of CMS enrollees. Results indicated that about 83 percent of the respondents had one person they thought of as their child's personal doctor or nurse. Eighty-six percent of respondents had a positive perception of care, based on the CMS Performance Measures Statewide Report.

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.

The FRC will continue to maintain Family Health Partners in all of the CMS area offices so that every CMS enrollee and their family will have access to family-to-family support as well as information about community resources.

CMS will continue working on developing new partnerships with the University of Florida, the University of Miami, and with University of South Florida for telehealth and telemedicine services to children with special health care needs and their families. Access to services, especially for subspecialties, remains a challenge for many areas of Florida.

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	2003	2004	2005	2006	2007
Annual Performance Objective			8	10	12
Annual Indicator	5.8	5.8	5.8	33.8	33.8
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	34	36	38	40	42

Notes - 2007

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

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

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

Measure 2: Teens and young adults will receive transition services that are age appropriate CMS Network Care Coordinators coordinated and facilitated transition activities, an enabling service. CMS tracked the successful completion of transition activities for each enrollee through the electronic Child Assessment Plan (CAP) with quarterly data. In fiscal year 2006-2007 the statewide average for the CMS Performance Measure 1 was 40.4 percent and the statewide average for CMS Performance Measure 2 was 30.4 percent.

Planning for the eventual transition of all teens and young adults with special health care needs to adult services, and coordinating and facilitating transition activities with each teen, were examples of enabling services provided to increase the percentage of teens ready to transition to adulthood. CMS maintained transition materials and resources, in English and Spanish, on the CMS website and participated in collaborative partnerships with community organizations and state agencies to support the federal New Freedom Initiative and the Healthy and Ready to Work Transition services and systems. The primary population served was adolescents and young adults with special health care needs. A new transition guide for middle school students was developed under contract with the Institute for Child Health Policy (IHP) and is available both as hard copy

and on the CMS transition website.

The web-based educational continuing education in-service modules, developed by ICHP, about youth health care transition continued to be available to CMS staff.

A CMS Network representative attended meetings of local and state workgroups, consisting of young adults, state agency professionals (including Exceptional Student Education and Vocational Rehabilitation), and other stakeholders to discuss youth transition issues and challenges. CMS continued its participation on the Interagency Services Committee for Youth and Young Adults with Disabilities. This committee was legislatively mandated to provide a multi-agency approach to improve outcomes for youth and young adults with disabilities in all aspects of their life as they transition to adulthood and produced recommendations for the governor to achieve those outcomes.

The Jacksonville Health and Transition Services (JaxHATS) program began its third contract year with CMS to provide health and related transition services in a five county area in northeast Florida to youth and young adults age 14 to 25 with special health care needs and disabilities. The program assisted with health care transition referrals to adult physicians, both primary care and specialists, and worked with other agencies, organizations, and post-secondary schools for successful youth transition to adult life.

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 Initiative and the Healthy and Ready to Work Transition services and systems.			X	
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 analyses from each CMS area office for CMS Goals/Performance Measures on youth transition.				X
7.				
8.				
9.				
10.				

b. Current Activities

CMS maintains the Youth Transition link on the CMS website, an infrastructure building service for youth with special health care needs and their families. CMS participates in collaborative partnerships with community organizations and state agencies. CMS care coordinators from the statewide area offices continue to work within their communities on transition panels and committees to ensure that health is included in planning for successful youth and young adult transition.

The CMS Statewide Transition Champion collaborates with other state agencies to facilitate and promote health care in adolescent/young adult transition activities. She serves on a National Workgroup on Transition and gave a presentation on CMS transition activities on a Healthy and

Ready to Work national conference call.

The Family Resource Coalition, Inc. (FRC), under contract with CMS, continues to supervise the CMS Young Adult Advisory Group. There are nine members who are CMS enrollees between ages 12 to 21. They participate in quarterly conference calls and the focus on these calls has been to help develop their leadership skills.

c. Plan for the Coming Year

CMS will continue to partner with Florida state agencies, including: the Department of Education, the Division of Vocational Rehabilitation; the Florida Developmental Disabilities Council, the Agency for Persons with Disabilities; the Department of Children and Families, Mental Health; and other Florida stakeholders, the University of Florida, the University of Miami Mailman Center for Child Development, and the University of South Florida's School of Medicine to ensure that health is included in every agenda that is developed for youth transition.

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	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	90	90	90
Annual Indicator	79.4	85.3	86.6	82.8	84.8
Numerator	163405	175360	183802	180541	191834
Denominator	205800	205580	212243	218045	226219
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
	2008	2009	2010	2011	2012
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 not fully implemented with all private health care providers and the partnership with WIC not fully implemented for 2007/08 in all county health departments.

During CY 2007, 84.8 percent of 2-year-olds received four diphtheria, tetanus, pertussis; three polio; and one measles, mumps, rubella, three Haemophilus Influenza B, and three hepatitis B immunizations. Florida SHOTS (statewide immunization registry) is functional in all 67 county

health departments, for over 2,000 healthcare providers and includes over 50 data upload partners that uploaded 10 million records in 2007. 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 2008, we continue activities to meet the goal of 90 percent of all 2-year-old children who are appropriately immunized with the complete series of four diphtheria, tetanus, pertussis; three polio; and one measles, mumps, rubella, three Haemophilus Influenza B, three hepatitis B, and one varicella/chickenpox (4-3-1-3-3-1). Achievement of this goal includes the addition of varicella vaccine to the measured immunization series. Other activities include parent education; involvement of Healthy Start, immunization coalitions, and community partnerships; linkage with WIC, CMS and managed care organizations; identification of pockets of need for under-immunization; tracking immunizations in the health department; implementation of recall systems; public and private provider site reviews to assess coverage levels and promote the Standards of Pediatric Immunization Practices; increased enrollment of the registry in the private sector; continued implementation of the Vaccines for Children Program; and a statewide initiative to improve collaboration with stakeholders/partners to increase coverage levels in the target population. We are increasing the emphasis on immunizations with all stakeholders with an ultimate goal of surpassing 90 percent immunization coverage by 2010. County health departments have developed immunization plans to raise immunization rates in their area. They work with WIC, local medical societies, CMS, and others to develop then implement their plans.

c. Plan for the Coming Year

Our objective for CY 2009 is that 90 percent of 2-year-olds receive age-appropriate immunizations. Outreach, promotion, and surveillance of rates will be utilized to support efforts in the private sector. The department will continue to coordinate with Healthy Start coalitions to increase parent education about the importance of childhood immunizations and encourage local community partnerships. We will continue to recommend that all health care providers implement the Standards for Pediatric Immunization Practices, and continue expansion of the registry (Florida Shots) in the private sector (infrastructure-building activities). The department will continue an active partnership with coalitions and service agencies. We will continue to implement the missed opportunities policy for public and private health care providers (population-based) and continue the WIC and CMS/Immunization linkage (enabling). We will continue to implement the statewide initiative to improve collaboration with stakeholders/partners

in order to increase coverage levels in this target population. The Bureau of Immunization manages six Racial, Ethnic and Diversity Immunization-focused grants (awarded through the Office of Minority Health) that focus on the elimination of racial and ethnic health disparities in Florida.

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	2003	2004	2005	2006	2007
Annual Performance Objective	23.2	23	22	21.5	21
Annual Indicator	22.4	21.9	21.8	23.0	22.4
Numerator	7171	7436	7590	8135	8059
Denominator	320440	339595	347795	353756	359017
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
	2008	2009	2010	2011	2012
Annual Performance Objective	20.5	20	19.5	19	18.5

a. Last Year's Accomplishments

Provisional data for 2007 indicate a birth rate of 22.4 per 1,000 for teens 15 to 17, which is higher than the annual performance objective of 21 per 1,000. Family planning, abstinence-only 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. The program served 23,427 teenagers age 15 to 17 last year.

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 Florida's 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 Abstinence Education Program is designed to promote sexual abstinence until marriage as the expected societal norm among adolescents. An underlying assumption of this program is that poor health outcome, low educational attainment, and poverty are intricately linked to early childbearing. The Section 510 Title V Abstinence Education Program supported 54 public and private organizations that served youth age 9 to 18. Abstinence-only education projects provided services to 49 cities and 18 counties in Florida. Local projects served 10,459 teenagers 15 to 17 FY2007.

Along with services, the Abstinence Education Program, as part of the It's Great to Wait marketing and media campaign, sponsored a number of community outreach activities designed to increase public awareness about abstinence as the only 100 percent effective way to avoid teen pregnancy and sexually transmitted diseases. The media campaign consisted of

enhancement of the interactive, hyper-media website at www.greattowait.com, annual youth rallies, parent workshops, and educator training classes held in major cities across the state, as well as radio, television and print advertisement.

During FY2007 school year, 46 of the 67 county health departments operated 335 Comprehensive School Health Services Projects in schools, serving 252,436 students in high-risk communities with high teen birth rates. These schools are designed to reduce predisposing risk factors associated with school failure, teen births, welfare dependency, violence, crime, and psychological problems. These projects provided 3,131 pregnancy prevention interventions to 3,535 students and 1,499 pregnancy prevention classes to and to 55,979 students. Aftercare and support services provided to parenting students enabled 82.67 percent of them to return to school after giving birth.

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 who give birth in Comprehensive School Health Services Projects.		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

Comprehensive family planning services are available in all 67 counties through county health departments and local contract providers. In addition to providing an array of family planning services, the department collaborates with other state agencies to provide the Medicaid Family Planning Waiver program. The waiver program is designed to reduce infant mortality, unintended pregnancies, and repeat births to teens 15 to 19 by increasing the utilization of family planning services following a pregnancy.

The Abstinence Education Program enhanced its marketing and media campaign this year with the production of print and media advertisements. These advertisements are produced in both English and Spanish. Along with providing education activities, the Abstinence Education Program continues to promote healthy families and to stress the important role of males in producing healthy families.

During FY2007, Comprehensive School Health Services Projects continue to operate in 46 counties, providing pregnancy prevention classes, case management, and aftercare services that enable parenting youth to return to school and graduate. These projects continue to coordinate activities with local county health departments' abstinence programs, school district health educators, county health department Healthy Start programs, Healthy Families Florida home visitors, school district teenage parent programs, and case managers from the Florida Department of Children and Families.

c. Plan for the Coming Year

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

Abstinence education will continue to focus on the management of locally funded projects in providing abstinence-only education. In the coming year, the marketing and media campaign will continue to target the main population centers in Florida. Plans for the coming year may be affected by the anticipated phase-out of the federal Section 510, Title V abstinence education program funding on June 30, should Congress not vote to extend funding. In addition, the program lost \$3.5 million in funding on the state level. Funds usually received from TANF and MCH Block Grant appropriations were shifted to cover budget deficits and other priorities.

The program will continue its community outreach events (youth rallies and parent workshops), which bring nationally renowned speakers to several regions across the state. Additionally, the program will continue to offer a series of abstinence educator training workshops designed to expand the number of persons in the state trained to teach abstinence-only 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	2003	2004	2005	2006	2007
Annual Performance Objective	25.2	25.4	25.6	37.5	39
Annual Indicator	27.0	34.0	37.3	37.5	33.2
Numerator	19407	24277	26504	27216	23984
Denominator	71823	71392	71092	72602	72317
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
	2008	2009	2010	2011	2012
Annual Performance Objective	34	36	38	40	42

a. Last Year's Accomplishments

The number of children receiving sealants in county health departments in 2007 is estimated to be over 33,000, a 5 percent increase from 2006. Because of issues with the department's Health Management System, county health department sealant data has to be estimated.

Presently, final 2007 data for this national indicator are not available. Until survey capabilities are developed, an estimate of the number of Medicaid-enrolled 8-year-olds that receive sealants on their permanent first molars is monitored as well as the number of children that receive sealants through county health department safety net programs. Medicaid estimates indicate a decreasing trend in the percent of Medicaid 8-year-olds that are receiving sealants on their permanent first molars. No sealant data are available from private providers in Medicaid Reform and managed care organizations. No sealant data were available from the community health centers. Thus, the 33 percent indicator may actually be underestimated.

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. Links to sites to order sealant promotional material are available on the program's Internet site. A strategy contained in the state oral health improvement plan relates to increasing the number of children receiving sealants. It is anticipated that the increased collaboration and partnerships resulting from the state oral health plan, which is facilitated by a HRSA Target Oral Health Services System grant, will enhance activities to assure more children receive sealants. We submit legislative budget requests annually to establish a statewide sealant program for third and seventh graders, and a regional-based surveillance system using the Association of State and Territorial Dental Directors' Basic Screening Survey Model. Through the department's Reducing Oral Health Disparities initiative to support county health department infrastructure expansion and contractual services, incremental progress will continue to expand sealant utilization to low-income and minority populations.

c. Plan for the Coming Year

The program will continue to promote the development of school-based sealant programs through the departmental quality improvement process and coordination with school systems. HRSA grant funding will be used to continue the process of implementing the State Oral Health Improvement Plan for Disadvantaged Persons and its recommendations and objectives. 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. As resources permit, we will continue to develop specific web-based materials to promote sealants for the Internet and for distribution as appropriate. Promotion of school-based sealant programs through the department's Reducing Oral Health Disparities initiative will continue.

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	2003	2004	2005	2006	2007
Annual Performance Objective	3.8	3.6	3.5	3.8	3.6
Annual Indicator	3.9	4.5	4.2	3.1	3.1
Numerator	125	147	142	107	106
Denominator	3206178	3269710	3352639	3403203	3440180
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
	2008	2009	2010	2011	2012
Annual Performance Objective	3	2.9	2.9	2.8	2.8

a. Last Year's Accomplishments

Activities to reduce child deaths in motor vehicle crashes include evaluation of children with special health care needs to determine the appropriate child safety seat or restraint and provision of loaner special needs seats or restraints when necessary. In addition, the Department of Health (DOH), Office of Injury Prevention, received a Florida Department of Transportation grant that funded the Florida Special Needs Occupant Protection Program. This program has seven sites located in children's hospitals in Orlando, Tampa, Miami, St. Petersburg, Gainesville, Ft. Myers, and Hollywood. The program staff evaluates children with special health care needs to determine the appropriate child safety seat or restraint, and provides loaner special needs seats or restraints when necessary. The DOH is also 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. SAFE KIDS Florida was active in child passenger safety by distributing child safety seats and launching public awareness campaigns.

During this year, DOH was able to meet its goal and staff is working to continue to reduce the rate of deaths to children, ages 14 and younger, caused by motor vehicle crashes. Activities during the reporting year included the activities listed above.

The motor vehicle crash data includes crashes that occur between automobiles and bicycles. The Office of Injury Prevention continued the Florida Bicycle Helmet Promotion Program through a Florida Department of Transportation grant. This program provided over 13,000 bicycle helmets to community partners who fit and distributed the helmets within their community. The single most effective safety device available to reduce head injury and death from bicycle crashes is a helmet. National estimates report that bicycle helmet use among child bicyclists ranges from 15 percent to 25 percent. Apart from the automobile, bicycles are tied to more childhood injuries

than any other consumer product. Helmet use reduces the risk of bicycle-related death and injury and the severity of head injury when a crash occurs. Helmet use can reduce the risk of head injury by 85 percent and severe brain injury by 88 percent. If 85 percent of all child cyclists wore helmets every time they rode bikes for one year, the lifetime medical cost savings could total between \$134 million and \$174 million. (Source -- SAFE KIDS Worldwide 2007 Fact Sheet)
 This program is designed to increase the helmet usage among children in low income households, rural counties, and in counties that experience a high incidence of bicycle-related injuries and death.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Florida Special Needs Occupant Protection Program operated in seven children's hospitals in Florida.	X			
2. Evaluation of children with special health care needs to determine the appropriate child safety seat or restraint.	X			
3. Provided loaner special needs seats or restraints when necessary.	X			
4. Purchased 172 special needs child safety seats/restraints and 50 replacement parts to be used at the seven children's hospitals.		X		
5. Through the local SAFE KIDS coalitions and state chapters, conducted numerous car seat check-up events on an ongoing basis and during National Child Passenger Safety Week, National SAFE KIDS Week, and Buckle Up America Week.			X	
6. Purchased over 13,000 bicycle helmets that were provided to community partners who fit and distributed the helmets within their community.		X		
7.				
8.				
9.				
10.				

b. Current Activities

On February 14, 2008, the Florida Department of Transportation funded the Florida Special Needs Occupant Protection Program. The staff is working to expand to an additional children's hospital. Through the local SAFE KIDS coalitions and state chapters, numerous car seat check-up events are conducted on an ongoing basis and during National Child Passenger Safety Week, National SAFE KIDS Week, and Buckle Up America Week. Staff identified 103 community partners for the Florida Bicycle Helmet Promotion Program. Over 16,500 bicycle helmets were purchased and distributed to the 103 community partners, who will fit and distribute the helmets within their community.

The Office of Injury Prevention is implementing the 2004-2008 Florida Injury Prevention Strategic Plan that will encourage evidence-based interventions to address motor vehicle injuries, a leading cause of death and injury among Florida's children. In addition, Florida is the only state in the United States who is strategically planning for and drafting its 2009-2013 Florida Injury Prevention Strategic Plan, while implementing its current plan. The Florida Injury Prevention Advisory Council and the Goal Team Leaders who are integral to the plan implementation are working on goal teams. The DOH has over 80 injury prevention liaisons from the county health departments, Children's Medical Services offices, and central office staff.

c. Plan for the Coming Year

The Office of Injury Prevention submitted a concept paper to the Florida Department of Transportation to continue the Florida Special Needs Occupant Protection Program for FY 2009. The Office of Injury Prevention intends to continue to function as the lead agency for SAFE KIDS Florida and to continue our work in the area of child passenger safety. Work will continue implementing the 2004-2008 Florida Injury Prevention Strategic Plan and planning and drafting the 2009-2013 Florida Injury Prevention Strategic Plan. A concept paper was submitted to the Florida Department of Transportation to continue the Florida Bicycle Helmet Promotion Program for FY 2009. The Office of Injury Prevention will also continue activities listed above regarding evaluation of needs, provision of child safety seats or restraints, training, and public awareness activities.

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	2003	2004	2005	2006	2007
Annual Performance Objective				31.5	35.2
Annual Indicator			31.4	35	37.5
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	38	38.5	39	39.5	40

Notes - 2007

The Department of Health does not track breastfeeding data in the general population. Prior to 2005, the Department reported Ross data (collected from the annual Infant Feeding Survey conducted by Ross Laboratories) for the percentage of mothers in Florida who were breastfeeding in the hospital. Beginning with the data for 2005, the Department began reporting Ross data for the percentage of mothers who were breastfeeding their infants at six months of age. The data source changed in 2006 when Ross Laboratories ceased to conduct their annual Infant Feeding Survey. At this time, the Department began using data provided by the Centers for Disease Control (CDC) which is obtained from the National Immunization Survey. The CDC data presents breastfeeding information according to the year of the child's birth. The data reflected in the chart above under 2007 is still information collected on children born in 2004 and obtained in interviews conducted through December 2006.

Notes - 2006

The Department of Health does not track breastfeeding data in the general population. The department has previously reported survey data from Ross Laboratories. Prior to 2005, the Department reported Ross data for the percentage of mothers in Florida who were breastfeeding in the hospital. In 2005, the Department began reporting Ross data for the percentage of mothers who were breastfeeding their infants at six months of age. However, Ross Laboratories has now ceased to conduct their Infant Feeding survey so data is no longer from this source. The Department will now begin to use indicator data provided by the CDC based on the National Immunization Survey. This data for 2005 is included. It is the latest data available.

Notes - 2005

Actual indicator data are not available. The Department of Health does not track breastfeeding data. The department uses survey data from Ross Laboratories.

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 to 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. The National Immunization Survey from CDC indicates 37.5 percent of all infants in Florida are being breastfed at six months of age. Our WIC program tracks breastfeeding rates monthly and this data helps us assess our progress in improving breastfeeding rates during the year.

During FY2007, the WIC program distributed manual breast pump kits to local WIC agencies to provide to WIC breastfeeding moms. The distribution of breastfeeding equipment and aids for WIC mothers and babies helped increase breastfeeding duration for this group, and has an even broader effect when breastfeeding WIC mothers influence their friends and relatives to also breastfeed their babies longer. The WIC program coordinated activities with Healthy Start program staff to ensure Healthy Start care coordinators offered breastfeeding information, education, and support to pregnant women in-need. One of the Department of Health's state office buildings continues to provide a "mothers' place" room for breastfeeding staff to use for pumping or nursing.

WIC continues to participate in the USDA's breastfeeding peer counselor program. The Florida WIC Program is in its fourth year of receiving a United States Department of Agriculture grant for a Breastfeeding Peer Counseling Program. Services have expanded in 15 counties to provide breastfeeding promotion and support above and beyond what the regular WIC grant could accomplish. During October 2007 to March 2008, personal interactions and group classes provided over 27,000 contacts. Unfortunately, funding from the USDA did not increase sufficiently this past fiscal year to allow for the expansion of this program to other local WIC agencies.

In August 2007, WIC and the state SIDS prevention program conducted a statewide audio conference on "Breastfeeding and Safe Sleep." The audio conference reached numerous WIC and Nutrition county health department staff and Healthy Start staff. Additionally, WIC developed new WIC check envelopes with a breastfeeding promotion message and distributed them to local WIC agencies to use with their clients. The state WIC program purchased and distributed World Breastfeeding Week kits to the local WIC agencies for use in promoting World Breastfeeding Week 2007.

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

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

breastfeeding, and enable postpartum women to overcome any perceived or actual breastfeeding problems.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distributed manual breast pumps to local WIC agencies for use by breastfeeding moms.		X		
2. Tracked “Infants Ever Breastfed” rates and “Infants Currently Breastfed” rates and the “Percentage of WIC Breastfeeding Women/Total Infants for WIC.”		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. Continued breastfeeding peer counselor programs in 15 WIC local agencies.			X	
6. Sponsored monthly telephone conference calls for peer counseling program administrators to share information and support.		X		
7. Posted all breastfeeding education materials on the web for other Florida residents to use as well as other state agencies to adopt and use. The web site is www.FloridaWIC.org .			X	
8. Posted all breastfeeding education materials on the web for other Florida residents to use as well as other state agencies to adopt and use. The web site is www.FloridaWIC.org .		X		
9.				
10.				

b. Current Activities

The program continues to provide breast pumps and breast pump kits, so more women have the equipment they need to breastfeed successfully. We continue to monitor breastfeeding rates and the percentage of women in the WIC program who breastfeed and efforts to improve data collection are ongoing. We hold monthly conference calls with WIC breastfeeding coordinators to share promotion and support activities and ideas. We also conduct monthly conference calls with the peer counseling program administrators. The WIC program will sponsor a breastfeeding training opportunity for all WIC staff who certify WIC mothers and children that will focus on increasing breastfeeding duration and exclusivity.

WIC provides breastfeeding updates as requested on the conference calls attended by county health department clinical staff, Healthy Start direct service providers, Healthy Start coalitions, and Mom Care advisors. Also, breastfeeding is one of the training topics included in the maternal and child health training provided by the Infant, Maternal, and Reproductive Health Unit.

c. Plan for the Coming Year

For FY2009, we will emphasize strategies and activities that help WIC mothers to continue breastfeeding, a population with traditionally lower breastfeeding rates. We will continue to distribute breastfeeding equipment and information as funding is available. We will continue the monthly conference calls with breastfeeding coordinators in the coming year as well as our efforts to collect breastfeeding statistics and monitor breastfeeding rates. The enhancement of currently established breastfeeding peer counselor programs with funding from the USDA grant will

continue and we may expand the breastfeeding peer counselor program if funding is available. The WIC program and the Healthy Start program will continue to coordinate their efforts to see that more women and families receive the education and support they need.

WIC and the Obesity Prevention Program will be working with the Florida Lactation Consultants Association (FLCA) to establish a statewide breastfeeding coalition.

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.

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	2003	2004	2005	2006	2007
Annual Performance Objective	99	99	99	99	99
Annual Indicator	98.0	96.6	95.1	94.3	93.3
Numerator	206806	210700	215160	223723	227005
Denominator	211027	218045	226219	237166	243350
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
	2008	2009	2010	2011	2012
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. By adding the hearing information to the metabolic specimen collection card, the program collects hearing results on all babies born in the state and sends letters to babies' physicians and the families whose babies refer on the hearing screen stressing the importance of the follow up testing. By identifying infants with hearing loss within the first 30 days of life, intervention services can be implemented that should help minimize any speech and language delays that might result. Web-based newborn hearing screening training for nurses, hearing screening technicians, audiologists, speech language pathologists, and physicians is available. A quarterly column regarding newborn hearing screening appears in the Florida Pediatric Newsletter. Technical assistance regarding universal newborn hearing screening training for hospital screening personnel began in July 2003. A symposium was offered in the fall of 2007 to share current information about newborn hearing screening with hospitals, providers and parents. The primary population served is children with special health care needs.

Birth hospitals are screening 93.3 percent of infants born in Florida for hearing loss prior to hospital discharge, which is short of the 99 percent goal. Some hospitals are not reporting all of their hearing screen results to the department. Two hospitals had broken equipment during this period and their newborns were not screened prior to discharge. Technical assistance directed towards these hospitals should improve their hearing screening program and reduce their missed rate and referral rate. Web-based newborn hearing screening training is available to birth hospitals to further educate personnel screening the hearing of newborns. Videos and brochures

are provided to parents, hospitals, and physicians regarding the importance of universal newborn hearing screening. Pediatric audiologists have enrolled as CMS Audiology Providers and provide audiological care to the newborn population. These providers work with the department to reduce lost to follow up. Three people were hired to phone parents of newborns failing hearing screening tests to facilitate their navigation of medical services and remove barriers preventing follow up care.

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.		X		
2. Providing technical assistance to all Florida birth facilities hearing screening personnel regarding newborn hearing screening.				X
3. Reporting of hearing screen results on metabolic specimen cards submitted to the state laboratory.			X	
4. Running data system reports to provide statistical information regarding births and the number of babies that refer on the hearing screen.				X
5. Decrease the lost to follow up rate to less than 25 percent.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A symposium will be offered in the fall of 2008 to share current information about newborn hearing screening with hospitals, parents and providers. A quarterly column regarding newborn hearing screening appears in the Florida Pediatric Newsletter. Web-based newborn hearing screening training for nurses, hearing screening technicians, audiologists, speech language pathologists, and physicians is available. Technical assistance for hospital hearing screening personnel is available. Pediatric audiologists will continue to enroll as CMS Audiology Providers and provide audiological care to the newborn population. These providers work with the department to reduce the number of people lost to follow-up. The three people hired to phone parents of newborns failing hearing screening tests continue to facilitate their navigation of medical services and remove barriers preventing follow-up care. The primary population served is children with special health care needs.

c. Plan for the Coming Year

A symposium will be offered in the fall of 2009 to share current information about newborn hearing screening with hospitals, parents and providers. A quarterly column regarding newborn hearing screening will continue to appear in the Florida Pediatric Newsletter. Educational programs will be developed as needed for hospital screeners, physicians, and parents. Technical assistance for hospital hearing screening personnel will be provided. A family support personnel network is being established that will contact families whose babies refer on the newborn hearing screen, stress the importance of the attending hearing appointments, and provide support when children are diagnosed with hearing loss.

Pediatric audiologists will continue to enroll as CMS Audiology Providers and provide audiological

care to the newborn population. These providers will work with the department to reduce lost to follow-up. Four people will continue to phone parents of newborns failing hearing screening tests to facilitate their navigation of medical services and remove barriers preventing follow-up care. The primary population to be served is children with special health care needs.

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	2003	2004	2005	2006	2007
Annual Performance Objective	15	15	15	11.2	13.5
Annual Indicator	15.7	12.1	11.3	14.0	13.6
Numerator	645741	532000	504000	570343	548000
Denominator	4113000	4396354	4476152	4073879	4015955
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
	2008	2009	2010	2011	2012
Annual Performance Objective	13.2	13	12.8	12.6	12.4

Notes - 2006

2006 Data Source: US Census 2005 Estimates

a. Last Year's Accomplishments

The Department of Health (DOH) continued to work throughout the year with the Covering Kids Coalition at the University of South Florida (USF), the Agency for Health Care Administration (AHCA), Department of Children and Families (DCF), Florida Healthy Kids Corporation, and a variety of public and private organizations to provide them with Florida KidCare materials.

The KidCare partner agencies started a major outreach initiative at the direction of the Governor's Office in August 2007. Outreach activities include: AHCA contracted with the USF Covering Kids and Families project to build business partnerships, create community-based coalitions to promote and sustain KidCare at the local level, and to provide technical assistance on successful outreach strategies. AHCA also incorporates the KidCare message in all the agencies initiatives.

The DOH updated and printed the most successful posters and brochures from the previously nationally recognized KidCare outreach program. The Department's Distribution Center houses, and covers the cost to ship materials to organizations throughout the state. The State Surgeon General encourages the incorporation of the Florida KidCare message into all activities and events. DOH staff incorporates the KidCare message into senior managers' presentations; provides applications and materials to families through Children's Medical Services, county health departments, school health and Healthy Start; maintains and distributes a weekly inventory of materials; and participates in special events to promote Florida KidCare. The department is collaborating with AHCA and USF's Covering Kids and Families project to do a special targeted outreach initiative in Gadsden County. DOH organized and partnered with agencies to staff a Florida KidCare table during 2008 Children's Week at the Capitol.

DCF staff ensures that families know about and apply for Florida KidCare by providing materials

and information to their community partners. DCF also is using direct mail techniques to contact families that do not qualify for Medicaid to encourage them to apply for Florida KidCare for their children.

Florida Healthy Kids Corporation received \$1 million in non-recurring general revenue to provide community matching grants for Florida KidCare outreach. In addition to awarding these grants, the corporation purchased Florida KidCare promotional items that are available to all organizations through the DOH Distribution Center. The corporation's Marketing and Outreach Committee meets regularly to award new grants and to identify additional resources that may be used for the Florida KidCare outreach effort.

The 2007 Florida Legislature allocated \$1 million in non-recurring tobacco funds to the Florida Healthy Kids Corporation for a Florida KidCare community based marketing and outreach matching grants program. In addition, the Legislature provided an increase in Title XXI funding for Florida KidCare to provide coverage to approximately 257,350 children.

In February 2006, the Florida Healthy Kids Corporation began an on-line Florida KidCare application at www.healthykids.org. Families may apply for KidCare online and mail or e-mail their income verification documents. The live process reduces application processing and enrollment time.

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

As a result of last year's activities, enrollment and enrollee retention increased in each of the Florida KidCare programs and the Governor's office has requested that outreach efforts be continued.

The Florida KidCare Coordinating Council, created in Section 409.818(2) (b), Florida Statutes, makes recommendations to the Governor and the Legislature for the implementation and operation of the Florida KidCare program. The council members represent the Department of Health, the Department of Children and Families, the Agency for Health Care Administration, the Florida Healthy Kids Corporation, the Office of Insurance Regulation of the Financial Services Commission, local government, health insurers, health maintenance organizations, health care providers, families participating in the program, and organizations representing low-income families. Major recommendations in this year's annual report include: 1) fully fund the Florida KidCare program; 2) restore and fund the Florida KidCare community coordination, retention efforts, and health, family education and utilization functions; 3) reinstate and implement

presumptive eligibility; 4) accept income and other necessary eligibility information electronically; 5) increase Medicaid reimbursement for physician and dental services; and 6) implement 12 months of continuous eligibility.

c. Plan for the Coming Year

The 2008 Florida Legislative session is now underway and several bills affecting the Florida KidCare Program have been filed. Most of the filed legislation deals with simplification and streamlining the program. The Department of Health Children's Medical Services Division is tracking the progress of these bills and will report on the outcomes and effects of legislative session in next year's report.

Department of Health staff will continue to work with the other Florida KidCare partners to increase Florida KidCare enrollment and retention. The partner agencies also will seek grant opportunities to continue outreach activities next fiscal year.

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	2003	2004	2005	2006	2007
Annual Performance Objective				30.7	30.5
Annual Indicator			30.9	30.7	30.9
Numerator			34901	37114	41730
Denominator			112905	121062	135187
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
	2008	2009	2010	2011	2012
Annual Performance Objective	30.3	30	29.8	29.6	29.5

a. Last Year's Accomplishments

Data for FY2007 indicate that 30.9 percent of children 2-5 who received WIC services had a BMI at or above the 85th percentile. This was a slight increase from the FY2006 data of 30.7 percent. One explanation might be that the percentage of Hispanic children in the WIC program had grown from 42.4 percent in 2006 to 43.6 percent in 2007. In 2007, 15.3 percent of the children who are Hispanic, 7.4 percent of children who are black, and 7.0 percent of children who are white had a BMI at or above the 85th percentile.

The Florida Department of Health's Bureau of WIC & Nutrition Services conducted a number of activities during FY2007 to continue to help reduce the number of children deemed overweight based on body mass index. The bureau developed quarterly nutrition education "kits" for local agencies to use in the provision of low risk nutrition education contacts to clients. The kits promote healthy nutrition and physical activity. The first kit developed was WIC Families: Let's Get Moving with a lesson plan, flipchart in English and Spanish, flyer in English and Spanish and a poster. The second kit was Make Half Your Grains Whole Grains with a lesson plan, flipchart in English and Spanish, flyer in English and Spanish, display, buttons, and coloring pages. The WIC program wrote and produced a 34-page children's book in English and Spanish called The Whole Grain Choo-Choo Train. We distributed the book to WIC children to encourage them to

eat more whole grains. The third kit was Eat More Fruits and Veggies with a lesson plan and a flipchart in English and Spanish. In addition, WIC staff, in conjunction with others in the Florida Interagency Food and Nutrition Committee, developed a resource manual called Fruits and Veggies: More Matters™ with lesson plans, flyers, research article, and press release.

The Florida WIC Program is in its fourth year of receiving a United States Department of Agriculture grant for a Breastfeeding Peer Counseling Program. This special grant allows expanded breastfeeding promotion and support in 15 counties above and beyond what could be accomplished with the regular WIC grant. During October 2007 to March 2008, over 27,000 contacts were provided through personal interactions and group classes.

We developed a new WIC envelope with a breastfeeding promotion theme. Local WIC agencies distribute the envelope to clients to hold their WIC checks.

In 2007, we also developed enhancements to the computer-generated growth charts. The system now permits staff to generate growth charts for either the infant or child less than 24 months of age or greater than 24 months of age, regardless of the current age of the child. In addition, the system generates age-adjusted growth charts for premature infants and children. These continue to serve as client education tools.

In June 2007, we revised the Basic Nutrition Module to include the 2005 Dietary Guidelines for Americans, the MyPyramid food guidance system, as well as any updates of the Dietary Reference Intakes. This module includes sections on physical activity and weight management techniques.

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 a children’s book, nutrition education materials, and annual nutrition education campaigns focusing on healthy nutrition.		X		
3. Continue to encourage local WIC agencies to assign the food package that limits the type of milk families can buy to low fat or fat free milk.	X			
4. Continue to translate all campaign materials and nutrition education materials into Spanish, since the Hispanic population has the highest percentage of overweight children on WIC.		X		
5. . 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
6. Post all nutrition education campaign materials and nutrition education materials on the web for other Florida residents to use as well as other state agencies to adopt and use. The new URL for the site is www.FloridaWIC.org .		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau of WIC and Nutrition Services is working on a fourth nutrition education kit called Drink More Water. We are developing a table top display with illustrations of different common beverages that children drink. Under each beverage is a small bag of sugar representing the teaspoons of sugar in each beverage. In addition, we distributed a survey to WIC staff to evaluate the kits, to provide recommendations for improving the kits, and suggestions of topics for future kits.

The Bureau of WIC and Nutrition Services is actively working towards implementing the new WIC food package based on recently issued Interim Federal Regulations. We made changes in the foods provided to WIC families based on recommendations by the Institute of Medicine. In addition to the reduction of some food items, we will add whole grains and fresh fruits and vegetables to the WIC food package for children, and whole we will be eliminating milk for children older than 2. We will complete implementation of the new food packages by October 1, 2009.

The Bureau of WIC and Nutrition Services is working on several training programs for staff to help them improve counseling skills, rapport building, cultural sensitivity, and ways to improve communication skills.

The Bureau of WIC and Nutrition Services is working on improving the child nutrition questionnaire, completed by the mother or caretaker, to get a better assessment of the child's nutritional status.

c. Plan for the Coming Year

The Bureau of WIC and Nutrition Services encouraged local WIC agencies to select a nutrition education objective when preparing their nutrition education program plan for Federal Fiscal Years 2008 and 2009 that relates to overweight and obesity prevention. Approximately two-thirds of the agencies (28 of them) chose obesity related objectives and all of the agencies had a breastfeeding promotion and support initiative.

We will develop and distribute four more nutrition education kits for the next year, based on results of a survey conducted for local agency staff. We will implement the food package regulations. We will also develop educational and training materials for staff, clients, and vendors.

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	2003	2004	2005	2006	2007
Annual Performance Objective				10.3	10.2
Annual Indicator				8.3	
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012

Annual Performance Objective	8	7.9	7.8	7.7	7.6
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Notes - 2007

Data for 2007 are not yet available.

Notes - 2006

Note: Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used determine performance on this indicator. Data for 2006 are not available. Problems with PRAMS survey administration may prevent updating this indicator until 2008. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state. Objectives for 2004-2010 differ from the objectives in SPM #3, women who report tobacco use during pregnancy, as data come from different sources.

Notes - 2005

Data are from the Florida Prams survey. Data for 2005 are not yet available. Objectives for 2006-2010 differ from the objectives in SPM #3, women who report tobacco use during pregnancy, as data come from different sources.

a. Last Year's Accomplishments

Florida's 2006 PRAMS data is not yet available, so we cannot determine our progress on this goal since the last report. In 2005, data showed 53.6 percent of women who smoked before they became pregnant quit while pregnant. Behavioral Risk Factor Surveillance System data reveals that in 2007, 54 percent of women smokers tried to quit smoking.

The Florida Constitution requires the Legislature annually to fund a comprehensive, statewide tobacco education and control program using tobacco settlement money. In May 2007, the Governor signed a bill that requires using some of the funds to reduce tobacco use among pregnant women. Last year, our ongoing activities continued, while most of our enhancement efforts went into developing contracts and infrastructure. Smokers and their families are eligible for Healthy Start smoking cessation services. During FY2006, 6,450 women received these services and 7,169 received them in FY2007. Smoking cessation services are also available for families of infants with a smoker in the home. In FY2006, 2,623 families received these services, increasing to 3,523 in FY2007.

The Infant, Maternal, and Reproductive Health Unit offers information on prenatal tobacco cessation and secondhand smoke onsite training, teleconferences, conference calls, site visits, meetings, and email. IMRH teamed with the AHEC Network to conduct 12 trainings around the state for over 300 professionals. In addition, DOH and AHECs provided two audio teleconferences for health care providers and home visitors. Over 128 people participated in the teleconference on ACOG's Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking and over 91 people participated on the teleconference on tips for using the Make Yours a Fresh Start Family (MYFSF) model of prenatal and postpartum tobacco cessation. CHDs, Healthy Start Coalitions (HSCs) and DOH 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.

Some HSCs train providers and provide public education in their area. For example, The Zero Exposure Project, (ZEP) co-sponsored by the HSC of Hillsborough, received a March of Dimes grant to share their lessons learned and make media campaign materials available statewide. They presented five trainings across the state, training over 500 professionals and distributing ACOG's Smoking Cessation during Pregnancy: A Clinician's Guide to helping Pregnant Women Quit Smoking. ZEP's website has 4,500 visitors each month with an average user spending 25 to 27 minutes at the site. They produced a DVD entitled A Pregnant Woman Never Takes Risks Alone, which is available to physicians and social service organizations. The DVD inspires and educates viewers to have substance-free pregnancies.

IMRH maintains an Alcohol, Tobacco, and Other Drugs webpage on the DOH Internet site. IMRH contracted with the University of Central Florida, where students produced two prenatal smoking cessation ads and used focus groups to evaluate their effectiveness. The ads are available to play on Orlando's Bussing for Health buses, in county health departments, at health fairs, and at other venues. IMRH secured permission from CDC to add Florida's Quitline information to a CDC infant second hand smoke reduction poster. The poster warns about the dangers of secondhand smoke for children and provides QuitLine information. The posters were sent to 6,000 day care centers, every county health department, and every Healthy Start coalition in Florida. Over 14,000 "I am a designated non-smoking area" bibs were ordered by CHDs and HSCs to use as incentives and to educate about the QuitLine and reduction of second hand smoke exposure. During May and June in 2007, IMRH and the DOH Division of Health Access and Tobacco teamed up to air a radio campaign with two different ads. One ad promoted prenatal smoking cessation and the other promoted second hand smoke reduction among fathers. Both promoted use of the Quitline. Through the media campaign, 2,899 commercials aired in Miami, Orlando, Tampa, Jacksonville, and Gainesville reaching the eight counties with the most women who smoked during pregnancy in 2005. HSCs and CHDs worked with local radio stations and aired at least 74 additional ads.

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 public about dangers of smoking during pregnancy and about the QuitLine using mass media.			X	
8. Enhancing preconception identification of and interventions with smokers.				X
9.				
10.				

b. Current Activities

Activities described for FY2007 continue in the current year, as do the activities described under SPM #3. In addition to working with current women who smoke, IMRH is working on reducing smoking prior to pregnancy through preconception and interconception initiatives. IMRH developed a handout on the dangers of smoking and resources for cessation that will be included with the Every Woman, Every Time preconception materials.

IMRH is working with DHAT and the marketing office on new prenatal tobacco cessation media

campaign materials. The AHECs received funding through DOH to provide smoking cessation training for health care professionals and to train on and provide prenatal smoking cessation. While the trainings include a prenatal cessation component, IMRH staff is working with the AHECS to increase training specifically for those working with pregnant women and infants.

c. Plan for the Coming Year

During FY2008, we will continue the activities listed above. We will continue to provide technical assistance and search for effective interventions for those who smoke. We will support training opportunities on Make Yours a Fresh Start Family, ACOG's Smoking Cessation, and A Clinician's Guide to Helping Pregnant Women Quit Smoking, and promote other vehicles found to be effective. We will continue to monitor smoking cessation activities statewide, evaluate data showing the success of these activities and data on smoking rates in general, and provide technical assistance as indicated. We will also continue to maintain a list of tobacco cessation contacts for each county health department and Healthy Start coalition and provide the contacts with updates on tobacco cessation activities and resources. IMRH plans to have a prenatal tobacco cessation training monthly reaching each coalition area within three years.

IMRH staff will work with the department's Division of Health Awareness and Tobacco on implementing the strategic plan, and to develop new initiatives for reaching women who have not responded to current initiatives. We hope to develop a unified Florida prenatal media campaign and expand the reach of the campaign. IMRH will work to engage additional partners on the advisory council, and, through other means of collaboration such as seeking stronger links with pharmacies, managed care providers, provider organizations and hospitals, promote effective tobacco dependence initiatives.

IMRH staff will work with DHAT Quitline staff to encourage adding a postnatal relapse prevention outreach component to the QuitLine.

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	2003	2004	2005	2006	2007
Annual Performance Objective	6.6	6.5	6.4	6.3	6.2
Annual Indicator	5.2	6.3	7.0	5.1	5.7
Numerator	58	72	82	61	69
Denominator	1111667	1147186	1177427	1197439	1214911
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
	2008	2009	2010	2011	2012
Annual Performance Objective	5.6	5.5	5.4	5.3	5.2

a. Last Year's Accomplishments

The suicide rate per 100,000 for youth 15-19 increased from 5.1 in 2006 to 5.7 per 100,000 in 2007 (provisional). During FY2007, Comprehensive School Health staff referred 10,571 students

to community-based mental health services. They also provided 4,421 mental health interventions to 9,859 students; 2,560 mental health education classes to 103,334 students; 87 suicide interventions to 380 students; 571 suicide prevention classes to 39,084 students; 2,317 violence prevention/conflict resolution interventions to 7,941 students; 2,140 violence prevention/conflict resolution classes to 115,975 students; 1,834 alcohol, tobacco and other drug interventions to 5,974 students; and 3,144 alcohol, tobacco, and other drug prevention classes to 162,361 students.

During FY2007, school nurses and social workers from the comprehensive school health services project schools continued to refer students for community-based mental health services. School health nurses and social workers also provided prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The Florida Suicide Prevention Task Force continued to meet, plan and implement suicide prevention activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Suicide prevention small group prevention-interventions and health education classes in Comprehensive School Health Services Projects.		X		
2. Youth suicide prevention train-the-trainer workshops for gatekeepers.			X	
3. Coalition building by the Florida Suicide Prevention Taskforce.				X
4. Utilization of proven mental health/screening programs.			X	
5. Implementation research-based suicide prevention pilot projects.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY2008, school nurses and social workers from the comprehensive school health services project schools will continue to refer students for community-based mental health services. Staff will also provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The Florida Suicide Prevention Task Force will continue to meet, plan and implement suicide prevention activities, including the fourth Suicide Prevention Symposium and the sixth annual Suicide Prevention Day at the Capitol. The Department of Health internal suicide prevention workgroup will continue to meet and coordinate the department's contribution to the state taskforce.

It is expected that during FY2008, Florida's health, mental health, education and law enforcement professionals will work closely on strategies to identify youth at risk for suicide so they can receive appropriate prevention and intervention services.

c. Plan for the Coming Year

During FY2009, school nurses and social workers from the comprehensive school health services project schools will continue to refer students for community-based mental health services. Staff will also provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The Florida Suicide Prevention Task Force will continue to meet, plan and implement suicide prevention activities, including the fourth Suicide Prevention Symposium and the sixth annual Suicide Prevention Day at the Capitol. The Department of Health internal suicide prevention workgroup will continue to meet and coordinate the department's contribution to the state taskforce.

It is expected that during FY2009, Florida's health, mental health, education and law enforcement professionals will work closely 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	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	90	90	90
Annual Indicator	83.1	86.8	79.1	86.5	88.1
Numerator	2737	2891	2855	3105	3454
Denominator	3293	3331	3610	3589	3920
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
	2008	2009	2010	2011	2012
Annual Performance Objective	90	90	90	90	90

a. Last Year's Accomplishments

Infrastructure-building activities continued during the past year to increase the percentage of very low birth weight infants being born at a high-risk facility included: five of the Regional Perinatal Intensive Care Centers (RPICC) providing 11 high-risk obstetrical satellite clinics and 1 telemedicine high-risk obstetrical site; RPICC staff at the 11 designated facilities provide a comprehensive high-risk obstetrical outpatient clinic; and RPICCs are monitored annually by physicians and Children's Medical Services Central Office consultants to ensure the quality of care for the high risk obstetrical patients and appropriate placement for neonates in the Level III NICU. Enabling activities included the provision of yearly educational programs to the community health providers by RPICC staff. In addition, transportation was provided through a contract for RPICC eligible high risk pregnant women to a RPICC and for neonates requiring care at a Level III NICU. The populations served are high-risk pregnant women and low birth weight/sick infants.

During 2007, 88.1 percent of very low birth weight infants were delivered at high-risk facilities. The goal of 90 percent was not reached, though there was an increase compared to the 86.5 percent rate reported for 2006.

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 five of the RPICCs provides 12 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. Transportation is provided through a contract for high risk obstetrical patients to facilities with Maternal Fetal Medicine physicians and for neonates requiring care at a Level III NICU.		X		
6. 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		
7.				
8.				
9.				
10.				

b. Current Activities

The CMS goal is to ensure that high-risk obstetrical patients and very low birth weight newborns are delivered and receive care at appropriate level hospitals. The following types of public health services continue to be provided through the RPICCs and by the RPICCs' staff. Direct health care services are provided at the RPICCs (inpatient and outpatient) and through the 12 high-risk obstetrical clinics located at varying distances from the RPICCs. Enabling services are provided, including transportation for high-risk obstetrical patients to a RPICC facility with a maternal fetal medicine physician and for low birth weight neonates that require Level III NICU services. This service is provided by a contract with one of the RPICCs. Enabling services include an educational program offered by the RPICC staff to the community health providers. Annual quality assurance on site or desk audit monitoring of the RPICCs is performed to ensure that standards of care are being met.

c. Plan for the Coming Year

The goal for FY2008-09 is to ensure that 90 percent of very low birth weight infants are delivered at appropriate hospitals with NICU services. Plans include an increase in the number of RPICC high-risk obstetrical satellite clinics in South Florida and the telemedicine sites in the panhandle area in order to increase access of high-risk obstetrical services to more women. Plans to acquire ultrasound machines with up-to-date technology for OB Satellites will increase the diagnostic capability at the clinic site and decrease the travel for patients to RPICC hospitals for testing. RPICC staff will continue to provide services at satellite clinics to decrease the number of low birth weight infants by providing easier access to high-risk obstetrical maternal care and education. CMS will continue to provide educational programs to community health providers. CMS will continue to monitor RPICCs to ensure appropriate placement of neonates in the Level III NICUs. Emergency transportation will be provided through a contract to relocate high risk obstetrical patients to a RPICC facility with a Maternal Fetal Medicine physician and to move low birth weight neonates requiring care at a Level III NICU. 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	2003	2004	2005	2006	2007
Annual Performance Objective	85.7	86	86.3	80	79
Annual Indicator	85.8	81.0	78.5	76.8	76.0
Numerator	180107	156879	158516	165076	165365
Denominator	209801	193780	201817	215035	217503
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
	2008	2009	2010	2011	2012
Annual Performance Objective	79.5	80	80.5	81	81.5

Notes - 2007

Starting in 2004 trimester prenatal care began to be calculated as the time elapsed from the date of the last menstrual period to the date of the first prenatal care visit. Prior to 2004 these data were obtained by direct question that noted the trimester the mother began prenatal care. Consequently these data are not comparable to data from prior years. Births with unknown information as to when prenatal care began are excluded from the denominator. Annual performance objectives have been lowered to accommodate the change in data collection.

Notes - 2006

Starting in 2004, trimester prenatal care began is calculated as the time elapsed from the date of the last menstrual period to the date of the first prenatal care visit. Prior to 2004, these data were obtained by direct question that noted the trimester the mother began prenatal care. Consequently, these data are not comparable to data from prior years. Births with unknown information as to when prenatal care began are excluded from the denominator. Annual Performance objectives have been lowered to accommodate the change in data collection.

Notes - 2005

Starting in 2004, trimester prenatal care began is calculated as the time elapsed from the date of the last menstrual period to the date of the first prenatal care visit. Prior to 2004, these data were obtained by direct question that noted the trimester the mother began prenatal care. Consequently, these data are not comparable to data from prior years. Births with unknown information as to when prenatal care began are excluded from the denominator.

a. Last Year's Accomplishments

Provisional data for 2007 indicate 76 percent of pregnant women received prenatal care in the first trimester, which was lower than the 76.8 percent reported in 2006. We continue to experience an increase in the number of uninsured pregnant women and a decrease in providers of prenatal care across the state. We continue to see a disparity between non-Medicaid and Medicaid women concerning first trimester entry.

We encouraged county health departments (CHDs) to offer Presumptive Eligibility for Pregnant Women (PEPW) or Simplified Eligibility for Pregnant Women to assist women with early entry. Until a final determination is made, PEPW allows women to be temporarily eligible for prenatal

care coverage by showing only proof of pregnancy and completing a limited application. One issue we are seeing around the state is that our private providers are reluctant to accept the PEPW client until final Medicaid approval, thus delaying entry into care. The Department of Health and the Department of Children and Families provided training and technical assistance to the PEPW eligibility staff in CHDs. We distributed posters and pamphlets with step-by-step instructions on helping pregnant women apply for Medicaid.

We worked with Healthy Start coalitions statewide to ensure an adequate infrastructure for the provision of first trimester prenatal care and continuous care for all pregnant women. We continue to work with the coalitions to promote awareness among providers that Medicaid pays additional reimbursement to providers who screen clients for Healthy Start in the first trimester. We developed policies that promoted wellness among women of childbearing age and helped educate women on the importance of first trimester entry.

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

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

Through the three-year collaboration with the March of Dimes Florida Chapter on the Vitagrants project, we provided over 565,000 bottles of multivitamins containing folic acid to women of childbearing age. The project also educated women about preconception and interconception issues that could influence their health and the health of their fetus during future pregnancies, including the importance of first trimester care when they do become pregnant.

We implemented the Group CARE Prenatal Project in six CHDs. The Group CARE model encourages women to take an active part in their prenatal care and empowers them through self-help and support activities. Community involvement is one of the main components that differentiate this model from existing group models. This link between the community and health has a particular importance for pregnant women and infants who are vulnerable to biological, psychosocial, social, and environmental events and circumstances that can influence health.

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. Continue to provide technical assistance for alternative prenatal care delivery options like the Group CARE Prenatal Project throughout the state.		X		
8.				
9.				
10.				

b. Current Activities

We continue to meet face-to-face with administrators, managers, and front-line staff and talk to them about local issues that may present barriers to first trimester entry into prenatal care in their communities. We participate in community summits to focus on solutions for increasing access to prenatal care.

We have implemented preconception health guidelines for the county health department clinics, Healthy Start programs, and with our family planning clinical staff. We continue to collaborate with the March of Dimes to promote preconception health and encourage women to access early prenatal care. The Department has received a \$50,000 grant to support the creation and function of a statewide Preconception Health Advisory Council that will identify best practices and make recommendations related to preconception health promotion and service availability in Florida.

The Group CARE Prenatal Projects educate and empower women to take a more active role in their health care including accessing prenatal care in the first trimester.

c. Plan for the Coming Year

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

We will continue to work through Healthy Start coalitions to encourage providers to see patients during the first trimester of their pregnancies, and we will continue to partner with the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate. We will also continue focusing efforts toward counties with first trimester entry levels below the state average for special technical assistance, and develop and implement strategies to improve access to early prenatal care. We will accomplish this through continued QM/PI 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 Preconception Health Advisory Council will identify opportunities 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.

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	2003	2004	2005	2006	2007
Annual Performance Objective	92	95	98	98	98
Annual Indicator	96.2	95.9	96.0	95.0	98.1
Numerator	39333	31982	30813	30243	35376
Denominator	40879	33359	32082	31818	36054
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	98	98	98	98	98

Notes - 2005

Early Steps has changed the methodology used to calculate the annual indicators due to recent improvements in our data collection. Thus the numbers for 2004 (which is our 2003-2004 Fiscal Year) were updated with the new methodology. We now use an unduplicated count of Part C eligible children with at least one service provided as the numerator. For the denominator we use the Part C eligible children enrolled during the period. We continue to refine our data collection and expect to have improved data in the future.

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 16 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 services 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 ITDS programs; maintaining the Early Steps Data System, and conducting quality assurance reviews and follow-up to ensure compliance with federal regulations and state policy. The State Performance Plan was developed and approved by the Office of Special Education Programs (OSEP) as a system of accountability and improvement for implementation of the Individuals with Disabilities Education Act (IDEA). This measure is related to the priority needs to prevent the incidence of disabilities for infants and children, and decrease the incidence of child morbidity. This measure is related to the outcome measures for reducing infant, neonatal, postneonatal and perinatal mortality. 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 Individuals with Disabilities Education Act (IDEA), Early Steps publicly reported on statewide and local Early Steps performance. Determinations of local Early Steps programs have been made in accordance with the provisions of IDEA and to identify those local Early Steps which meet requirements and those that are in need of some level of assistance or intervention to meet the requirements of IDEA.

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 16 regional programs.	X			
4. Maintain reduced service coordination caseload size at 1/65.		X		
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

In accordance with federal requirements, an Annual Performance Report was submitted on February 1, 2008, which includes actual target data from federal fiscal year 2006. Early Steps policies have been revised to be consistent with the 2004 reauthorization of the Individuals with Disabilities Education Act, Part C. Monitoring is conducted to assess local and statewide performance and to identify noncompliance. Technical assistance, which includes policy clarification, training, and support, is provided to local Early Steps to ensure timely correction of noncompliance and to promote continued improvement. Coordination has continued with Medicaid, Insurance, the Department of Education, and other agencies to access funding to support increased numbers of children eligible for services.

A stakeholder workgroup assisted Early Steps in development of a training plan addressing short and long term needs of Florida's early intervention system. Implementation has begun. Training on the Team Based Primary Service Provider model is planned for the spring and summer of 2008. An on-line training module on the Individualized Family Support Plan (IFSP) will be available in the spring of 2008.

A family survey is conducted each year to determine the extent to which families perceive that Early Steps has helped their child and family.

Data integrity continues to be a focus and revisions to the data collection system are currently being planned.

c. Plan for the Coming Year

Early Steps will continue to implement the infrastructure and improvement activities described in the Florida Part C State Performance Plan. Recruitment and retention of a highly qualified work force to meet the service needs of eligible children will be a focus, including training on the team-based primary service provider model of early intervention service delivery.

State Performance Measure 2: *The percentage of subsequent births to teens age 15 to 19*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	15.5	15.2	15.2	15	15.2
Annual Indicator	15.2	15.5	16.2	16.5	16.3
Numerator	4530	4361	4493	4635	4693
Denominator	29749	28048	27816	28008	28736
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	15	14.8	14.6	14.4	14.2

a. Last Year's Accomplishments

Activities designed to reduce subsequent births to teens consisted of individual and small-group pregnancy prevention interventions, case management, family planning counseling and education services, comprehensive contraceptive services, abstinence education, peer education and mentoring, and collaboration with other programs that work to reduce subsequent teen pregnancy. Provisional data for 2007 indicates that 16.3 percent of youth age 15 to 19 who had previously given birth had subsequent births, which is higher than the annual objective of 15.2 percent.

The statewide family planning program provided services at local county health departments and contract agencies to 49,866 youth (male and female), age 15 to 19 during 2007, compared to 51,626 in 2006. County health departments and local contract providers continued to train and work to improve pregnancy prevention strategies for youth.

Another important initiative in the effort to curtail subsequent teen births was special educational activities that highlighted the role of sexual coercion by men, particularly older men. Local public and private family planning programs provided services that addressed male responsibility in teen pregnancy and educated males about coercive sexual behavior. County health departments in the counties of Broward, Suwannee, and Lafayette continued to provide health education activities for male teens with special initiative funds.

The Healthy Start program provided universal risk screening for pregnant women and their newborns to identify those at risk for poor birth, health, and developmental outcomes. Healthy Start provided family planning counseling to participants throughout their pregnancies. Healthy Start staff provided clients with information on the various methods of birth control to assist them in making an informed decision concerning their preferred family planning method.

Comprehensive School Health Services Projects (CSHSP), now located in 332 schools, provided pregnancy prevention, preconception education, and intervention services for pregnant and parenting teens. Services included individual and facilitated small group activities, case management, and care coordination to help students access support services, return to school

after delivery, stay in school, learn to avoid subsequent births, and ultimately graduate. CSHSP staff worked closely with Healthy Start care coordinators, Healthy Families Florida home visitors, school district teen parent programs, and case managers from the Department of Children and Families. Workforce development activities included measures to help youth break the cycle of teen pregnancy and welfare dependence.

The Medicaid Family Planning Waiver Program had an impact on subsequent birth rates and costs to the Medicaid program for teens that chose to utilize family planning services. This is significant since the avoidance of a second birth by a teen is highly correlated with a reduction in poverty, increased high school graduation rates, and reduction in child maltreatment.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Individual and small group pregnancy prevention interventions in Comprehensive School Health Services Projects and Healthy Start Programs.	X			
2. School Health case management and care coordination in Comprehensive School Health Projects to enable parenting students to remain in school and graduate.		X		
3. Provision of confidential family planning counseling, education and comprehensive contraceptive services.	X			
4. Collaboration of Department of Health programs working to reduce subsequent teen pregnancy.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The family planning program provides services in all 67 counties. In addition to providing an array of services, the program has implemented the revised family planning Medicaid waiver. County health departments receive lists of teens who lose full Medicaid eligibility. They contact those teens during CHD clinic appointments and refer them to Medicaid Family Planning Waiver services. They can send applications and outreach materials to adults but cannot contact teens in this way due to confidentiality issues. The family planning program evaluates county health departments for teen accessibility and provides technical assistance on pregnancy prevention and program strategies for serving the teen population.

The Comprehensive School Health Services Projects continue to operate in 46 counties, providing individual and small group prevention, intervention services on pregnancy prevention, case management, and care coordination to prevent subsequent births to parenting students. To accomplish this, CSHSP staff works closely with county health departments, Healthy Start care coordinators, Healthy Families Florida home visitors, school district teen parent programs, abstinence programs, teen counselors, and case managers from the Department of Children and Families.

c. Plan for the Coming Year

Our plan to reduce subsequent births to teens age 15 to 19 will include the provision of family planning services in all 67 counties, including pregnancy prevention, Healthy Start services, abstinence education, health education, and health services in schools. County health

departments submitted \$529,088 in proposals for Title X special initiatives and male projects. Many address unique local challenges in the areas of teen pregnancies and male involvement. 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.

The Comprehensive School Health Services Projects will continue to operate in 46 counties to provide individual and small group prevention, intervention services on pregnancy prevention, case management and care coordination to prevent subsequent births to parenting students. These services will be coordinated closely with all programs and agencies. Collaboration will continue among department programs working with teens through the sharing of information and resources. Strategic planning efforts regarding teen pregnancy prevention and intervention will continue to be a top priority.

County health departments, local contract providers, Healthy Start programs, Healthy Families Florida programs, and other agencies that provide maternal and infant care services will inform postpartum teens about extended family planning services available through the Medicaid Family Planning Waiver services. These providers will have access to applications and client information brochures to distribute to youth to increase awareness and use of family planning services under the special Medicaid program. Education and reduction in the number of subsequent births for teens are two goals of the programs. Another goal is to increase the number of teens accessing services. If the youth is not eligible to participate in the waiver program, we can provide family planning services under the department's Title X program.

The county health departments are participating in the May 7, 2008 National Day to Prevent Teen and Unplanned Pregnancy Campaign. County health departments will encourage teen clients to go online to "Take the Test" on the National Day Campaign website. The test offers realistic scenarios for teens to consider, with feedback and education about their responses. The message of the campaign is "Sex has Consequences." Informational materials will be sent to the health departments to display and distribute to teen clients and parents. The goal of the program is to educate teens and parents of teens, to encourage teen discussion about decision making, and to bring attention to the problem of unplanned pregnancies in the state.

State Performance Measure 3: *The percentage of women reporting tobacco use during pregnancy*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	8.4	8.2	8	9.5	7.5
Annual Indicator	8.1	9.0	8.0	7.6	7.0
Numerator	17165	19668	17719	17915	16706
Denominator	212243	218045	221731	237142	237924
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	6.9	6.8	6.7	6.6	6.5

Notes - 2006

2004 estimates include those that reported "quitting" on the birth certificate in the numerator. Analysis against PRAMS has demonstrated this quit group is not valid for use in program and policy decision making. Data for 2005 and later year estimates exclude unknowns for smoking status and quits from the numerator and denominator. This removes a demonstrated bias from reporting that existed previously (2004).

a. Last Year's Accomplishments

Provisional data for 2007 indicate that 7 percent of pregnant women used tobacco, compared to 7.6 percent in 2006. Thanks to Florida voters, the Florida Constitution now requires the Legislature to annually fund a comprehensive, statewide tobacco education and control program using tobacco settlement money. In May 2007, the Governor signed a bill specifying how this money will be spent. Some of the funds are directed towards reducing tobacco use among pregnant women through specialized cessation services, education, and media.

Last year, our ongoing activities continued, while most of our enhancement efforts went into developing contracts and infrastructure. Pregnant women who smoke were identified in a variety of ways including the Healthy Start prenatal risk screen that asks if the woman smoked in the last two months. Smokers and their families are eligible for Healthy Start smoking cessation services. During FY2006, 6,450 women received these services and 7,169 received them in FY2007. Smoking cessation services are also available for families of infants with a smoker in the home. In FY2006, 2,623 families received these services, increasing to 3,523 in FY2007.

The Infant, Maternal, and Reproductive Health Unit (IMRH) forwarded information on prenatal tobacco cessation and secondhand smoke to providers and home visitors through onsite training, teleconferences, conference calls, site visits, meetings, and email. IMRH teamed with the Florida Area Health Education Center Network (AHEC) to conduct 12 trainings around the state for over 300 professionals. In addition, the Department of Health (DOH) and AHEC provided two audio teleconferences for health care providers and home visitors. Over 128 people participated in the teleconference on ACOG's Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking and over 91 people participated on the teleconference on tips for using the Make Yours a Fresh Start Family (MYFSF) model of prenatal and postpartum tobacco cessation.

County health departments (CHDs), Healthy Start Coalitions (HSCs) and DOH 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. Staff provided technical assistance when indicated. Monitoring occurred through data review, HSC monitoring, review of coalition service delivery plans and annual action reports, and through CHD monitoring visits. We provided technical assistance during these visits, as requested, or when data indicated a need.

Some HSCs train providers and provide public education in their area. For example, The Zero Exposure Project, (ZEP) co-sponsored by the HSC of Hillsborough, received a March of Dimes grant to share their lessons learned and make media campaign materials available statewide. They presented five trainings across the state, training over 500 professionals and distributing ACOG's Smoking Cessation during Pregnancy: A Clinician's Guide to helping Pregnant Women Quit Smoking. ZEP's website has 4,500 visitors each month with an average user spending 25 to 27 minutes at the site. They produced a DVD entitled A Pregnant Woman Never Takes Risks Alone, which is available to physicians and social service organizations. The DVD inspires and educates viewers to have substance-free pregnancies.

IMRH maintains an Alcohol, Tobacco, and Other Drugs webpage on the DOH Internet site. IMRH contracted with the University of Central Florida, where students produced two prenatal smoking cessation ads and used focus groups to evaluate their effectiveness. The ads are available to play on Orlando's Bussing for Health buses, in county health departments, at health fairs, and at other venues. IMRH secured permission from CDC to add Florida's QuitLine information to a CDC infant second hand smoke reduction poster. The poster warns about the dangers of secondhand smoke for children and provides QuitLine information. The posters were sent to 6,000 day care centers, every county health department, and every Healthy Start coalition in Florida. Over 14,000 "I am a designated non-smoking area" bibs were ordered by CHDs and HSCs to use as incentives and to educate about the QuitLine and reduction of second hand smoke exposure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing guidelines and contract language directing health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use.				X
2. Monitoring prenatal smoking indicators by county health department, Healthy Start coalition, and state health office staff, with development of corrective action plans when indicted.				X
3. Training and providing 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, and other prenatal smoking cessation models.			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. Using mass media, educate the public about dangers of smoking during pregnancy and about the QuitLine.			X	
8. Enhancing preconception identification of and interventions with smokers.				X
9.				
10.				

b. Current Activities

Current activities designed to reduce smoking include most of the activities described above and current activities described under NPM #15. DOH staff continues to monitor prenatal smoking indicators, compliance with guidelines on counseling all pregnant women and women of childbearing age on the dangers of tobacco use and second hand smoke, and provide technical assistance when indicated.

IMRH will begin electronic publication of Clearing the Air: A Newsletter for Those Who Care for Pregnant Women and Families. The newsletter provides information on perinatal and postpartum smoking cessation and second hand smoke reduction. The newsletter will be sent to prenatal care providers, CHDs, Healthy Start and Healthy Families staff, Healthy Start coalitions, pediatric health care providers, Planned Parenthood programs, community health centers, AHECs, and other interested parties.

We put additional focus on decreasing relapse once the baby is born. A number of AHECs are providing physicians with Forever Free for Baby and Me relapse prevention booklets developed by Moffett Cancer Center. A new supply of 24,000 "I am a designated non-smoking area" bibs have been ordered to meet the requests from staff in the field. Staff has a variety of creative ways they will be using the bibs to promote smoking cessation. IMRH staff is working with DHAT and AHEC staff to strengthen the initiatives for pregnant women.

c. Plan for the Coming Year

The department will continue to focus on reducing tobacco use in all populations, and particularly in women who are pregnant or intend to become pregnant. Activities listed above will continue during FY2008, and we will continue to provide technical assistance and search for effective interventions for those who smoke. We will also continue to maintain a list of tobacco cessation contacts for each CHD and Healthy Start coalition, and expand linkages with other private and public prenatal care resources and provide the contacts with updates on tobacco cessation activities and resources.

DOH staff is enhancing the Health Management System so CHD staff can code for tobacco use and indicate whether a client with a tobacco cessation referral kept her appointment. We are strengthening our preconception interventions with plans to train Family Planning and WIC staff on motivational interviewing to help clients quit smoking. The training will either be in eight regions or via Webcast.

IMRH developed a tobacco handout that will be included in the Every Woman, Every Time preconception materials. We plan to distribute 25,000 similar handouts for use by prenatal care providers. The handouts will also be online for downloading. IMRH will work with DHAT and the marketing office on the new prenatal tobacco cessation media campaign using radio, posters, brochures, bibs, and other outreach tools to educate the public about the dangers of smoking during pregnancy, second hand smoke, and risks of SIDS. IMRH will work with the marketing office to add TV media and bill boards in the next contract year. IMRH is working with an AHEC to develop a Spanish version of ACOG training.

State Performance Measure 4: *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	2003	2004	2005	2006	2007
Annual Performance Objective	18.7	19.2	22.5	22.8	24.3
Annual Indicator	22.7	22.5	23.5	22.9	
Numerator	464099	468140	478086	472330	
Denominator	2047614	2079779	2031717	2063891	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	23.8	24.1	24.4	24.7	25

Notes - 2007

Data for 2007 are not available.

Notes - 2006

Data for 2006 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 2007. CHD data are also used but no dental data can be gotten from HMS and no estimate can be given as to its availability.

Notes - 2005

Data for 2005 are not yet available. Much of the data comes from Medicaid processing claims, and will not be available until September 2006.

a. Last Year's Accomplishments

The increase in access to dental care for children below 200 percent of the federal poverty level has shown a small increasing trend from 2003 to 2005, but there was a slight decrease in 2006. This decrease is partially due to the difficulty in getting data under Medicaid reform and capitated programs, from community health centers, Healthy Kids and volunteer programs. We will continue our efforts to obtain reliable data from these sources. The number of children county

health department dental programs reached increased by 9 percent over the previous year, reaching over 112,000 children. This increase resulted from both increased capacity and improved performance.

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

Currently, 78 percent of Florida's population on community water systems receives the benefits of fluoridation. Long-term benefits will impact access through reduced treatment needs resulting in increased access through existing providers.

County health department program guidelines continue to facilitate quality improvement activities, an orientation and guidance resource for newly hired dental directors, and 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 MCH funded Emergency Referral and Preventive 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 CDC's campaign, "Brush Up on Healthy Teeth."			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

State oral health improvement plan activities continue. State forums to develop specific objectives and to increase awareness of the needs of specific population groups, such as children with special needs and the elderly, are currently underway. We will conduct county-level meetings to increase collaboration and partnerships at the local level. The integration of oral health into all appropriate DOH programs through the development of protocols and implementation activities at the county level will continue to receive emphasis, but this has been progressing slowly.

The promotion of increased capacity through county health department programs and increased quality improvement activities will continue. Statewide assessments of county health department guidelines and records have been analyzed and a schedule has been promulgated for on-site QI

visits, conference calls, and technical assistance.

Promotional activities to increase fluoridation will continue.

c. Plan for the Coming Year

Ongoing FY2008 activities will continue. 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 program will continue to advocate for an outcome-based surveillance system that is vitally needed to increase public awareness and to monitor the impact of activities on the improvement in oral health status.

State Performance Measure 5: *The percentage of pregnant women screened by Healthy Start*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	52	54	62	68	69
Annual Indicator	51.2	59.7	67.5	65.3	67.4
Numerator	108218	129693	152666	154808	160374
Denominator	211203	217131	226178	237142	237924
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	70	70.5	71	71.5	72

a. Last Year's Accomplishments

During 2007, 67.4 percent of pregnant women were screened by Healthy Start (provisional), an increase from the 2006 final rate of 65.3 percent. Florida statutes require providers to offer Healthy Start prenatal risk screening to all pregnant women. The screen identifies environmental, social, psychosocial, and medical risk factors that make a woman more likely to experience preterm delivery or delivery of a low birth weight baby. Depending on need and available resources, the Healthy Start program provides services to address identified risk factors.

The department continued the prenatal risk screen revision process that began November 2005, by facilitating the process by which a list of proposed risk factors for the Healthy Start Prenatal Screen was developed, the process of determining the structure and quantity of questions needed to best ascertain each proposed risk factor and the process for developing of the final draft of the revised prenatal screening form with scores for each risk factor. Field staff and stakeholder feedback was then solicited and incorporated into the draft. The department initiated the process for updating the Health Management System (HMS) to incorporate changes related to the revised prenatal risk screen. HMS is the local county health department data system that is used to input information from the screening forms, that is then uploaded to the state central registry for reporting purposes.

In June 2007, the Florida Department of Health launched Florida's first statewide Healthy Start Screening Marketing Campaign, which concluded August 2007. The campaign included television and radio public service announcements in 10 media markets and 33 billboards posted throughout the state. We provided print materials encouraging pregnant women to ask their doctor about Healthy Start to the offices of 3,000 doctors. Additionally, 353 Winn Dixie grocery stores across the state displayed point of purchase coupon dispensers in the pregnancy test aisle.

We developed and launched a webpage, www.HealthyStartBaby.com, that provides information

about screening and the Healthy Start program. The webpage was also translated in Spanish.

The campaign primarily targeted women of childbearing age (15-44), especially those who are pregnant, prenatal care providers, and birthing facility staff. This campaign encouraged mothers to take an active role in their health and the health of their baby by requesting their prenatal health care provider to screen them with the Healthy Start risk screening form. The goal was to increase the screening rates in Florida by 10 percent.

The department continued to hold bimonthly conference calls with the Healthy Start community liaisons who conduct community outreach activities, and to provide education to prenatal health care providers on the benefits of the Healthy Start program and the importance of offering each patient the risk screen in a manner that encourages consent. The community liaison conference calls involve Healthy Start screening data updates, information and strategy sharing, training, technical assistance, and discussion regarding successes and challenges faced while conducting promotion activities. The conference calls also provided a venue for the department to solicit input from the community liaisons regarding materials developed for the marketing campaign and the revised prenatal risk screen.

The department continued to collaborate with the coalitions and Healthy Families Florida to identify innovative strategies to promote the importance of Healthy Start screening and the Healthy Start program through monthly and quarterly meetings. The department provided conference call trainings on screening as appropriate. Healthy Start coalition contracts included screening rates as a core outcome measure. The department also provided ad hoc data reports to the coalitions for trend analysis.

The department added the Healthy Start Prenatal Risk Screening brochures (English, Spanish and Creole) to the Infant, Maternal, and Reproductive Health internet website. We also revised the screening chapter in the Healthy Start Standards and Guidelines (HSSG) and provided statewide conference call training regarding the updates.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start prenatal screening outreach will continue to provide training and technical assistance for all prenatal health care providers.				X
2. Strategies to increase screening rates are elicited from county health departments and coalitions on the monthly Healthy Start meet-me-call.				X
3. Promotion of Healthy Start screening as beneficial for all pregnant women.			X	
4. Healthy Start Screening Central Workgroup meetings to discuss annual analysis of infant risk screening instrument and strategies for addressing trends of screening data.				X
5. Community Liaison Bi-Monthly Conference Calls to provide technical assistance on marketing strategies and consumer response; share information, ideas, and resources; and issues related to provider and consumer outreach regarding risk screening.			X	
6. Calculation of the percentage of pregnant women screened by Healthy Start, specified as a core outcome measure in the Healthy Start coalition contracts as of July 1, 2002.			X	
7. Conduct annual QA/QI monitoring of Healthy Start coalitions and county health departments, which includes review and				X

discussion of percentage of women screened by Healthy Start.				
8.				
9.				
10.				

b. Current Activities

The department piloted the draft revised prenatal risk screen to identify other needed improvements or clarifications prior to implementation. The revised form was modified as a result of feedback received from the pilot process. The revised screen will be approved, translated, printed and disseminated for statewide use. The department will update the HSSG Screening chapter to incorporate the screen revisions and provide training as needed. Updates to the Health Management System (HMS) related to the revised prenatal risk screen were completed and implemented. The department will provide multiple statewide training sessions for the field staff and a train-the-trainer session for the community liaisons, who will be responsible for training local prenatal care provider office staff.

Healthy Start coalition contracts include screening rates as a core outcome measure and coalition contract monitoring occurs annually. We provide ad hoc data reports to the coalitions for trend analysis upon request.

We provide Healthy Start screening rate updates on the quarterly MomCare conference calls, and bimonthly conference calls continue with the Healthy Start community liaisons. Collaborations continue with the coalitions and Healthy Families Florida through monthly and quarterly meetings, and we continue to hold conference call trainings on screening as needed.

c. Plan for the Coming Year

In FY2009, the department will continue to complete activities needed to launch the revised prenatal risk screen. This will include training and technical assistance as needed regarding the revised screen, the revised Healthy Start Standards and Guidelines Screening chapter, and the revised HMS components.

The department will continue to provide technical assistance to Healthy Start coalitions, helping them identify and confront issues that may impact their screening rates. Coalitions will continue to develop, implement, and share strategies to increase prenatal screening rates, provide ongoing technical assistance to communities, and coordinate with the Healthy Families Florida program to reduce duplication of services.

Furthermore, the department will continue to work with the coalitions to identify and implement new strategies for improving the prenatal screening rates, facilitate conference calls with community liaisons, and market the program through the revision and distribution of the Healthy Start Prenatal Risk Screening brochures in English, Spanish, and Creole.

The department will continue to maintain the HealthyStartBaby.com website we developed as a component of the 2007 statewide marketing campaign. The department will continue to hold bimonthly conference calls with community liaisons for information sharing and problem solving, develop ad hoc reports for local use, and solicit additional partners to assist in the promotion of Healthy Start risk screening. We will continue the Healthy Start monthly Meet Me Calls with care coordinators and coalitions in order to share strategies to impact Healthy Start screening rates. We will also continue to provide Healthy Start screening rate updates on the MomCare conference calls. Healthy Start coalition contracts will continue to include a core outcome measure on the Healthy Start screening consent rate in addition to the Healthy Start screening rate.

State Performance Measure 6: *The percentage of infants screened by Healthy Start*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	74	76	77	77.5	78
Annual Indicator	70.9	69.6	73.3	80.3	81.7
Numerator	149644	151150	165761	190362	194442
Denominator	211203	217131	226219	237142	237924
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	82	82.5	83	83.5	84

a. Last Year's Accomplishments

Provisional data for 2007 indicate that 81.7 percent of all infants were screened by Healthy Start, which reflects an increase over the final 2006 rate of 80.3 percent. This indicates that more parents are being informed about the importance of Healthy Start risk screening and encouraged to consent to having their infants screened. Florida's Healthy Start initiative provides for universal screening for infants. This measure is used as an indicator for ensuring all families of infants are offered the Healthy Start infant risk screening as required by Florida statutes. The screen identifies environmental, social, psychosocial, and medical risk factors that make an infant more likely to experience death in the postneonatal period.

The infant screening form is completed in the birthing facility, and it contains risk factors that are also available on the birth certificate. When the parent or guardian consents to the screen, the infant screen report data is extracted from the birth certificate rather than the screening form. If the parent or guardian's screening consent is not expressed or unknown on the birth certificate, the infant will be screened and counted in the screening rate.

The Department's Office of Vitals Statistics began statewide roll-out of an Electronic Birth Certificate system, of which, the Healthy Start Infant Risk screen is a component. The department's Infant, Maternal and Reproductive Health Unit (IMRH) provides technical assistance and resource documents to Healthy Start coalitions as they work with hospital staff to ensure a smooth transition of the current screening delivery system to the incorporation of the EBR system. IMRH staff acts as a liaison between the Office of Vital Statistics, the Healthy Start coalitions, and local county health department Healthy Start staff.

In June 2007, the Florida Department of Health launched Florida's first statewide Healthy Start Screening Marketing Campaign, which concluded in August 2007. The campaign included television and radio public service announcements in 10 media markets and 33 billboards posted throughout the state. We provided print materials encouraging pregnant women to ask their doctor about Healthy Start to the offices of 3,000 doctors. Additionally, 353 Winn Dixie grocery stores across the state displayed point of purchase coupon dispensers in the pregnancy test aisle.

We developed and launched a webpage, www.HealthyStartBaby.com, that provides information about screening and the Healthy Start program. The webpage was also translated in Spanish.

The department continued to hold bimonthly conference calls with the Healthy Start community liaisons responsible for conducting community outreach activities and to provide education to birth facility staff on the benefits of the Healthy Start program and the importance of offering the parent of each newborn the risk screen in a manner that encourages consent. The community liaison conference calls involve Healthy Start screening data updates, information and strategy sharing, training, technical assistance, and discussion regarding successes and challenges faced while conducting promotion activities. The conference calls also provided a venue for the department to solicit input from the community liaisons regarding materials developed for the marketing campaign.

The department continued to collaborate with the coalitions and Healthy Families Florida to identify innovative strategies to promote the importance of Healthy Start screening and the Healthy Start program through monthly and quarterly meetings. The department provided conference call trainings on screening as appropriate. Healthy Start coalition contracts included screening rates as a core outcome measure. The department also provided ad hoc data reports to the coalitions for trend analysis.

The department added the Healthy Start Infant Risk Screening brochures (English, Spanish and Creole) to the IMRH internet website. Also, the department's Infant Maternal and Reproductive Health Unit completed revisions to the screening chapter in the Healthy Start Standards and Guidelines and provided statewide conference call training regarding the updates.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start infant screening outreach to provide training and technical assistance for birthing facilities.				X
2. Strategies to increase screening rates are elicited from county health departments and coalitions on the monthly Healthy Start meet-me-call.				X
3. Promotion of Healthy Start screening as beneficial for all newborn infants.			X	
4. Healthy Start Screening Central Workgroup meetings to discuss annual analysis of infant risk screening instrument and strategies for addressing trends of screening data.			X	
5. Community Liaison Bi-Monthly Conference Calls to provide technical assistance on marketing strategies and consumer response; share information, ideas, and resources; and issues related to provider and consumer outreach regarding risk screening.				X
6. Conduct annual QA/QI monitoring of Healthy Start coalitions and county health departments, which includes review and discussion of percentage of women screened by Healthy Start.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Department's Office of Vitals Statistics continues statewide roll-out of the Electronic Birth Registration (EBR) system, which includes offering the Healthy Start Infant Risk screen. The department's Infant, Maternal and Reproductive Health Unit continues to provide technical assistance to Healthy Start coalitions and acts as a liaison between the Office of Vital Statistics, the Healthy Start coalitions, and local county health department Healthy Start staff.

Healthy Start coalition contracts include screening rates as a core outcome measure and coalition contract monitoring occurs annually. We provide ad hoc data reports to the coalitions for trend analysis upon request and we continue to produce the Healthy Start Annual report.

We provide Healthy Start screening rate updates on the quarterly MomCare conference calls, and bimonthly conference calls continue with the Healthy Start community liaisons. Collaborations continue with the coalitions and Healthy Families Florida through monthly and quarterly meetings, and we continue to hold conference call trainings on screening as needed.

c. Plan for the Coming Year

In FY2009, the Department's Office of Infant, Maternal and Reproductive Health will continue to work collaboratively with the department's Office of Vitals Statistics in the progressive statewide roll out the Electronic Birth Certificate system, which includes the Healthy Start infant risk screening. Statewide implementation is expected to occur within the next two years.

The department will continue to provide technical assistance to Healthy Start coalitions, helping them identify and confront issues that may impact their screening rates. Coalitions will continue to develop, implement and share strategies to increase prenatal screening rates, provide ongoing technical assistance to communities, and coordinate with the Healthy Families Florida program to reduce duplication of services.

Furthermore, the department will continue to generate the Healthy Start Annual Report, work with the coalitions to identify and implement new strategies for improving the prenatal screening rates, facilitate conference calls with community liaisons, and market the program through the revision and distribution of the Healthy Start Prenatal Risk Screening brochures in English, Spanish, and Creole. Additionally, the department has plans to design a framework for the revision of the infant risk screen at the conclusion of the revision and implementation of the prenatal risk screen which is scheduled to be fully implemented in 2008.

The department will continue to maintain the HealthyStartBaby.com website, which was developed as a component of the statewide marketing campaign held in 2007. The department will continue to hold bimonthly conference calls with community liaisons for information sharing and problem solving, develop ad hoc reports for local use, and solicit additional partners to assist in the promotion of Healthy Start risk screening. The Healthy Start monthly Meet Me Calls with care coordinators and coalitions will continue to occur and be used a medium for sharing new and proved strategies to impact Healthy Start screening rates. Healthy Start screening rate updates will continue to be provided on the MomCare conference calls. Healthy Start coalition contracts will continue to include a core outcome measure on the Healthy Start screening consent rate in addition to the Healthy Start screening rate.

State Performance Measure 7: *The rate per 1,000 of hospital discharges due to asthma in children 0-14*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	2.8	2.6	2.5	2.4	1.8
Annual Indicator	3.2	2.9	2.3	2.2	2.0
Numerator	10263	9393	7864	7600	6777
Denominator	3188880	3213214	3352639	3415172	3440180
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	1.9	1.8	1.7	1.6	1.5

a. Last Year's Accomplishments

Hospital discharges for asthma among 0 -- 14 year-olds decreased from 2.2 per 1,000 in FY2006 to 2.0 per 1,000 in FY2007. The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -- 493.9) per 10,000 children 0 -- 14 years of age is calculated with inpatient hospital discharge data from the Florida Agency for Health Care Administration (AHCA) and population data for children 0 -- 14 from Florida Community Health Assessment Resource Tool Set (CHARTS) - <http://www.floridacharts.com/charts/PopQuery.aspx>.

School Health activities to reduce childhood hospitalization included: in-school care and management (individual care plan and emergency plan development, medication administration, monitoring, and training) and health education (child self-care education, asthma management education) using the American Lung Association's Open Airways for Schools curriculum and partnership promotion for asthma friendly school environments using the federal Environmental Protection Agency's Tools for Schools. Populations served included pre-kindergarten through 12th grade student, including those with special health care needs.

Annual school health data reflect an increase in students in kindergarten to 12th grade identified with asthma from 56.9 per 1,000 for FY2006 to 60.78 per 1,000 for FY2007 (2006-07 Annual School Health Services Reports). School health nurses collaborate with multiple entities to support students with asthma in the school environment while paying specific attention to prevention, early detection, and individual in-school case management. This includes review of student health information obtained through consultation with parents and physicians, observations from school personnel and health care providers, nursing assessments, records review, referral and follow-up, medication administration and provider ordered procedures, and health education. These efforts are designed to enable school nurses to work with students to better manage their asthma and avoid hospitalization.

The Florida Department of Health (DOH) county health departments, and community partners provided technical assistance and asthma information via Web links, health education training materials, and patient brochures. Partnerships were developed with Environmental Health, School Health Services, the Environmental Protection Agency, and the Centers for Disease Control and Prevention (CDC) to facilitate these activities.

Infrastructure-building services are ongoing in many DOH programs and include supporting education and prevention initiatives through the provision of expertise, technical assistance, and guidance in childhood asthma management and care, and provision of asthma resources to community health care providers, schools, day care facilities, children and families.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Asthma education and prevention efforts through Healthy Start coalitions and county health department (CHD) school health programs to reduce asthma hospitalizations and re-hospitalizations for children.	X			
2. Training and educational initiatives to improve the early identification of high-risk young children with asthma and assist in establishing a medical home for children with asthma.		X		
3. Provision of technical assistance and supportive asthma resources and training materials to Healthy Start coalitions and CHDs.			X	
4. Provision of childhood asthma educational web links, health education training materials and patient brochures and posters to Healthy Start coalitions, CHDs, and community partners.			X	
5. Development of a child health strategic plan for Florida's children to address early identification, diagnosis, and treatment of children at high risk for asthma.				X
6. Partnerships with Environmental Health, EPA, and CDC that address asthma reduction and asthma control.				X
7.				
8.				

9.				
10.				

b. Current Activities

The DOH is collaborating with public/private agencies and organizations to reduce indoor and outdoor environmental factors that contribute to asthma in children. Partners include local county health departments, hospitals, health care providers, advocacy organizations and universities. We address lay public and health care provider education and training, and indoor and outdoor air quality issues. To raise awareness of childhood asthma, county health department staff serves on community health advisory boards, local early learning coalitions and school health advisory committees that provide input for schools, childcare programs, early care and education agencies, and Head Start programs. The department's Environmental Public Health Tracking Program links environmental and asthma hospital data to learn more about environmental factors such as wildfires and emergency room visits for individuals living with asthma.

The School Health Services Program provides technical assistance regarding school health clinic procedures for asthma management in the Florida School Health Administrative Guidelines (2007) and Nursing Guidelines for the Delegation of Care for Students with Asthma in Florida Schools (2005) <http://www.doh.state.fl.us/Family/school/health/asthma.html>. These guidelines provide administrative and clinical guidance for school nurses providing health services to students with asthma, and also provide additional links to asthma related resources.

c. Plan for the Coming Year

The DOH will continue to partner with state and national agencies to reduce airborne pollutants in homes, schools, and workplaces. Reductions in re-hospitalization are an indicator of the health care system's success in helping families and children manage and control asthma. Through a number of DOH programs, we provide existing childhood asthma resources for the county health departments to educate their staff, health care providers, children, and families about the disease and how it is affected by environmental prompts.

In FY2009, the School Health Services Program will continue to work with the county health departments and their school health programs to promote childhood asthma education and prevention activities for children and their families, and provide resources to assist school nurses with school-based asthma management to reduce hospitalizations of students with asthma. The Department of Pulmonology at the University of Florida is developing a CD to train school health staff and community partners on effective asthma management. The School Health Services Program office staff will facilitate the distribution of this CD to local school health coordinators. In addition, the program office staff will continue to partner with DOH Environmental Health staff and community agencies and organizations to improve the early identification of young children with asthma and promote the establishment of medical homes for children with asthma. It is a priority of the department to raise public awareness and educate the public that severe asthma episodes can be prevented through early identification, monitoring, and proper management of the disease.

State Performance Measure 8: *Excess feto-infant mortality attributed to the maternal health/prematurity category in the PPOR statewide analysis.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				3.7	2.6
Annual Indicator	3.8	2.8	2.4	2.7	
Numerator	805	261	263	321	
Denominator	211444	93276	111726	120919	
Is the Data Provisional or Final?				Final	

	2008	2009	2010	2011	2012
Annual Performance Objective	2.6	2.5	2.5	2.4	2.4

Notes - 2007

Data for 2007 are not yet available.

Notes - 2006

Data for 2005 and 2006 are not yet available. The PPOR analysis uses birth record data linked to infant death data. Since infant death can occur up to 1 year from the date of birth, infant death data for a full year after the birth dates must be linked to the birth records. For births occurring in 2004, infant deaths occurring in 2004 and 2005 need to be linked to the births. Complete data for infant deaths occurring in 2006 will not be available until August of 2007 and plans are to have the linked file available in December 2007. The PPOR analysis for 2005 would be available by February 2008, and the PPOR analysis for 2006 would be available by February 2009.

These data are revised for 2002 and 2003 due to changes in the definition of the comparison group. This was necessitated by changes in the 2004 birth record.

Notes - 2005

Data for 2005 are not yet available. The PPOR analysis uses birth record data linked to infant death data. Since infant death can occur up to 1 year from the date of birth, infant death data for a full year after the birth dates must be linked to the birth records. For births occurring in 2005, infant deaths occurring in 2005 and 2006 need to be linked to the births. Complete data for infant deaths occurring in 2005 will not be available until August of 2007 and plans are to have the linked file available in December 2007. The PPOR analysis for 2005 would be available by February 2008.

a. Last Year's Accomplishments

Healthy Start continues to play an active statewide role in preconception and interconception health for women in Florida. Healthy Start services are available to women statewide who have risks that may impact their pregnancy outcome. Through Healthy Start, interconception risk screening, education and counseling, and needed referrals are being provided to Healthy Start prenatal clients, to the mother of a Healthy Start enrolled infant, or to a Healthy Start woman who has experienced a fetal loss or miscarriage. Counseling may be provided to an individual or in a group setting, but must be provided in person. Changes to rule were made in order to provide and code for services for the interconception woman to include the woman who is past the six week postpartum period but has no infant to code to due to fetal loss, adoption, miscarriage, etc.

Topics that must be addressed in each curriculum include: access to care, baby spacing, nutrition, physical activity, maternal infections including immunization status and periodontal disease, chronic health problems, substance abuse, smoking, mental health, and environmental risk factors. Mothers of infants who were born prior to 37 weeks gestation or under 2500 grams at birth or with congenital abnormalities, teen mothers, and those with chronic health conditions are critical groups considered for these services; however, any woman may have risk factors that could be mitigated through intervention or behavioral change implemented prior to embarking on a subsequent pregnancy. Screening tools such as the Women's Health Questionnaire and the Tell Us About Yourself Questionnaire are utilized to identify many of these risk factors.

The department collaborates with the Healthy Start coalitions, as well as community partners, to facilitate the provision of interconception education and counseling. Standards and guidelines and coding structures are in place so Healthy Start providers can provide and track interconception education services provided to clients. Bi-annual training on the topic of interconception education and counseling remains part of Healthy Start core training. At the local level, coalitions trained their staff and provider staff on interconception topics and appropriate use of their approved curriculums. In 2007, all coalition areas were providing interconception education and counseling through the Healthy Start system. During 2007, Healthy Start

coalitions provided 55,221 interconception education and counseling services to 17,922 clients for an average of 3.08 services per client. These numbers represent a 50 percent increase over the number of services delivered and clients served in 2006.

The department also continues to promote technical assistance guidelines that direct preconception and interconception education and care topics that should be provided to women of child bearing age who access clinical care within the county health department programs. Educational presentations have been shared with providers in Children's Medical Services, prenatal care, school health, and family planning programs.

The VitaGrant project completed its third and final year. Over the grant period the project distributed over 565,000 bottles of multivitamins containing 400 mcg of folic acid and preconception education to nonpregnant, low-income women of child bearing age. A total of 182 sites, including community health centers, WIC, family planning, and private providers were recruited as distribution sites for this project. Field staff throughout the state trained providers and communities about preconception and interconception topics. The VitaGrant project collected data suggesting that free multivitamin distribution and preconception education can dramatically increase multivitamin consumption among participants, especially among at-risk populations such as Mexican Hispanics.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Interconception Education and Counseling provided through Healthy Start according to Healthy Start Standards and Guidelines, Chapter 21.		X		
2. County health departments providing preconception and interconception education according to Technical Assistance Guidelines: Maternal 11.		X		
3. Collaboration with the March of Dimes to administer the VitaGrant project, which makes available multivitamins, containing 400 mcg of folic acid, and preconception education to women of childbearing age.			X	
4. Training and education on preconception and interconception interventions offered to clinical providers who interact with women of childbearing age, such as family planning, school health, visiting doula programs, CMS and private sector providers.				X
5. Develop a Preconception Advisory Council for Florida.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Florida Department of Health was allotted a one-time sum of \$2.7 million in Federal funding in 2006, as part of the Maternal and Child Health Block Grant, to provide Interconception services and education to women of childbearing age in Florida, in order to reduce the number of poor birth outcomes. Funding was distributed to Florida's 32 Healthy Start coalitions.

Proposals were submitted in September of 2006, and were based on the Centers for Disease Control and Prevention's 10 Recommendations to Improve Preconception Health and Health Care. Proposals included activities that specifically encompass Recommendation 5,

Interconception Care for women who have had a previous adverse pregnancy outcome, and included at least one of the following: community outreach, provider education, or direct services. Projects ended December 31, 2007.

On an individual level, 3,700 clients were provided with direct services, with a total of 5,477 client encounters over a one-year period. Services ranged from prenatal risk screenings, to education about folic acid and obesity, to dental cleanings.

On a group education level, 5,762,177 Floridians were reached through various media outlets and public service announcements. In addition, focus groups, workshops, and group counseling sessions took place to educate women on the topic of preconception and interconception health care.

c. Plan for the Coming Year

Florida's Pregnancy Associated Mortality Review (PAMR) team and 12 state funded Fetal Infant Mortality Review (FIMR) projects will continue to collect data that supports the theory that our state has a significant opportunity to improve our maternal and infant mortality outcomes by intervening prior to or at the time of conception, by controlling chronic disease or infection, promoting healthy weight and lifestyles, and planning for pregnancies.

The Department has received a \$50,000 grant to support the creation and function of a statewide Preconception Health Advisory Council that will identify best practices and make recommendations related to preconception health promotion and service availability in Florida.

We are also developing client education materials that primary care providers can utilize to share preconception education with their clients based on identified client risks and needs. We have permission from the California March of Dimes to utilize the format and name of their Every Woman Every Time product that has already been developed and tested.

We will continue to train our county health department providers working with women of reproductive health age to incorporate preconception health screening, education, and services into their existing practices based on existing preconception health guidelines. We continue to collaborate with the March of Dimes to promote preconception health and encourage women to access early prenatal care.

Healthy Start will continue to provide interconception education to participants. The department will help the few coalition areas not currently providing this service to develop or adopt a curriculum, train staff, and build capacity to provide interconception education. Only four counties have been unable to offer this service to date. .

VitaGrant will finalize the evaluation phase of the project and the department, and the March of Dimes will work to distribute outcome information to providers and community agencies to show evidenced based practices that can be helpful in education women about the importance of adequate folic acid consumption and effective strategies to promote healthy lifestyle changes.

The department will continue to provide education and training to public and private providers who interact with women of childbearing age in any capacity so they can reinforce preconception and interconception topics with their clients.

E. Health Status Indicators

Provisional data for 2007 indicate the percentage of low birth weight remained the same as the previous year, 8.7 percent. This percentage remained fairly steady over the past five years,

fluctuating between the low of 8.5 percent in 2003 to a recent high of 8.8 percent in 2005. Provisional data for 2007 for the percentage of singleton births that were low birth weight also indicate no significant change, with a provisional rate of 7.0 percent compared to 7.1 percent in 2006. This indicator has also remained fairly static over the past five years, ranging between 6.8 percent in 2003 to a recent high of 7.1 percent in 2006. Provisional data on very low birth weight deliveries indicate that the percentage remains at 1.6 percent, the same as it has been every year since 2001. Very low birth weight among singleton deliveries has also remained fairly constant, at either 1.2 percent or 1.3 percent for each of the past five years.

According to provisional data for 2007, the death rate per 100,000 due to unintentional injuries among children age 14 and younger is 10.0 per 100,000. Over the past five years, this rate has declined steadily since a high of 11.7 per 100,000 in 2003, with a final rate of 10.7 per 100,000 in 2006. Provisional data for 2007 indicate a rate of 3.1 per 100,000 for fatal unintentional injuries among children 14 and younger due to motor vehicle crashes. The final rate was 3.1 per 100,000 in 2006, a considerable decrease from the 4.2 per 100,000 rate reported in 2005. Provisional data for 2007 indicate a rate of 29.2 per 100,000 from unintentional injuries due to motor vehicle crashes among youth 15 through 24, compared to a 2006 rate of 33.9 per 100,000 in 2006.

Provisional data for 2007 on nonfatal injuries among children 14 and younger indicate a rate of 174.7 per 100,000. Final data for 2006 indicate a rate of 175.7 per 100,000, the lowest rate over the past five year by a significant margin. Provisional data for 2007 for the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children 14 and younger indicate a rate of 27.6 per 100,000, compared to 28.8 per 100,000 in 2006. Provisional data for 2007 for nonfatal injuries due to motor vehicle crashes among youth 15 through 24 indicate a rate of 174.1 per 100,000, compared to 168.3 per 100,000 in 2006.

Over the past five years, the rate per 1,000 women age 15 through 19 with a reported case of chlamydia has varied between a high 26.0 per 1,000 in 2002 to a low of 23.2 per 1,000 in 2005. Provisional data indicate a rate of 27.4 per 1,000 for 2007, compared to a final rate of 25.3 per 1,000 in 2006. Between 2002 and 2005, the rate per 1,000 women 20 through 44 with a reported case of chlamydia remained fairly constant, between 6.9 per 1,000 in 2002 and 7.1 per 1,000. In 2006, the rate jumped to 7.7 per 1,000. Provisional data indicate an even higher rate of 8.6 per 1,000 for 2007.

Data for indicators HIS 06A through HIS 12 are included in the forms. Much of the data has been noted as being estimates, as Florida does not tabulate population estimates for Hispanics and various racial categories, only on white, black, or other.

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.

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 2006, there were 27,119 incoming calls to the Family Health Line,

compared to the 20,981 calls in 2004.

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 Council: The Florida Folic Acid Council (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.

Osteoporosis Prevention and Education Program: Provides information to Floridians across the lifespan. Curriculums are designed to build foundation for healthy living through increased awareness of the benefits of physical activity, healthy eating habits, to not smoke and drink alcohol in order to build and maintain healthy bones. The following osteoporosis educational programs are provided statewide: Families Building Strong Bones, an adult education program; Food for Thought, a high school program; Fit for Life, a middle school educational program, and The Bone Zone, a children's educational program.

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: Program staff provides training and technical assistance to county health departments and rape crisis centers, develops program and policy guidelines, responds to legislative issues, provides professional and public education, and conducts a public awareness campaigns on rape risk reduction and on the prevention of rape.

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. The project has two phases, planning and implementation. Florida completed the first two phases. Phase III begins in July 2006.

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.

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

Effective strategies to help private and public practitioners integrate preconception health and infant developmental screening and education into existing clinical practice patterns and how to bill Medicaid and private insurance for these services.

V. Budget Narrative

A. Expenditures

There were no significant variations in expenditures in forms 3, 4, and 5 from previous years. Expenditure data for Florida is included on forms 3, 4, and 5. Expended amounts differ from budgeted amounts by more than 10 percent. In Florida, we do not receive budget authority to allocate the entire budgeted amount.

B. Budget

Federal funding through the Title V MCH Block Grant provides needed support to our statewide efforts. Of the \$19,012,075 budgeted as the expected federal allotment for 2008, \$6,620,004 is budgeted for preventive and primary care for children (34.82 percent), \$7,874,801 for children with special health care needs (41.42 percent) which meets the 30 percent-30 percent requirements. In addition, \$1,283,315 (6.75 percent) is budgeted towards Title V administrative costs, less than the maximum of 10 percent requirement. Total state match for 2008 is \$169,471,378, which exceeds the state's FY 1989 maintenance of effort amount of \$155,212,322. Sources of other federal funds include the SSDI grant, the Abstinence Education Block Grant, WIC, the USDA CACFP grant, the Preventive Health Services Block Grant, Florida's Medipass Waiver, and CDC grant awards. A complete list of other federal funds with funding amounts is included on Form 2 and the notes for Form 2. Budget numbers for Florida are included on forms 2, 3, 4, and 5.

Expended amounts differ from budgeted amounts by more than 10 percent. In Florida, the state legislature approves the amount of funding that can be expended for all programs, including the allocation of federal funds. We do not receive budget authority to allocate the entire budgeted amount.

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.