



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.3 Table of Contents

I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT

1.1 Letter of Transmittal

1.2 Face Sheet 1

1.3 Table of Contents 2

1.4 Overview of the State 4

1.5 The State Title V Agency..... 6

1.5.1 State Agency Capacity..... 6

1.5.1.1 Organizational Structure 6

1.5.1.2 Program Capacity 9

1.5.1.3 Other Capacity..... 15

1.5.2 State Agency Coordination 16

II. REQUIREMENTS FOR THE ANNUAL REPORT [Section 506]

2.1 Annual Expenditures..... 23

2.2 Annual Number of Individuals Served 24

2.3 State Summary Profile 24

2.4 Progress on Annual Performance Measures..... 25

2.5 Progress on Outcome Measures 40

III. REQUIREMENTS FOR APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population..... 47

3.1.1 Needs Assessment Process..... 47

3.1.2 Needs Assessment Content 48

3.1.2.1 Overview of the Maternal and Child Health Population’s Health Status..... 48

3.1.2.2 Direct Health Care Services 66

3.1.2.3 Enabling Services..... 66

3.1.2.4 Population-Based Services 70

3.1.2.5 Infrastructure Building Services 73

3.2 Health Status Indicators 74

3.2.1 Priority Needs 74

| | | |
|---------|---|----|
| 3.3 | Annual Budget and Budget Justification..... | 75 |
| 3.3.1 | Completion of the Budget Forms | 75 |
| 3.3.2 | Other Requirements..... | 75 |
| 3.4 | Performance Measures..... | 75 |
| 3.4.1 | National "Core" Five Year Performance Measures | 76 |
| 3.4.1.1 | Five Year Performance Targets..... | 76 |
| 3.4.2 | State "Negotiated" Five Year Performance Measures | 76 |
| 3.4.2.1 | Development of State Performance Measures | 76 |
| 3.4.2.2 | Discussion of State Performance Measures | 76 |
| 3.4.2.3 | Five Year Performance Targets..... | 78 |
| 3.4.2.4 | Review of State Performance Measures | 78 |
| 3.4.3 | Outcome Measures | 78 |

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

| | | |
|-----|--|----|
| 4.1 | Program Activities Related to Performance Measures | 80 |
| 4.2 | Other Program Activities | 90 |
| 4.3 | Public Input | 94 |
| 4.4 | Technical Assistance | 95 |

V. SUPPORTING DOCUMENTS

| | | |
|------|--|--------|
| 5.1 | Glossary | 95 |
| 5.2 | Assurances and Certifications..... | 102 |
| 5.3 | Other Supporting Documents..... | 108 |
| 5.4 | Core Health Status Indicator Forms | SD 1 |
| 5.5 | Core Health Status Indicator Detail Sheets..... | SD 6 |
| 5.6 | Developmental Health Status Indicator Forms..... | SD 17 |
| 5.7 | Developmental Health Status Indicator Detail Sheets | SD 29 |
| 5.8 | All Other Forms..... | SD 46 |
| 5.9 | National "Core" Performance Measure Detail Sheets | SD 90 |
| 5.10 | State "Negotiated" Performance Measure Detail Sheets | SD 110 |
| 5.11 | Outcome Measure Detail Sheets | SD 120 |
| | Notes..... | SD 126 |

1.4 Overview of the State

Demographic and geographic characteristics of Florida create unique challenges. The south Florida region is primarily urban, with tremendous ethnic diversity. The Hispanic population continues to grow, particularly in the Miami-Dade area, which is predominantly Hispanic. Additionally, although areas of central Florida are experiencing massive growth, much of the growth is in the service industry where, typically, few benefits are provided for workers and contributions to the tax base of counties are small. In addition to urban pockets of poverty, Florida has agricultural rural areas that are sparsely populated, have lower than average per capita income, and few health care providers and other support services. The undocumented citizen population continues to grow, especially in agricultural rural areas in the state. The health care issues for this group, because of their citizenship status and geographic location, create unique challenges for the local communities. Florida Native American Indians also continue to present a challenge for MCH service delivery. As in other states, the service delivery system in Florida has undergone immense change in the past five years. The traditional fee-for-service provider relationship has given way to managed care systems with varying degrees of accessibility and welfare reform has changed the support available for poor families.

Florida is a multicultural state with complex growth and health care problems. Florida's population is projected to reach 17 million by the year 2010. Immigration and agricultural migration of foreign workers continue to contribute to Florida's challenge of meeting health needs of vulnerable populations. These populations, which tend to cluster in certain geographic areas, are often the most difficult to reach and contribute disproportionately to the health problems of pregnant women and children. Additionally, Florida, like many other states, experiences significant racial and ethnic disparity in health outcomes in the MCH population.

The 2000 Florida legislative session included the passage of several bills that will impact the maternal and child health population. The most significant, perhaps was a racial and ethnic disparity bill entitled "Closing the Gap" which will provide approximately \$5,000,000 of general revenue funding to address racial and ethnic disparities in health outcome indicators including infant mortality. The session also included the passage of a bill related to abandoned newborns. This legislation provides mechanisms by which newborns may be left at either hospitals or fire stations in order to reduce the incidence of newborns being abandoned in unsafe locations. The bill also includes the creation of a media campaign to create public awareness about the issue. Legislative changes in the KidCare program included moving children

age 0-1 from MediKids to Medicaid, authorizing presumptive eligibility for Medicaid-eligible children, and adding an optional dental benefit to KidCare. Additional appropriations include funding for 102,000 new KidCare slots, for an available total of 309,482. New legislation calls for the screening of all infants for hearing impairment prior to hospital discharge. Finally, legislation was also passed that creates domestic violence fatality review teams. The Department of Health will work closely to assure close collaboration among our existing mortality review teams with these new teams.

Florida has been successful in accessing state welfare reform resources for the provision of services to the maternal and child health population. In fiscal year 2000, the department will receive \$10 dollars in Temporary Assistance for Needy Families (TANF) funds for the following activities:

- \$2 million allocated to Title XXI efforts to increase outreach activities,
- \$4 million allocated to Abstinence Only Education, and
- \$2 million allocated to maternal and child health to provide statewide training on a home visiting curriculum that teaches early brain development concepts within the structure of MCH prenatal and infant home visiting curriculum. Over 2000 Healthy Start and Healthy Families Florida staff members will have received this training by the end of the funding period.

The coming year will include program emphasis in the following areas:

- 1) addressing the issue of access to prenatal care for all women;
- 2) the continued collaboration between the Healthy Start program and Healthy Families Florida (modeled after Healthy Families America, this is a child abuse prevention effort);
- 3) expansion of our quality improvement process to include analysis using the WHO Periods of Risk analysis, for use in determining the best point for a community to intervene to reduce infant mortality;
- 4) addressing the need for increased maternal and child health data capacity;
- 5) participating in departmental efforts to implement the Sterling Quality Management Process; and
- 6) Abstinence Only Education to reduce teen pregnancy, out of wedlock births, unintentional pregnancies, sexually transmitted infections, and psychological traumas.

The state Title V director and the deputy secretary for Children's Medical Services (CMS) are recognized as innovative leaders in building a strong infrastructure and service delivery system for maternal and child health (MCH) services. The department has built a system of locally-based providers, families and

coalitions with informal as well as formal mechanisms for providing input into the status of health services delivery for families and children. These include the county health departments, Healthy Start Coalitions, CMS regional offices, MCH and CMS staff, and various consumer representatives. Department of Health leadership continues to strengthen collaboration with Florida's traditionally black colleges and universities to assure adequate representation of minority populations. Lastly, close collaboration with other major universities in Florida, including colleges of public health, medical schools and MCH-related foundations, also contributes information essential for setting priorities and determining the magnitude of importance of competing factors in the environment.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

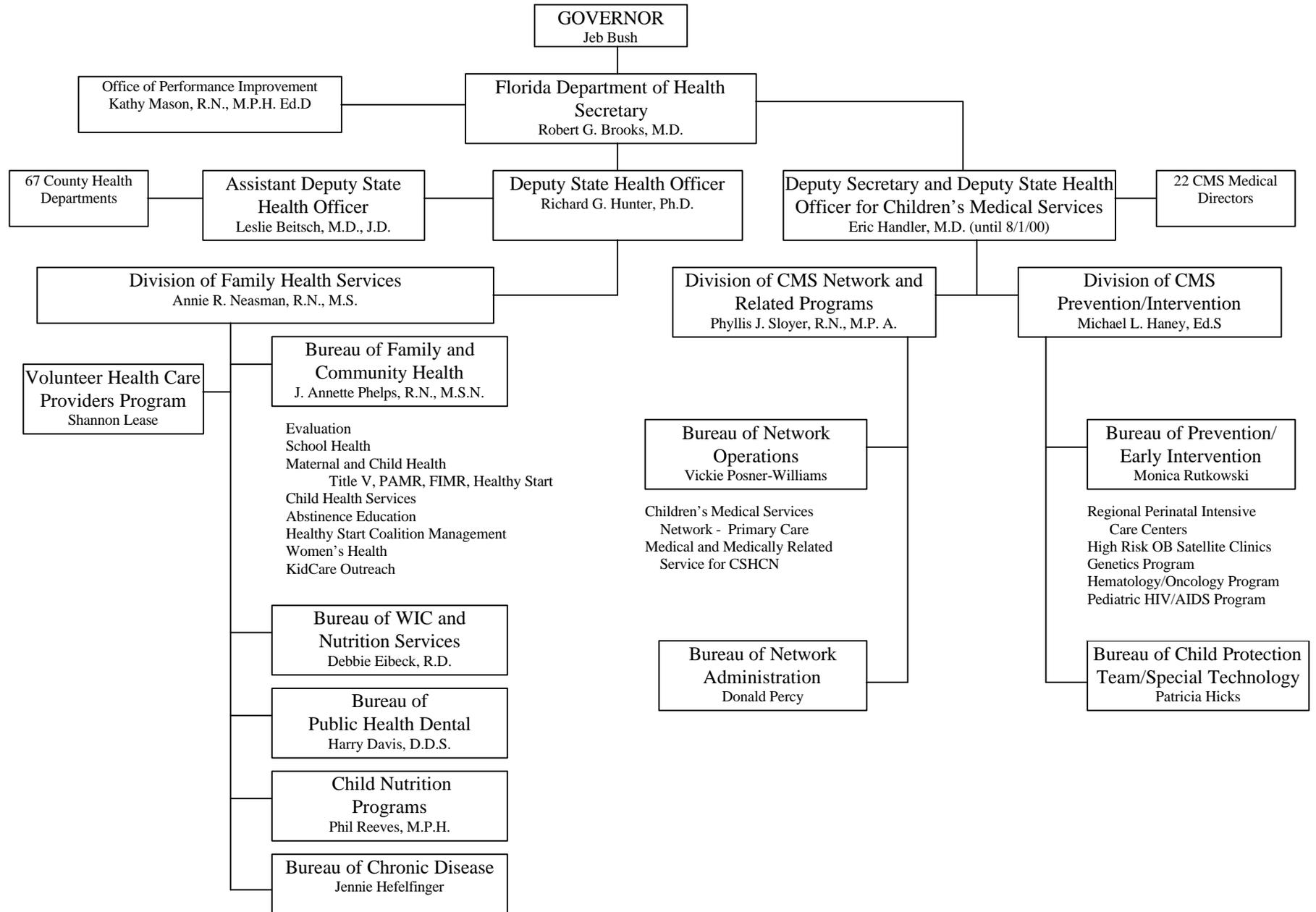
1.5.1.1 Organizational Structure

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 including CMS. The Secretary is assisted by a Deputy Secretary for CMS, a Deputy State Health Officer and an Assistant Deputy State Health Officer. The Deputy State Health Officer is responsible for the Division of Family Health Services. The Division Director of Family Health Services provides leadership, policy and procedural directions for Family Health Services, and the Chief of the Bureau of Family and Community Health is responsible for direction of the MCH unit, school health, Title V Outreach, Abstinence Education, and women's health. The Deputy Secretary for CMS is responsible for the provision of a family-centered, coordinated, managed system of care for CSHCN, and for providing essential preventive, evaluative and early intervention services for children. These services are provided through the Division of Network and Related Programs, the Division of Prevention/Intervention and 22 local clinics.

DEPARTMENT OF HEALTH

Location of Title V programs

July 1, 2000



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.

1.5.1.2 Program Capacity

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. 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

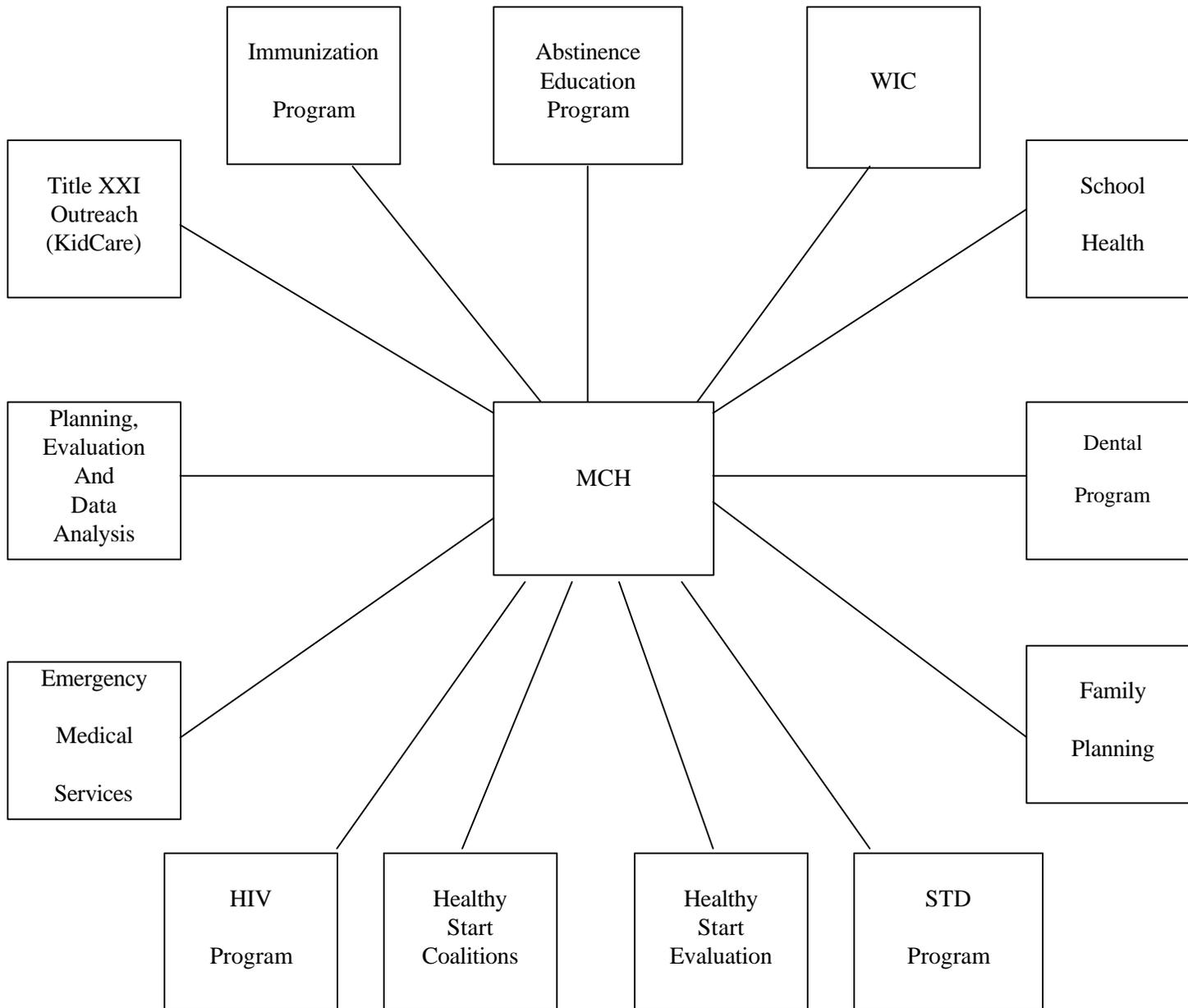
delivery systems, but also on the psychosocial, environmental and structural processes that contribute to fetal and infant deaths, and simultaneously complement the community-based nature of the Healthy Start Coalitions.

School health is the primary delivery system for preventive and primary care services for children. School health mandates preventive health services in grades K-12 including record reviews; health, nursing and nutrition assessments; preventive dental program; vision, hearing, scoliosis, growth and development screening; and curriculum development to children in public and private schools.

Within the Title XXI Outreach section (KidCare) strategic planning for child health initiatives beyond those provided in schools is being developed, including work towards establishing a health care home for all children. Florida KidCare is dedicated to getting all children through age 18 covered by comprehensive child health insurance that promotes a medical home for each child. Over 220,000 applications were processed during the first year because of linkages at the state and local levels with public and private partners. Our capacity to motivate families is enhanced by partnerships with the four major insurance components: KidCare Medicaid, MediKids, Florida Healthy Kids, and the Children's Medical Services Network at the state and local levels. We have 26 Regional KidCare Outreach Projects that link with the insurance partners and community-based organizations that serve families throughout the state. The regional projects educate community leaders and work with families on a one-to-one basis to promote child health insurance. We also reach out to families through multi-media marketing strategies including radio, television, endorsements by local leaders, and through incentive items such as pens, toothbrushes and key chains.

The department's dental health program, family planning and women's health programs, and abstinence education program provide additional services to the MCH population.

Department of Health Offices and Programs
That Coordinate with MCH on Title V Activities



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 assure services are delivered, but not necessarily by the county health departments 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, 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. Through an allocation methodology developed at the state level, MCH block grant funds are distributed to local Healthy Start Coalitions for the support of building infrastructure and the provision of services to the MCH population.

The Children's Medical Services program provides children with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric care. The CMS statewide, integrated system of care includes a network of services ranging from prevention and early intervention programs to primary and specialty care programs including long-term care for medically complex, fragile children. Patients 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. CMS, in coordination with Medicaid, has established 17 Children's Multidisciplinary Assessment Teams to staff the needs of children and families who require long-term care services. Long-term care services include Medical Day Care, Medical Foster Care, Nursing Home Care and in-home wrap-around services. All CMS services are provided through a panel of CMS consultant physicians who meet specific credentialing requirements to ensure quality pediatric care. The benefit package mirrors Florida's Medicaid package of services plus additional supporting services such as respite and parenting-skill programs.

In 1996, the Florida Legislature passed legislation making the CMS Network available as a recognized managed care choice for Medicaid recipients who are required to choose a managed care option, i.e. Medicaid HMO or MediPass (managed fee-for-service). Medicaid children with special health care needs may choose the CMS Network as their health care choice if they

meet medical screening criteria. Services are reimbursed directly by Medicaid in a fee-for-service arrangement. Each child has a primary care physician who provides or directs the care of the child and a CMS nurse case manager.

In 1998, the Florida Legislature extended CMS Network benefits to children with special health care needs who are enrolled in Florida's KidCare program for uninsured children through the Children's Health Insurance Program (Title XXI). This program is capitated and operates within enrollment limits established by the legislature. In addition, it includes a joint partnership with Children's Mental Health in the Department of Children and Families in the Behavioral Health Network to provide coordinated physical and behavioral health care for school-age children with a mental health diagnosis including substance dependence.

In addition to the two CMS Network insurance products (Title XIX and XXI), the program maintains the original CMS Safety Net program for special needs children who may not be eligible for either of these programs.

Prevention programs are integral to the CMS service system and include the Regional Perinatal Intensive Care Centers (RPICC) that provide optimal medical care for high-risk pregnant women and sick/low birth weight newborns requiring neonatal intensive care unit services. Eleven regional centers provide a complete range of medical and medically-related services for pregnant women and sick or low birth weight newborns, and community-based consultative obstetrical services for high-risk pregnant women are available at 15 satellite clinics. Participants in the program must be Medicaid or Title XXI eligible.

The Genetics Program provides services to help prevent the primary occurrence of genetic disease and the occurrence in subsequent pregnancies. Services are provided at Florida's three medical centers with outreach services available at CMS clinic locations. Through the Teratogen Information Service (TIS), health professionals are provided information on agents that are known or suspected to have an adverse effect on prenatal development of the fetus. Services include diagnosis, evaluation, counseling and laboratory testing.

The Pediatric AIDS/HIV program include services such as, but not limited to, evaluation, diagnosis, care coordination, nutrition counseling, permanency planning, assistance with

transportation and other support services. Infants and children with HIV/AIDS have access to a continuum of services through a network of nine HIV centers and CMS satellite clinics.

Florida's Infant Screening Program is a statewide program, through which all newborns are screened for certain metabolic, congenital, and hereditary disorders prior to discharge from the birthing facility. Florida began screening all newborns for phenylketonurea in 1965. Since that time, four additional disorders have been added to the program, which include: congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia and hemoglobinopathies. The primary goals of the program are: (1) to assure that all infants born in Florida are screened and that testing is processed within two weeks of birth; (2) to assure that all affected infants receive appropriate confirmatory testing, counseling and treatment as soon as possible; and (3) to assure that all affected newborns are placed into a system of care in a timely fashion. All disorders currently screened through the Infant Screening Program may result in death, mental retardation, or physical disability if they are not promptly diagnosed and treated. Early diagnosis and treatment allows these newborns to grow and develop normally.

The Child Protection Teams (CPTs) are medically directed, multidisciplinary teams available to supplement the Department of Children and Families Family Safety and Preservation program in assessment activities in suspected reports of child abuse and neglect. In January 1999, the authority for oversight of the child protection teams was placed under the direction of the Children's Medical Services program office. The Child Protection Teams function as independent consultative resources in their respective communities. There are 23 teams available throughout the state to provide specialized assessments and services to child victims and their families. Services provided may include: medical diagnosis and evaluation, medical consultation, specialized interviewing of suspected child victims, family psychosocial assessment, nursing assessment, psychological evaluation, and multidisciplinary staffing. The Sexual Abuse Treatment Program (SATP) also serves as a resource for the Department of Children and Families when the Child Protection Team assessment process identifies children and their families as needing sexual abuse treatment services. Services include group counseling and adjunctive family and individual counseling. The goal of this treatment component is to prevent further child sexual abuse from occurring.

CMS also oversees the Poison Information Center Network. Poison Information Centers, located in Tampa, Miami and Jacksonville, provide information regarding poison exposures to

consumers and health practitioners throughout Florida. Poison prevention and management information is provided 24 hours a day through a toll-free number. During 1999, approximately 170,000 calls were handled by poison information specialists at the three centers. About 50 percent of the poison exposure calls involved children under age 6. Prevention education programs for consumers and health providers are offered by all poison centers in local communities. In 1999, more than 1,500 educational programs were provided throughout the state.

1.5.1.3 Other Capacity

The Title V programs are distributed among the Division of Family Health Services and the Division of CMS. As of May 2000, there were approximately 25 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: Annie R. Neasman, R.N., M.S., Division Director for Family Health Services; Annette Phelps, A.R.N.P., M.S.N., Bureau Chief, Family and Community Health, State Title V Director; Cindy Lewis, R.N., M.P.H., B.S.N., Executive Community Health Nursing Director; Lynn Elliott, R.N., M.S.N., Registered Nursing Consultant Coordinator for MCH unit; Carol Graham, Ph.D., Associate in Research; Jim Bailey, Senior Management Analyst II/Coordination, Healthy Start Coalition Management; and Maurine A. Jones, Ph.D., Director of Evaluation. Additional capacity is provided through the 30 Healthy Start Coalitions covering 65 of the 67 counties in Florida, and through the coalition's partnership with the private sector, the public sector, state government, local government, community alliances, and maternal and child health care providers.

As of May 2000, there were approximately 57 central office staff in the Division of Children's Medical Services who perform duties for Title V funded programs. There are approximately 670 out-stationed staff in the 22 CMS area offices located throughout the state. The senior level management employees include: Eric G. Handler, M.D., M.P.H., Deputy Secretary for CMS; Phyllis Sloyer, R.N., M.P.A., Division Director for CMS Network and Related Programs; and Michael Haney, Ed.S., Division Director for CMS Prevention and Early Interventions Programs. There is one full-time statewide resource parent consultant at headquarters (Tom Nurse) and one part-time parent consultant (Conni Wells). Also, each of the 16 early intervention contracts has budget support for a 1.5 full-time Family Resource

Specialists in 15 service areas. The role of these parents is to ensure that all programs, policies, activities, and materials are family-friendly and support the concept of family-centered care. Dr. Handler will be leaving the Deputy Secretary position on August 1, 2000, and as of June 1 a replacement has yet to be named.

1.5.2 State Agency Coordination

The Department of Health provides or coordinates a wide range of public health services through headquarters programs, county health departments, primary care associations, and tertiary care facilities. Public health services are often provided in collaboration with other state human services agencies, including education, juvenile justice, corrections, social services, child welfare, Medicaid, social security, emergency medical services, and alcohol, drug abuse and mental health. This collaborative effort focuses on the provision of health and preventive care services, the promotion of optimal health outcomes, and the monitoring of the health status of the population. The following are descriptions of state agency coordination efforts to promote these efforts.

In an effort to present an integrated, seamless service delivery system to families of vulnerable children, the Department of Health Division of Family Health Services has worked in close collaboration with Children's Medical Services to assure communities have procedures for coordinating services to the population eligible for both Healthy Start and the CMS Early Intervention Program. This population includes those infants who are eligible for Part C because they were severely low birth weight or have other developmental disabilities. A statewide project, Florida's Transition Project for Infants, Young Children, and Their Families continues to provide statewide oversight and technical assistance to 15 local county teams who are developing transition plans for their communities and are negotiating interagency agreements among providers in order to ensure smooth transitions for children from birth to age 6.

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 are provided to expand health care services and are placed in schools where there are high incidences of medically underserved high-risk children, teenage pregnancy and poor birth outcomes.

The MCH role in the State Children's Health Insurance Program under Title XXI of the Social Security Act, is to assure access to care through outreach and the eligibility application process. CSHCN are served through the CMS Network. The Florida KidCare plan provides services to children from birth to age 5 through either a Medicaid managed care plan or Medipass, extending Medicaid coverage for children age 15-19 in families with incomes up to 100 percent of the federal poverty level.

MCH programs are involved in work force development and other welfare reform activities through collaboration with the Department of Labor and Employment Security and the Department of Children and Families. Specific activities directed towards the MCH population include activities designed to target the prevention of primary and secondary teenage pregnancy and the reduction of unwed pregnancy.

The Department of Health works in partnership with the Department of Children and Families to implement 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 comprehensive system of support for the prevention of child abuse and neglect. Current work efforts are focusing on the effective integration of this program with Florida's Healthy Start within local communities. State level coordination is directed toward integrated training and client identification through the development of a coordinated screening process. A state level workgroup has successfully revised the Healthy Start prenatal screening instrument to include the risk factors for referral into Health Families Florida. The revised instrument will be implemented following statewide training on the integrated tool. An additional workgroup has been formed to address referral and care coordination issues among the two programs. Through MCH program quality assurance monitoring and technical assistance to communities, staff are evaluating successes and challenges of the local Healthy Start/Healthy Families Florida partnerships and providing assistance accordingly.

In an effort to increase health care access for indigent people in Florida through volunteerism, the 1992 Florida Legislature passed the Florida Health Care Access Act that created the Volunteer Health Care Provider Program. The Department of Health administers the Volunteer Health Care Provider Program through the county health departments. Currently, Florida has

over 17,000 health care professionals statewide who donated over \$50,000,000 in services to the needy in 1999.

The Department of Health works collaboratively with Florida universities to implement maternal and child health initiatives and projects. These collaborations enable the state to access resources unique to the university setting. The following are current university partnerships:

University of South Florida: Lawton and Rhea Chiles Center for Healthy Mothers and Babies at the University of South Florida

Maternal and Child Health workforce development initiative, which includes the development of a plan to address the following issues:

- Identification of MCH occupations.
- Determination of the demand for staff in each of these occupations, now and over the next 10 years.
- Determination of the skills and competency level required for effective practice in each of these occupations.
- Identification of curriculum available for training of MCH staff in all occupational areas, with particular emphasis on application of knowledge in practice settings.
- Development and testing of curriculum, training materials and training methodologies when such are not already available.
- Organization and management of a statewide training network for MCH workforce development.
- Creation of occupational ladders within the MCH field.
- Adoption of certification procedures for relevant MCH occupations.

Perinatal Data Center : The Perinatal Data/Research Center, located at the University of Florida and under the direction of Dr. Michael Resnick, provides a warehouse for maternal and child health data from statewide sources and many local sources. The center stores and validates this data, links related data files, publishes and analyzes data, and studies the impact of program interventions on health status outcomes. The center makes the raw and linked data files available to program managers at the state and local level and to people doing research.

Maternal and Child Health Child Development Training: During the 2000/2001 fiscal year, Chiles Center staff will coordinate and implement training programs directed to health care providers who serve Medicaid-eligible pregnant women and children. Staff will:

- 1) Coordinate, plan and conduct statewide and regional education programs for maternal and child health care providers serving Medicaid-eligible pregnant women and children. The programs will provide continuing education and university credits for various professionals.
- 2) Develop a curriculum for preceptors to train MCH staff on the use of the Ages and Stages Questionnaire. The curriculum will include guidelines and checklists for the preceptors to use in guiding practicum experiences.
- 3) Provide technical assistance and support to the Agency for Health Care Administration and the Department of Health in the coordination of training needs for health care providers who serve Medicaid-eligible pregnant women and children.

Outreach Childbirth Education: This project will create a statewide regional system for delivering high quality, accessible childbirth and parenting education classes for low-income, low-literacy pregnant women, new mothers, and their partners. This project will also establish, on a limited basis, a training program for doulas to support low-income, low-literacy women, new mothers and their families prenatally and postpartum. This project is complementary to the Maternal and Child Health Workforce Development Program. The Chiles Center will organize a network of training providers (faculty), observation and practicum providers (preceptors) utilizing the existing Area Health Education Center (AHEC) system. This system will be responsible for training professional and paraprofessional outreach childbirth educators and doulas throughout the state. The Chiles Center will have primary responsibility for the design of the curriculum, provision of training materials, and evaluation of the impact of training on health status outcomes. Statewide oversight of the Outreach Childbirth Education is handled through a contract with the Chiles Center. This collaboration assures coordination of efforts related to accessibility to quality childbirth and parenting education for low-income, low-literacy families throughout Florida at county health departments, Healthy Start Coalitions and adult and community education centers.

University of South Florida College of Public Health: The department contracts with the university for the provision of maternal and child health professionals who work with the department to provide technical assistance and consultation.

Florida and Florida A&M University: The department contracts with the university for the provision of a perinatal epidemiologist to provide expertise in maternal and child health data collection and analyses. Additionally, the department serves as a site for public health interns from this university.

The Florida State University:

Center for Prevention and Early Intervention: The department contracts with the university center for the provision of maternal and child health professionals who work with the department to provide technical assistance and consultation. The department also contracts with this center to provide services for the infant brain development initiative discussed elsewhere in the block grant.

School of Social Work: The department serves as a site for public health social work interns from this university.

The Department of Health's training of health care providers for efficient and unduplicated delivery of health care services is often provided in partnership with local Area Health Education Consortiums (AHECs). The AHECs often serve as local community hosts of events handling registration and the coordination of CEU and CME credits.

The Department of Health, Division of Family Health Services, in conjunction with the Florida Association of Healthy Start Coalitions and the Agency for Health Care Administration, is pursuing avenues to maximize funding for Healthy Start services for the MCH population. A Medicaid 1915 (b) (1) waiver for Healthy Start services was submitted January 2000. This waiver would increase the percentage of Medicaid women screened for Healthy Start, decrease the unmet need for Healthy Start services for Medicaid-eligible pregnant women and children, increase the intensity of service provision as needed for risk appropriate care, and minimize overhead and service duplication through locally driven systems of care targeting those most in need. Maternal and child health staff have also worked closely with key partners to assure that the needs of the MCH population are addressed in policies related to managed care. This has been accomplished through a variety of activities including: participation in the statewide choice counseling workgroup for managed care, the provision of customer service training for choice counselor to educate them on the unique needs of the MCH population, participation in the development of the Medicaid managed care contract, and consistent communication with AHCA regarding the enrollment of Medicaid-eligible pregnant women into managed care.

The department continues to monitor access to primary care as it relates to services for the MCH population through quality assessment/quality improvement and technical assistance. During 2000, QA/QI activities have expanded to include clinical care for maternal health, including prenatal care and pediatrics, through record reviews, on-site discussions with clinic staff, and observation of clinic operation. Local Healthy Start Coalitions are encouraged to work to identify needs of special populations such as Florida Native Americans, and include this in their local service delivery plans.

The Pregnancy Risk Assessment Monitoring System (PRAMS) is 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, and generates data for the planning and evaluation of prenatal health programs. Local PRAMS data are reviewed as part of the quality assurance process for each county's MCH program review.

The Department of Health and the Department of Children and Families continue coordinated efforts to increase the proficiency of health care providers in recognizing and treating substance-abusing woman and substance-exposed newborns and in identifying and working toward resolution on issues impacting equal, continuous, and comprehensive prenatal and infant care for this high-risk population. The MCH staff is in the process of developing a Substance Exposed Newborn Workgroup that will address issues related to alcohol use during pregnancy, such as fetal alcohol syndrome. In addition, staff share their knowledge and expertise on the latest substance-exposed newborn service delivery issues with other health professionals at the annual Sharing Solutions Conference

The Prenatal Care Task Force was developed in June 1999 to identify barriers to low-income women accessing prenatal care. Representatives from the task force include Healthy Start Coalitions, county health departments, the Department of Health, the Department of Children and Families, the Agency for Health Care Administration, the Chiles Center, Humana, the Migrant Farm Worker Justice Project, the Farm Worker Health Services, the Florida Association of Counties, the North Florida Maternity and Infant Care Project, and the FSU Center for Prevention and Early Intervention Policy. Results of an extensive statewide prenatal care survey of county health departments and Healthy Start Coalitions were presented to

identify perceived barriers to prenatal care in Florida. The task force then identified potential solutions to prenatal care barriers through the formation of four subcommittees: funding, eligibility, respect/attitude, and public awareness/knowledge. The Office of Maternal and Child Health serves as the leader of the prenatal care task force. We provide representation on each of the four subcommittees and assist in the coordination of the task force activities.

In response to the statewide Florida Healthy Start Advisory Group's recommendation to increase the number of nurse midwives and birth centers, the Florida Midwifery Resource Center was developed to increase both the number of nurse-midwifery graduates and the number of nurse-midwifery services. Grant funding helped establish the resource center, and state general revenue provides additional financial support. The center, which is located at the Lawton and Rhea Chiles Centers for Healthy Mothers and Babies at the University of South Florida, works closely with Department of Health MCH unit staff.

The Department of Health, Environmental Health Program and the MCH unit continue to work cooperatively to provide interagency coordination of lead poisoning issues. Quarterly reports of county-specific and statewide data, *Analysis of Childhood Lead Poisoning Surveillance Data*, from DOH Environmental Health and Statewide Services, is used to track trends and identify possible program needs. In addition, one of the MCH staff participates as a member on the Childhood Lead Poisoning Surveillance Program Advisory Council.

Florida's Abstinence Education Program is located within the Bureau of Family and Community Health. In addition to the national abstinence goals, state goals include: 1) to increase the number of males participating in abstinence and abstinence promoting activities; 2) to increase the number of parents, guardians, and significant adults participating in abstinence and abstinence promoting activities; 3) to increase community collaboration and support for abstinence activities; and 4) to reduce the unwed birth rate among females age 15-19. Abstinence program activities and status of achievement for performance measures are reported as a separate document from MCH block grant reporting; however, there is a close tie to other Title V activities.

MCH staff coordinate with social workers across the state to address pertinent issues. The central office public health social workers organize a statewide conference every several years for the county public health social workers and those who perform social work functions. The

first day of the conference is an orientation to public health social work. The central office public health social workers also answer questions and distribute information to those working in the counties. Central office public health social workers are members of the Association of State and Territorial Public Health Social Workers and the National Association of Social Workers.

The women's health unit within the Bureau of Family and Community Health includes the Sexual Violence Resource Program. Maternal and child health staff work collaboratively with this program to address violence as a public health issue. Services provided by this program include a 24-hour hotline, crisis intervention, short-term counseling, and medical and legal advocacy.

An MCH nursing consultant works closely with the Florida Birth Defects Registry to address preventive strategies and interventions related to the MCH population. The Florida Folic Acid Council has been formed to specifically address issues related to the prevention of neural tube defects through the use of folic acid supplementation. The council has identified community action, professional education, and mass media campaigns as its focus. Additionally, the maternal and child health staff track the effectiveness of folic acid community education in the PRAMS survey by measuring respondents' knowledge and utilization of folic acid.

Community education is also provided on osteoporosis prevention through the Osteoporosis Prevention and Education Program, which educates Florida citizens about the steps they can take to prevent this devastating disease. The program educates children and young adults about the importance of building strong bones, and has developed a special curriculum called the *Bone Zone* to teach children in the second grade about the importance of building their bone bank. An educational program was also developed for young adults, which stresses the importance of continuing to build strong bones.

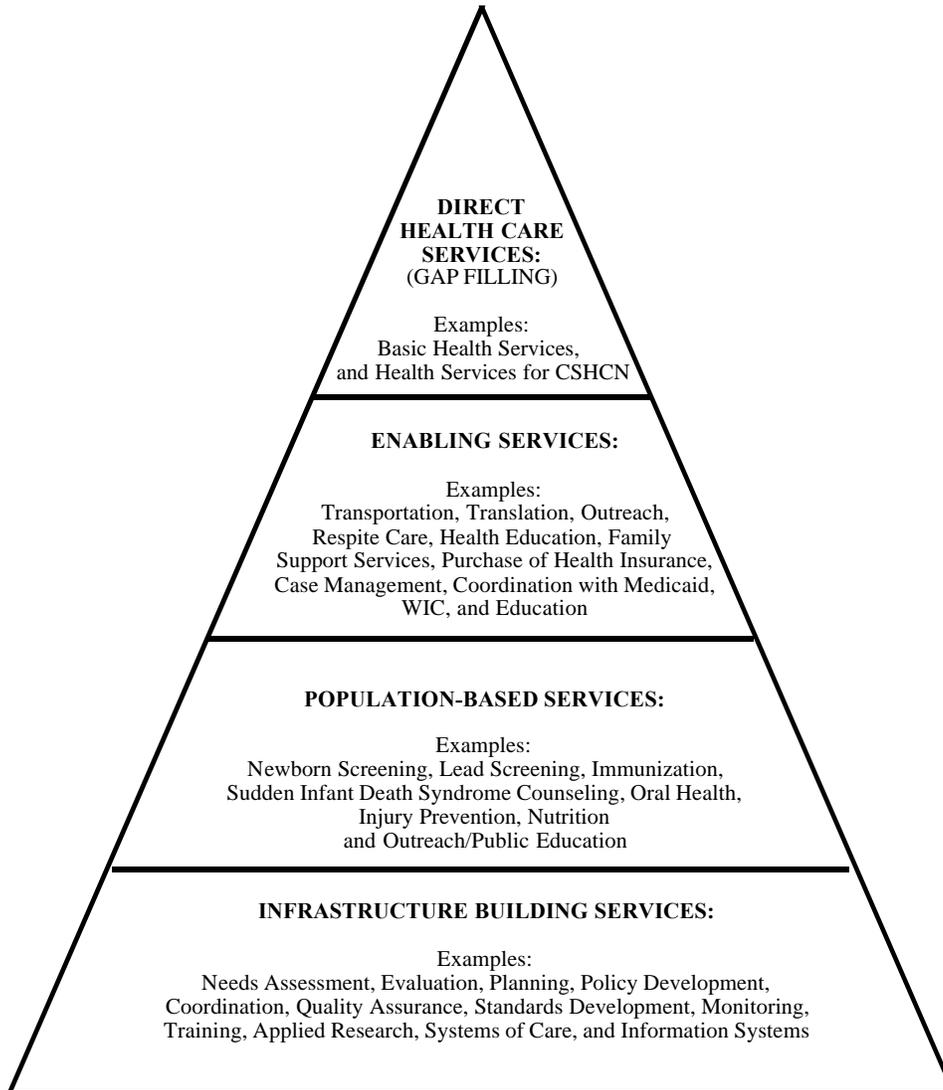
II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

see forms 3, 4 and 5

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/OSCH 10/20/97

2.2 Annual Number of Individuals Served

see forms 6, 7, 8 and 9

2.3 State Summary Profile

see form 10

2.4 Progress on Annual Performance Measures

2.4.A: Direct Health Care Services

2.4.A.1: Services for Pregnant Women, Mothers and Infants There were no national or state performance measures for direct health care services for this population group.

2.4.A.2: Services for Children There were no national or state performance measures for direct health care services for this population group.

2.4.A.3: Services for Children With Special Health Care Needs

NPM#1 *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.* All children in Florida receiving SSI benefits are eligible for Medicaid. The Florida Department of Children and Families serves children on SSI with a diagnosis of developmental delay (42 percent) or mental illness (25 percent). Children on SSI with a medical diagnosis are eligible for services of CMS, the state CSHCN program. Although it is estimated that 33 percent of children on SSI have a medical diagnosis, historically CMS has served 23 percent because the remaining families have chosen other service providers to meet their child's needs. An increase in the percent of children on Medicaid was anticipated in 1999 because of the outreach initiative of the Florida KidCare Act and an overall increase in the population in Florida. During 1999, there was an increase of 3,710 child SSI beneficiaries in Florida, but the number of children on SSI being served CMS decreased by 239. This decrease may have resulted from families choosing a Medicaid Health Maintenance Organization instead of CMS for their child's medical home, or it may have resulted from a larger number of children on SSI being served by Developmental Services or the Children's Mental Health program in the Florida Department of Children and Families. To ensure that all children receive needed services, a written agreement states that CMS refers children to SSA and provides medical and other evidence to the Office of Disability Determination Services (DDS) for eligibility determination. DDS refers all child applicants age 0-16 with a medical or mental health diagnosis to CMS for follow-up. The Title V CSHCN liaison in the CMS program office receives and reviews the referrals from DDS for CMS or the Children's Mental Health Program for eligibility and appropriate referrals. Applicants who appear to meet CMS medical eligibility criteria are forwarded to the appropriate CMS area offices, regardless of whether the child is eligible or ineligible for SSI benefits. If the child is not a CMS patient, but appears medically eligible for CMS services, the family is contacted and CMS services are offered. If the child does not meet the CMS medical eligibility criteria, but would benefit from the services of another program, a referral

is made to that program. CMS participates on the Federal SSI/CSHCN Workgroup and provides information and outreach to increase SSI awareness of families and professionals.

NPM#2 *The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.* During FY1999, each child enrolled in the CSHCN program received a medical evaluation to identify his or her specific medical needs. Based on this evaluation, services were provided through purchase of service arrangements with a panel of specialty and sub-specialty consultant physicians or through a contractual relationship with special provider agencies or medical schools throughout the state. Each child is assigned a case manager to coordinate, arrange, and follow up on his service needs. Funding for services is through Medicaid for Title IXX and CHIP for Title XXI eligible patients and services and state general revenue funds services for non-Medicaid or CHIP eligible patients and services.

SPM#1 *The percentage of Part C eligible children receiving service.* During FY1999, a number of activities assisted in exceeding the projected percentage of the eligible population actually served (80 percent). The Early Intervention Program began implementing recommendations from the long-term planning effort during this period. Strategies emphasized local responsibility and interagency collaboration. Local early intervention service areas have increased their effort to engage hard-to-reach groups and have made efforts to become more visible as a resource for families with concerns about their child's development. Local Regional Policy Councils were established in each of the 15 early intervention service areas, which has greatly enhanced community involvement in the on-going development and implementation of the Early Intervention Program. In addition, each service area began year one of a three-year phase-in for the development of a local community plan that addresses all components of the early intervention service delivery system, including public awareness, child find and referral, outreach and family involvement.

2.4.B: Enabling Services

2.4.B.1: Services for Pregnant Women, Mothers and Infants

SPM#3 *The percentage of pregnant women reporting domestic violence on the PRAMS survey.* Data for 1999 are not yet available. In 1998, the reporting of domestic related assaults by pregnant women on the PRAMS survey was 5.5 percent. As the occurrence of domestic violence among Florida's citizens remains an eminent concern of the Department of Health, many initiatives have taken place to address this issue. In continuous effort to assure risk appropriate care through Healthy Start care coordination, markers have been identified that provide assistance with the identification of clients who previously or currently have been a victim of domestic violence. These markers have been compiled in a risk factor matrix, which provides examples of possible underlying

situations that may be associated with the risk factors identified through Healthy Start prenatal and infant risk screening. Some of the risk factors targeted for evaluation and possible intervention, which are indicated on the Healthy Start prenatal and infant risk screening form, include: access to services, frequent moves, unsafe living conditions, and the use of tobacco, alcohol, and/or other drugs. During FY1999, the Department of Health provided training on screening for domestic violence to health care providers who provide services to pregnant women. Concurrently, Florida focused efforts to increase the quantity and quality of services for victims of domestic violence through federally designated Violence Against Women Act dollars. The department will continue to work with the Florida Task Force on the Family Violence Prevention Fund's National Health Initiative on Domestic Violence. This joint project was continued into FY2000. As one of 10 states to participate in this National Health Initiative, Florida engaged in the development and implementation of comprehensive plans at 15 selected health care facilities around the state. These plans were developed to assist Florida's health care system's response to screening and assisting victims of domestic violence. The initiative included multidisciplinary team training, the development of individual plans, and their implementation. The Putnam and Pinellas county health departments have written action plans on how to develop and implement a domestic violence program and protocols for their individual facilities. The Florida Task Force on Domestic Violence Fatality Prevention continues to coordinate amendments to several Florida laws to enhance the response to and prevention of further domestic violence related assaults. These efforts led to the 1999 Florida Legislature passing important domestic violence bills and increased funding to domestic violence centers. It is expected that increased awareness and training will positively effect reporting rates, as rates are low due to the reluctance of women to share any information pertaining to domestic violence experiences. Many reasons why battered women stay in abusive relationships have been identified, including concerns about judgmental or insensitive responses, fears about losing children, fear of retaliation from the abuse, and concern about confidentiality. Victims of domestic violence spend a great deal of time in different facets of the health care system and are more likely to divulge victim status to their health care provider than other service providers. The Department of Health training of health care providers in domestic violence screening and intervention is provided on an ongoing basis to assure that victims are identified and referred for appropriate intervention. A meeting took place in October 1999 in Orlando to discuss screening, protocol development, administrative support, and other areas not covered at the original training. The meeting was attended by the general public and professionals from various disciplines who shared information on the identification, treatment, and ultimately prevention of domestic violence victims and incidences.

SPM#4 *The percentage of subsequent births to teens age 15 to 19.* During FY1999, provisional data indicate that 15.1 percent of teenagers age 15-19 had subsequent births, which is higher than our objective of 12.74 percent but slightly better than the 15.5 percent rate for 1998. We are in the process of evaluating why there is not a greater decline in the birth rate to this population. The Statewide Family Planning Program provided 34,271 services to teenagers age 15-19 years old. These services were provided at local county health departments and other contracting agencies. Also, we are in the second year of our five-year demonstration waiver project for extended Medicaid coverage for family planning services for two years after a pregnancy-related service. One of our goals for the demonstration project is to reduce the number of repeat teen births. The Agency for Health Care Administration has contracted with The University of South Florida, College of Public Health to evaluate the project. The Healthy Start Coalitions have established task forces and other work groups to study the issue of teen pregnancy and to develop local strategies to address the issue. These work groups have done numerous things in their communities such as need assessments, public and targeted awareness campaigns, and developed linkages across programs and agencies to facilitate teen interventions to reduce the number of repeat births. In the area of Healthy Start services, family planning counseling was performed early in the pregnancy and throughout the pregnancy. Prior to closing a client to Healthy Start services, staff document the client's chosen method of family planning and that clients have access to the chosen method. Comprehensive School Health Services Projects (CSHSP) served 236,195 students in 47 of Florida's 67 counties. Health and education services were provided to students exhibiting risk factors for pregnancy with the goal of reducing the number of teen births. CSHSP worked closely with the Department of Education, the Department of Children and Families, and other Department of Health programs that worked towards the prevention of teen pregnancy and helping teen parents to graduate. CSHSP are located in areas with traditionally high numbers of reported teen births and provided support services to assist teen parents in returning to school after giving birth. In addition, Florida's work force development activities include measures designed to help teens break the cycle of teen pregnancy and welfare dependence. Lowering the incidence of teen pregnancy is one of the Department of Health's top priorities. Despite the best programmatic efforts to impact the percentage of subsequent births to teens, the objective has not yet been met. The department is considering innovative ways to address this long entrenched problem which include recruiting those with expertise and practical experience in this area to form a "problem solving team." This problem solving team will draw on the knowledge of its "best and brightest" to recommend strategies that will lower the incidence of this complicated and costly issue.

2.4.B.2: Services for Children

SPM#2 *The rate per 1,000 of hospital discharges of children due to dehydration* With only three quarters of fiscal year 1999 data available, the rate of hospital discharges due to dehydration per 1,000 children age 0-14 was 1.1, significantly exceeding the goal of 4.8 for the year. The State Health Office offered technical assistance on recognizing early signs of dehydration and the need for early oral rehydration in children to all county health departments. Ten county health departments worked in collaboration with the Florida Department of Children and Families to provide child day care centers with technical assistance on the transmission and prevention of enteric diseases. County health department Healthy Start care coordinators have access to our policy and technical assistance guideline entitled *The Management of Acute Diarrhea in Children: Oral Rehydration, Maintenance, and Nutrition Therapy* to use as a teaching tool with new mothers.

2.4.B.3: Services for Children With Special Health Care Needs

NPM#3 *The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."* Currently no method is available to determine the number of CSHCN in the state. Therefore, Florida is measuring the percent of CSHCN in the state program who have a medical/health home. All eligible CSHCN enrolled in CMS are considered to have a medical/health home. CSHCN eligible for Medicaid are required to select a primary care provider under Medicaid's MediPass Program. CMS enrolled children who are not eligible for Medicaid may select a medical home provider from the panel of CMS consultant physicians.

2.4.C: Population-Based Services

2.4.C.1: Services for Pregnant Women, Mothers and Infants

NPM#9 *Percentage of mothers who breastfeed their infants at hospital discharge.* Hospital discharge data available to the Department of Health does not track breastfeeding data. A survey by Ross laboratories indicates that in Florida 64.1 percent of all mothers are breastfeeding in the hospital, a much higher rate than our objective of 59 percent. For WIC mothers this figure is 53.4 percent. In FY1999, activities to promote breastfeeding included: tracking and evaluating the number of clients receiving breastfeeding education and support at county health departments through the CIS system; collaborating with WIC regarding breastfeeding and coordination of Healthy Start; and collaborating with special interest groups to promote breastfeeding. During FY1999, Healthy Start provided 7,337 women a total of 19,108 breastfeeding education and support services during the prenatal period. Also during this same period, the mothers of 2,527 infants received 5,186 Healthy Start breastfeeding education and support services.

SPM#5 *The percentage of women reporting tobacco use during pregnancy.* Provisional data for 1999 show that 10.2 percent of pregnant women reported smoking during pregnancy, slightly lower

than the objective of 10.5 percent. It is important to note that research indicates pregnant women are becoming less likely to be honest about their smoking status. The birth certificate report is a self-report instrument, though sometimes a health care provider assists in filling out the information. Through the second half of 1999, a comprehensive series of trainings were held throughout Florida using a train the trainer program called *Make Yours a Fresh Start Family*, produced by the American Cancer Society. It is expected that this program, with free materials provided to participants through the Department of Health, began to have an impact on the smoking rate, but will likely have a larger impact on the 2000 statistics. Other initiatives during 1999 that impacted tobacco use during pregnancy were television and radio public awareness advertisements. Nicotine patches, gum and Zyban were available in Florida for Medicaid clients. In addition, many of the Healthy Start Coalitions made reducing tobacco use a high priority. The Central Pharmacy of the Florida Department of Health offers nicotine patches free or at significantly reduced rates to people willing to participate in a series of educational counseling sessions on quitting smoking. This resource assists other smokers in the family to quit smoking, thus reducing exposure of children to environmental tobacco smoke.

SPM#6 *The rate per 100,000 of reported cases of perinatal transmission of HIV.* During 1999, 49 children under age 2 were reported as having pediatric HIV compared with 62 in 1998. A total of 15 children under 2 were reported as having pediatric AIDS, compared with 16 children in 1998 and 17 in 1997. Thus 64 children under 2 were either HIV-infected or diagnosed with pediatric AIDS, or 16.8 per 100,000 for 1999 compared with 20.9 per 100,000 children in 1998. These figures are higher than the annual performance objective of 10 children per 100,000. The higher number reflects improvements in identification of pediatric HIV cases. Section 384.31, F.S., requires all health care providers to provide prenatal counseling on the benefits of HIV testing, describe treatment options if they are infected, and offer HIV testing. Statewide data indicated that in 1999, 49 percent of prenatal clients were offered HIV testing. This percentage is low due to inclusion of counties that do not provide prenatal care and receive a 0 in this field. According to PRAMS data, counseling on HIV testing rose from 79 percent in 1996 to 85 percent in 1997. Of women who were counseled, 91 percent were tested for HIV compared with 53 percent of those who were not counseled. All of Florida's pregnant women and infants who are HIV positive or who have AIDS are to be referred for Healthy Start care coordination, and are required to receive priority care coordination services. During FY1999, staff participated in a workgroup to collaborate on strategies to prevent perinatal transmission of HIV, and conducted site visits to county health departments and Healthy Start service providers to review implementation of technical assistance guidelines and protocols relating to reducing perinatal transmission of HIV.

MCH staff are forming a team to look more closely at offering HIV testing to all CHD prenatal clients at the initial prenatal visit. The team will have eight members, each who have expertise in a particular area relating to this issue. They will participate in a two-day training on the Qic Story problem solving methodology, and then they will have subsequent team meetings focusing on this HIV indicator. The MCH unit also included HIV prevention training at the Partners Sharing Solutions Conference. Through this and five other conferences, about 390 prenatal care providers received training in reducing HIV transmission including vertical transmission. By early 1999, Targeted Outreach for Pregnant Women pilot programs were established in Florida's five counties with the highest rates of HIV and AIDS, Miami-Dade, Broward, Palm Beach, Hillsborough and Orange counties. Projects provided outreach services to pregnant women encouraging HIV testing, educating about prenatal care, providing HIV-infected women with information so they can make informed decisions about the use of Zidovudine, linking those in need of substance abuse treatment with that treatment, and linking women with other needed service providers. TOPWA providers contacted 3,304 women. None of the babies born to TOPWA clients have been born HIV-infected.

2.4.C.2: Services for Children

NPM#5 *Percentage of 2-year-old children who have completed age-appropriate immunizations.*

Our objective for FY1999 was that 85.8 percent of 2-year-olds receive appropriate immunizations. During FY1999, 86.2 percent of 2-year-olds had received four diphtheria, tetanus, pertussis immunizations; three polio immunizations; and one measles, mumps, rubella immunization. Additionally, the data shows that 94.1 percent of 2-year-olds had received three hepatitis B immunizations and 97.9 percent had received age-appropriate *Haemophilus influenzae* type B. Initiatives such as the department's missed immunization opportunities policy, expanded clinic hours, outreach clinics, linkages with WIC, working with Kiwanis, Healthy Start, managed care organizations and promotion of the *Standards for Pediatric Immunization Practices* in the private sector, and continued implementation of the Vaccines for Children Program has contributed to an increase in immunization coverage levels in 2-year-old children.

NPM#6 *The birth rate (per 1,000) for teenagers age 15 through 17 years.* During FY1999, the provisional birth rate for teenagers age 15-17 was 33.8 per 1,000, which is better than our goal of 37.4 per 1,000. This rate was reached through the collaborative efforts of the Department of Health Family Planning Program, School Health Program, Abstinence Only Education Program, and Maternal Child Health Program. A total of 17,036 teenagers age 15-17 received services through the Department of Health Family Planning Program during FY1999. County health departments scheduled special clinic hours to provide family planning services and other health information to make access to services easier for teens. Local county health department staff, school health nurses,

and Healthy Start staff developed systems for teens to easily access family planning services in the community. Special Initiative Projects funded with Title X funds provided opportunities for county health departments, in collaboration with other community agencies, to expand their services. These projects allowed for staff and program development that was not possible in the context of regular operations. The projects used a holistic approach to assist males in making responsible sexual decisions to avoid becoming teenage fathers. Beginning in 1998, Florida's welfare reform and work force development activities included the funding of \$1.5 million for three years to fund five projects focusing on reducing teen births by promoting the postponement of sexual activity among teens. Also during 1998, the Abstinence Education Program was established, as mechanisms were put in place to initiate abstinence programs across the state. During FY1999, 17 programs throughout the state were funded to provide abstinence only education targeting 9-14 year-olds, their parents, guardians, or significant others, and the community. Local county health departments, not-for-profit community-based organizations, and not-for-profit social service programs were awarded funds to provide abstinence only education services. All of these activities contributed to lowering the number of births to this age group.

NPM#7 *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.* The Public Health Dental Program promoted development of school-based sealant referral programs by attending statewide School Health and Education Consortium meetings, collaborating with the Florida Department of Education on a grant proposal to CDC for oral disease prevention for school-aged children, and developing an information packet for promoting sealants. Legislative budget requests were submitted the last four years requesting state funds; however, funding to specifically increase the number of sealant programs or sealant surveillance was not allocated. The 1998 legislature appropriated \$500,000 and the 1999 legislature an additional \$1M to increase access to dental care for children and adults who are not eligible for Medicaid. As these programs mature, it is expected that additional children will receive sealants. County health departments were actively encouraged through the quality improvement process to explore the development of school-based sealant programs; however, no new programs were initiated. The Public Health Dental Program monitors Medicaid recipient and eligibility data by calendar year, to estimate the percentage of Medicaid-enrolled 8-year-olds who receive sealants on permanent first molars. This data is useful in determining trends; however, because of fluctuations in Medicaid enrollment and eligibility that produce corresponding fluctuations in the annual performance indicator, adjustments in the performance objectives may need to be made annually. In FY1999, it is estimated that 40.5 percent of Medicaid-enrolled 8-year-olds received sealants, compared to a reported estimate of 54.7 percent in FY1998. The performance objectives

for 2000 and 2001 have been adjusted accordingly and we will continue to monitor the fluctuations and possible causes. A statewide surveillance work group continues to make recommendations on a system to obtain the currently unavailable data on the percentage of third-graders who have received protective sealants on at least one permanent molar.

NPM#8 *The rate of deaths to children age 1-14 caused by motor vehicle crashes per 100,000 children.* The motor vehicle death rate for children age 1-14 decreased significantly in FY1999, to 2.5 per 100,000. The Florida Department of Health is the lead agency for the Florida SAFE KIDS Coalition, part of the National SAFE KIDS Campaign, a nationwide effort to prevent injuries to children under the age of 14. The Florida SAFE KIDS Coalition has been most active in child passenger safety, distributing child car seats to low-income families, participating in car seat safety check-up events and launching public awareness campaigns. In 1999, the Florida SAFE KIDS Coalition organized two car seat check-up events; 202 car seats were checked, and less than 10 percent of them were correctly installed. Through the Occupant Protection Program, funded by the Florida Department of Transportation, the Bureau of Emergency Medical Services trained 63 EMS, fire/rescue, and law enforcement personnel and safety advocates were trained as nationally certified child car seat technicians. Through the Head Start Injury Prevention Program, funded by the Florida Department of Transportation, the Bureau of EMS distributed booster seats to children in Head Start Programs in several counties in the Panhandle. The Bureau of EMS applied for outside funding to distribute car seats to low-income parents through the county health departments, but did not receive that funding. Additional public efforts are needed to increase the correct use of seat belts and child safety seats.

SPM#7 *The rate per 1,000 of hospital discharges due to asthma in children age 0-14.* During FY1999, the goal of 3.0 children with hospital discharges due to asthma per 1,000 children age 0-14 was not achieved. With only three quarters of fiscal year 1999 data available, there were 3.76 hospital discharges due to asthma per 1,000 children 0-14. Environmental factors may be related to the number of hospital discharges due to asthma in children age 0-14. Activities related to this performance measure for FY1999 included providing technical assistance to county health departments on the importance of providing asthma education on prevention to parents, and follow-up chart review during quality improvement visits. A policy and technical assistance guideline for the management of asthma in children was developed for all county health departments. This policy and technical assistance guideline is currently under the review process at the State Health Office prior to statewide distribution. The Department of Health School Health Program staff has coordinated with the American Lung Association's regional directors and Integrated Therapeutics

Group to promote asthma management and prevention programs to school-aged children. In addition, an interagency workgroup has met to discuss issues related to asthma.

2.4.C.3: Services for Children With Special Health Care Needs

NPM#4 *Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).* In FY1998 there were 195,564 births, of which 272 newborns were identified and confirmed with one of the five disorders screened through Florida's program and placed into a system of care. (See Form 6 for numbers for each disorder.) Preliminary data for FY1999 indicate that 99 percent of the 196,288 infants born in Florida were screened for phenylketonuria, congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia and hemoglobinopathies. The primary reasons all infants are not tested are that a number of neonates die before being tested and some parents refuse testing, with the deaths of neonates being the most common reason.

NPM#10 *Percentage of newborns who have been screened for hearing impairment before hospital discharge.* The Department of Health, through the Children's Medical Services Early Intervention Program, initiated a project to provide incentives for risk-based screening programs to convert to universal hearing screening programs. Through this project, which was initiated in November 1998, start-up funding was provided to identified hospitals to implement universal newborn hearing screening. Since November 1998, 34 additional hospitals have agreed to implement universal screening. Thus, in response to national trends, technical assistance provided by the Department of Health, reduced equipment costs, and current research, 46 of Florida's approximately 150 birthing facilities had initiated a universal newborn hearing screening program or were actively developing a program during FY1999. When programs at these hospitals are fully operational, they will constitute screening of 58 percent of all newborns, a dramatic increase over previous projections. Since not all programs were fully operational for the entire fiscal year, their actual performance is estimated to be 35.9 percent of all Florida newborns universally screened, which significantly surpasses our goal of 5 percent in FY1999.

2.4.D: Infrastructure-Building Services

2.4.D.1: Services for Pregnant Women, Mothers and Infants

NPM#15 *Percent of very low birth weight live births.* During FY1999, although we did not reach our goal of 1.2 percent, the rate from the previous year was unchanged, remaining at 1.6 percent. As a Title V agency, many efforts were made in the prevention of very low birth weight births, such as Healthy Start prenatal care and care coordination. These activities included outreach to get women into prenatal care earlier, risk screening to identify risks that may contribute to a poor birth outcome, linkages to support that will address these risks, and other services such as smoking

cessation, nutritional counseling, psychosocial counseling, and cessation of drug use during pregnancy. Fetal Infant Mortality Review projects helped us identify factors related to very low birth weight. The FIMR projects present an ongoing collaborative effort to identify system-wide factors that may contribute to fetal and infant deaths, and some FIMR projects work to identify factors that contribute to low birth weight as well. Through this process we continue to gain knowledge to improve prenatal care systems and contribute to the prevention of very low birth weight births.

NPM#17 *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.* During FY1999, 86 percent of very low birth weight infants were delivered at high-risk facilities. To assure that very low birth weight newborns are delivered and receive care at appropriate level hospitals, the Florida Agency for Health Care Administration regulates the establishment of tertiary health services, including neonatal intensive care services, under the Certificate of Need program. There are 53 hospitals that are licensed for 790 Level II neonatal intensive care beds which are approved to provide care to neonates of 1000 grams birth weight and greater. There are 24 hospitals that are licensed for 457 Level III beds, which are approved for care of very low birth weight neonates of any weight. Both Level II and Level III neonatal intensive care services require separate certificate of need approval for each level of care and must meet minimum standards and requirements established by the Agency for Health Care Administration for personnel, equipment, and support services. These regulations pertain to the care of neonates to ensure that very low birth weight infants are more likely to survive and thrive if they are born or cared for in an appropriately staffed and equipped facility. To provide a more accurate reflection of Florida's performance in caring for very low birth weight infants, the annual performance indicator is derived from the following information: the numerator includes neonates with a birth weight of 0-500 grams born at a Level I or II hospital (the pre-viable neonates), neonates with a birth weight of 1000-1499 grams born at a Level II hospital, and neonates with a birth weight of 0-1499 grams born at a Level III hospital; and, the denominator includes the total number of live births with a birth weight of less than 1,500 grams. Non-compliance is based on the number of neonates with a birth weight of 500-999 grams born at a Level II hospital and neonates with a birth weight of 500-1499 grams born at a Level I hospital. As noted in the data, the state in FY1999 bettered its performance objective as it moves toward its Year 2001 goal of 90 percent.

NPM#18 *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.* During FY1999, we did not reach our goal of getting 87 percent of pregnant women into prenatal care during their first trimester. Provisional data indicate the rate increased slightly from the previous year, from 83 percent to 83.2 percent. A number of activities were implemented

to increase the percent of women receiving prenatal care in the first trimester. The importance of obtaining early prenatal care was advertised throughout the state. The Family Health Line toll-free number was displayed on buses in several areas of the state, and posters, bookmarks and brochures were distributed. The outreach materials informed pregnant women they could receive confidential counseling and referral for substance abuse treatment. Clients calling the Family Health Line were provided information on how to access early prenatal care and other services. The Targeted Outreach for Pregnant Women (TOPWA) program, through contracts with community-based organizations in specified locations, provided outreach and service linkages for pregnant women at risk for inadequate prenatal care and HIV infection. The Healthy Start Coalitions developed outreach programs to get pregnant women into early prenatal care, and have also developed strategies to get indigent women and women with undocumented citizenship into early care. Most county health departments and indigent care hospitals provided Medicaid Presumptive Eligibility for Pregnant Women (PEPW) to ensure Medicaid coverage. We expanded this coverage by authorizing outside providers through an approval process to provide PEPW. Medicaid pays additional reimbursement to providers who screen their clients for Healthy Start during their first trimester.

SPM#9 *The percentage of pregnant women screened by Healthy Start.* Florida statute requires that all pregnant women are offered Healthy Start prenatal risk screening. The screening instrument identifies those women who are at increased risk for preterm labor or for delivering a low birth weight infant. Since screening is voluntary, only a percentage of those offered screening consent to the screening process. In FY1999, 52 percent of the estimated number of pregnant women were screened for Healthy Start. Our objective was met and we continue activities to increase screening such as training Healthy Start Coalition community liaisons, monitoring screening trends, and providing technical assistance to communities for Healthy Start screening. Other activities include the formation of an interagency workgroup to develop an integrated screening process with Healthy Families Florida.

SPM#10 *The percentage of infants screened by Healthy Start.* Florida statute requires that all birth facilities offer Healthy Start infant risk screening to families of newborns. The screening instrument identifies those infants who are at an increased risk for postneonatal death. During FY1999, 75.13 percent of infants born in Florida were screened for Healthy Start, exceeding our objective of 73 percent. The screening rate has remained relatively stable over the past three years. Activities during FY1999 to increase the infant screening rate included: 1) work on an infant screening form revision to increase the ease of completing the screening tool; 2) infant screening form training provided at birth facilities by Healthy Start Coalitions; and 3) State Health Office monitoring and reporting on screening trends.

2.4.D.2: Services for Children

NPM#12 *Percent of children without health insurance.* In May 1998, the Florida Legislature enacted Florida KidCare, a full benefit health insurance program for children and teens, from birth through 18 years, who are not covered by any other insurance program. Florida KidCare is an umbrella entity that offers insurance to uninsured children, depending on their needs and eligibility, through one of the following affordable options: Medicaid, MediKids, Florida Healthy Kids, the Children's Medical Services Network, or the Behavioral Healthy Specialty Care Network. Federal, state and private partnerships fund KidCare. To evaluate Florida KidCare, the Florida Legislature funded a statewide survey during FY1999 to obtain more in-depth estimates of the uninsured - data that was not available during FY1998. Data from the Florida Health Insurance Study conducted in mid-1999 indicates that there were approximately 489,891 uninsured children and teens, from birth through 18 years of age, in Florida. A number of activities during FY1999 resulted in an increased opportunity for children to become insured in Florida. Florida Healthy Kids was expanded and the eligibility for Medicaid for teenagers age 15-18 was increased from 33 percent to 100 percent of the federal poverty level as a result of the federal Balanced Budget Act. Additionally, FY1999 activities included a focus on addressing the racial disparities in health care among ethnic and minority populations, by performing targeted outreach activities to these populations to assist them in obtaining health insurance.

NPM#13 *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.* During FY1999, the percentage of children eligible for services who actually received a service increased to 86.7 percent. Many activities were conducted to encourage parents of Medicaid-eligible children to seek preventive as well as primary medical care. Efforts included outreach by the 67 county health departments, and continued collaboration with local Healthy Start Coalitions, other health care providers and local social service agencies. KidCare provided outreach to families through statewide and targeted media campaigns. The KidCare regional coordinators provided outreach to community leaders and families across the state. New *Child Health Check-up Campaign* educational materials were developed through collaborative efforts to promote prevention and health education issues.

NPM#16 *The rate (per 100,000) of suicide deaths among youths 15-19.* During the past several years, the Florida Department of Health's School Health Services Program has worked with local school health programs to expand health programs or collaborate with other providers, to ensure that children who were depressed or potentially suicidal were provided with the appropriate referral resources to facilitate access to services. Partnerships included county health departments, school districts and community mental health centers. During FY1999, a variety of activities helped the

Comprehensive School Health Services Projects achieve a statewide rate of 4.74 suicides per 100,000 6th-12th grade students. These activities included 6,890 mental health interventions, 2,138 classes on mental health, 98 suicide interventions, 352 suicide prevention classes, and 3,368 referrals for mental health services. The suicide rate for youths 15-19 in the general population decreased from 9.3 per 100,000 in FY1998 to 5.0 in 1999. Planned activities for FY2000 include an increased focus on the general population in this age group. During 1999, the Department of Health's Emergency Medical Services program helped convene a statewide Task Force on Adolescent Suicide. This task force will research current suicide prevention efforts in Florida and the nation, and develop a report of their findings. This report will be available after May 1, 2000. Using reported findings, the task force will develop a suicide prevention plan for Florida to include goals, objectives, methodologies, and evaluation. The plan will be available after June 15, 2000.

SPM#8 *The percentage of low-income children under age 21 who access dental care.* Data for 1999 are not yet available. The number of children below 200 percent of the federal poverty level (FPL) receiving dental services through publicly funded programs increased to 390,947 children in FY1998 from 343,871 in FY1997. The access rate for low-income children below 200 percent FPL also increased from 17.1 percent in FY1997 to 18.8 percent in 1998. MCH-funded programs provided dental services to 1133 non-Medicaid funded children during FY1999. The Statewide Dental Coordinating Council established district advisory committees in 1999 to increase local involvement in addressing the issue of dental access for low-income populations. In 1998, the legislature appropriated \$500,000 to increase access to dental care for people who are not eligible for Medicaid through county health departments; this was followed with \$1,000,000 in 1999.

2.4.D.3: Services for Children With Special Health Care Needs

NPM#11 *Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.* During FY1999, all children enrolled in Children's Medical Services, the Florida Title V Agency for Children with Special Health Care Needs, were funded for primary and specialty care services by Medicaid, CHIP or through state general revenue funding. For the uninsured, the underinsured, and during "ineligible" months, state general revenue provides gap coverage for these services. Under the Florida KidCare and Children's Medical Services Acts of 1998, Medicaid coverage was expanded to include 12 month continuous eligibility for 0-5 year-olds up to 200 percent of the federal poverty level and six month continuous eligibility for 6-19 year-olds up to 200 percent of the federal poverty level.

NPM#14 *The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.* During FY1999, CMS maintained two parent consultants; one part-time position (10 hours per week) was filled by the mother and grandparent of CSHCN

and the other position was held by a father of a child with special needs. The part-time position focused upon helping the state develop services and policies to serve Title V-CSHCN. The full-time position assisted the Early Intervention/Part C Program and their families. The parent consultants played a pivotal role in ensuring that the practices and guidelines for all services to CSHCN, infants and toddlers with special needs, and their families are founded upon family-centered principals that foster independence and maximize the potential of each child and their family. The part-time CSHCN parent consultant served on the state KidCare Outreach Advisory Board, the CMS Network Case Management Advisory Committee, and sat on the state CMS Network Advisory Council. This CSHCN parent consultant worked in partnership with families in resolving issues related to CMS/CSHCN services and sat on the CMS Grievance Committee. The part-time parent consultant also worked in collaboration with the AAP and the Shriners Hospital on the planning and development of the AAP Medical Home Training Pilot. CMS families were identified and supported as co-presenters. At the end of the block grant period, the CSHCN parent consultant position was still part-time, which left the state CSHCN monitoring and evaluation team without a parent consultant or family representative for quality improvement activities for a second year and severely restricted the inclusion of family input on all levels of service development and planning. The production of the newsletter and the cultivation of new leaders among CMS families were also abated for the year due to the lack of additional and flexible resources. CMS was unable to establish the resources necessary to replace the family resource specialists (FRS) lost two years earlier due to budget reductions. Three of the 21 CMS Offices had active FRS during the year. The FRS, parents of children who currently or previously received services through CMS, utilized informal needs assessments and participated as members of monitoring/quality assurance teams as the voice of the families served within their community. They facilitated a collaborative partnering process, served as presenters at in-service, workshops, and conferences, and also expanded their community roles by serving on interagency workgroups, councils, and other grassroots initiatives. To help address the need to have FRS functioning in each CMS community, the CMS Network proposals included a requirement for each contracted network to hire a family resource specialist as a component of their Integrated Care Network (ICN). With technical assistance and support from the CMS Program Office, it is felt that this will assist community networks to identify and support the FRS positions. CMS continued to provide support during 1999 for the expenses of the Florida Family Voices organization, a grassroots organization of family and friends speaking on behalf of families of CSHCN. Through Family Voices, national, state, and community information on health care reform, the state children's insurance program, managed care, and other resources important to families of CSHCN were disseminated to over 400 families throughout the state.

2.5 Progress on Outcome Measures see form 12 for outcome status

2.5.A: Direct Health Care Services

2.5.A.1: Services for Pregnant Women, Mothers and Infants There were no national or state performance measures for direct health care services for this population group.

2.5.A.2: Services for Children There were no national or state performance measures for direct health care services for this population group.

2.5.A.3: Services for Children With Special Health Care Needs

NPM#1 *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.* Although it is estimated that 33 percent of children on SSI have a medical diagnosis, historically CMS has served 23 percent because the remaining families have chosen other service providers to meet their child's needs. In 1999, The number of child SSI beneficiaries in Florida increased by 3,710. The number of child SSI beneficiaries served by CMS, however, decreased from 23 percent to 21 percent. The specific reasons for this decrease are unknown. Tracking these trends bears watching and outreach efforts should be continued. Assuring that more SSI beneficiaries receive rehabilitative services has a positive effect on outcome measure 6 related to the child death rate.

NPM#2 *The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.* During FY1999, each child enrolled in the CSHCN program received a medical evaluation to identify his or her specific medical needs. Based on this evaluation, services were provided through purchase of service arrangements with a panel of specialty and sub-specialty consultant physicians or through a contractual relationship with special provider agencies or medical schools throughout the state. Providing medical evaluation to each child enrolled in the CSHCN program and assigning a case manager to coordinate, arrange, and follow up on his/her service needs, using either Medicaid or state general revenue funds depending on eligibility, has a positive effect on outcome measures number 3, 4, and 5 related to infant, neonatal, postneonatal and perinatal mortality.

SPM#1 *The percentage of Part C eligible children receiving service.* During FY1999, a number of activities assisted in exceeding the projected percentage of the eligible population actually served (80 percent). Increasing the percentage of Part C eligible children receiving a service has a positive effect on the outcome measures number 3, 4, and 5 related to reducing infant, neonatal, postneonatal and perinatal mortality. Identification and referral to appropriate services improves access to care for the MCH population.

2.5.B: Enabling Services

2.5.B.1: Services for Pregnant Women, Mothers and Infants

SPM#3 *The percentage of pregnant women reporting domestic violence on the PRAMS survey.*

Data for 1999 are not yet available. In 1998, the reporting of domestic related assaults by pregnant women on the PRAMS survey was 5.5 percent. Research findings succinctly indicate a correlation between domestic violence and pregnancy, however data collection and analysis remain difficult due to persistent under-reporting of this sensitive subject matter. When pregnant women are victims of domestic violence increased risk of adverse outcomes result such as pre-term birth, miscarriage, or a low birth weight baby. A domestic violence related question was first placed on the PRAMS survey in 1996. The analyses of PRAMS data for both 1997 and 1998 are necessary in order to determine the affect of domestic violence prevention activities. Presently, analysis of this data is pending. Additionally, the Healthy Start Prenatal Risk Screening Instrument contains an item that provides an opportunity to look at domestic violence and its impact on birth outcomes. Analysis of this item and its relationship to birth outcomes is also pending. It is expected that the capacity to reduce the incidence of domestic violence during pregnancy will impact the infant mortality rate.

SPM#4 *The percentage of subsequent births to teens age 15 to 19.* During FY1999, provisional data indicate that 15.1 percent of teenagers age 15-19 had subsequent births. We did not meet our objective of 12.74 percent. Reducing the percentage of subsequent births has an impact on outcome measures number 1, 3, 4, and 5 related to infant, neonatal, postneonatal and perinatal mortality.

2.5.B.2: Services for Children

SPM#2 *The rate per 1,000 of hospital discharges of children due to dehydration.* With only three quarters of fiscal year 1999 data available, the rate of hospital discharges due to dehydration per 1,000 children age 0-14 was 1.1, exceeding the goal of 4.8 for the year. This performance measure affects outcome measure 6, related to the child death rate.

2.5.B.3: Services for Children With Special Health Care Needs

NPM#3 *The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."* All eligible CSHCN enrolled in CMS are considered to have a medical/health home. This has a positive effect on outcome measures number 1, 3, 4, and 5 related to infant, neonatal, postneonatal and perinatal mortality.

2.5.C: Population-Based Services

2.5.C.1: Services for Pregnant Women, Mothers and Infants

NPM#9 *Percentage of mothers who breastfeed their infants at hospital discharge.* A survey by Ross laboratories indicates that in Florida 64.1 percent of all mothers are breastfeeding in the hospital, a much higher rate than our objective of 59 percent. Increasing the number of women who

breastfeed should have an impact on outcome measures number 1, 3, 4 and 5, related to infant, neonatal postneonatal and perinatal death rates.

SPM#5 *The percentage of women reporting tobacco use during pregnancy.* The number of women who report tobacco use during pregnancy has declined steadily since 1991. Provisional data for 1999 show that 10.2 percent of pregnant women reported tobacco use during pregnancy, a significant improvement over the 11.2 percent rate reported in 1998. This decline has had a positive impact on outcome measure number 1, related to the infant mortality rate. Research has clearly shown a strong relationship between maternal smoking and infant mortality caused by infants born too soon or born too small because of intrauterine growth retardation. Reducing the number of pregnant women who use tobacco also positively impacts the perinatal death rate. Tobacco use during pregnancy and after pregnancy is a contributing factor to sudden infant death syndrome and respiratory ailments that can cause mortality. The tobacco cessation program offers assistance in quitting tobacco for all family members, and education on the danger of smoking in confined areas when children are present.

SPM#6 *The rate per 100,000 of reported cases of perinatal transmission of HIV.* During 1999, 15 children under age 2 were reported as having pediatric AIDS and 49 other children were identified as pediatric HIV cases. This is a decrease from 1998 when 16 children under age 2 were reported as having pediatric AIDS and 62 other children were identified as pediatric HIV cases. By reducing AIDS in children under age 2, the infant mortality rate per 1,000 live births will be decreased, as well as the perinatal mortality rate. The ratio of the black to white infant mortality may also be decreased since 77 percent of the cumulative pediatric HIV cases are black. This measure impacts outcome measures number 1, 2, and 5.

2.5.C.2: Services for Children

NPM#5 *Percentage of 2-year-old children who have completed age-appropriate immunizations.* Our objective for FY1999 was that 85.8 percent of 2-year-olds receive appropriate immunizations. During FY1999, 86.2 percent of 2-year-olds had received four diphtheria, tetanus, pertussis immunizations; three polio immunizations; and one measles, mumps, rubella immunization. Additionally, the data shows that 94.1 percent of 2-year-olds had received three hepatitis B immunizations and 97.9 percent had received age-appropriate *Haemophilus influenzae* type B. Activities to increase the number of 2-year-old children receiving age-appropriate immunizations contribute greatly towards reducing the disease morbidity rate of children through age 0-18. Reducing the child morbidity rate is not an identified outcome measure for the application; however, it indirectly impacts outcome measures number 1 and 6 related to infant mortality and child death.

NPM#6 *the birth rate (per 1,000) for teenagers age 15 through 17 years.* During FY1999, the provisional birth rate for teenagers age 15-17 was 33.8 per 1,000, which is better than our goal of 37.4 per 1,000. Reducing the teen birth rate impacts outcome measure number 1, related to infant mortality. Reducing teen pregnancy also impacts outcome measures number 1, 3, 4, and 5 related to infant, neonatal, postneonatal and perinatal mortality.

NPM#7 *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.* In spite of efforts to increase access to dental care and knowledge regarding the value of sealants in caries prevention, the number of children receiving sealants through county health departments decreased 8.5 percent from 17,794 in FY1998 to 16,281 in FY1999. Early placement of sealants on permanent first and second molars has been shown to significantly reduce the morbidity rate for dental caries in those teeth where 80 percent of the decay in permanent teeth of children occurs. Reducing dental caries morbidity rate for children improves the general health of children but does not directly impact the outcome measures adopted for this application and annual report.

NPM#8 *The rate of deaths to children age 1-14 caused by motor vehicle crashes per 100,000 children.* The motor vehicle death rate for children age 1-14 decreased significantly in FY1999, to 2.5 per 100,000. Injuries are the leading cause of mortality in the 1-14 year old age group and they are one of the most serious health problems affecting the nation's children. About 50 percent of all deaths to children age 1-14 are due to injuries, and approximately 80 percent of these are from motor vehicle crashes. Reducing deaths of children due to motor vehicle crashes will significantly lower the child death rate, impacting outcome measure 6.

SPM#7 *The rate per 1,000 of hospital discharges due to asthma in children age 0-14.* During FY1999, the goal of 3.0 children with hospital discharges due to asthma per 1,000 children age 0-14 was not achieved. With only three quarters of fiscal year 1999 data available, there were 3.76 hospital discharges due to asthma per 1,000 children 0-14. Environmental factors may be related to the number of hospital discharges due to asthma in children age 0-14. Reducing the number of children hospitalized for asthma contributes greatly towards reducing the disease morbidity rate of children age 0-14, which indirectly impacts outcome measures 1 and 6 related to infant mortality and child death.

2.5.C.3: Services for Children With Special Health Care Needs

NPM#4 *Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).* In FY1998 there were 195,564 births, of which 272 newborns were identified and confirmed with one of the five disorders screened through Florida's program and placed into a system of care. (See

Form 6 for numbers for each disorder.) Preliminary data for FY1999 indicate that 99 percent of the 196,288 infants born in Florida were screened for phenylketonuria, congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia and hemoglobinopathies. Screening for certain metabolic, congenital, and hereditary disorders has an impact on outcome measures 1, 3, and 4, related to infant, neonatal and perinatal mortality.

NPM#10 *Percentage of newborns who have been screened for hearing impairment before hospital discharge.* Of Florida's approximately 150 birthing facilities, 46 have voluntarily initiated or were actively developing a universal newborn hearing screening program during FY1999. When programs at these hospitals are fully operational, they will constitute screening of 58 percent of all Florida newborns, a dramatic increase over previous projections. This performance measure has no direct impact on the outcome measures adopted for this application, but the measure contributes significantly to the overall health and well being of children.

2.5.D: Infrastructure-Based Services

2.5.D.1: Services for Pregnant Women, Mothers and Infants

NPM#15 *Percent of very low birth weight live births.* During FY1999, although we did not reach our goal of 1.2 percent, the rate from the previous year was unchanged, remaining at 1.6 percent. During the report period, efforts were made to decrease the incidence of very low birth weight by means such as increasing early entry into prenatal care, delaying teenage pregnancy and repeat teenage pregnancy, and decreasing the use of tobacco and alcohol during pregnancy. Prevention of very low birth weight has an impact on outcome measures number 1, 3, and 5, related to the mortality rate during the perinatal, neonatal and infant stages, as premature birth is the leading cause of infant death.

NPM#17 *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.* During FY1999, 86 percent of very low birth weight infants were delivered at high-risk facilities. Assuring that very low birth weight newborns are delivered and receive care at appropriate level hospitals impacts outcome measures number 1, 3, 4, and 5, related to infant, neonatal, postneonatal and perinatal mortality.

NPM#18 *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.* During FY1999, we did not reach our goal of getting 87 percent of pregnant women into prenatal care during their first trimester. Provisional data indicate the rate increased slightly from the previous year, from 83 percent to 83.2 percent. Early entry into prenatal care helps assure that pregnant women receive early screening, assessment, and risk-appropriate medical and psychosocial services geared to prevent maternal and infant morbidity and mortality, relating to outcome measures number 1 and 5.

SPM#9 *The percentage of pregnant women screened by Healthy Start.* In FY1999, 52 percent, of the estimated number of pregnant women were screened. This objective relates to outcome measure number 1 related to the infant mortality rate. The prenatal screening process is intended to directly reduce the incidence of preterm delivery and low birth weight, by identifying those factors that contribute to poor maternal outcomes. Identification of high-risk pregnant women followed by assessment and appropriate interventions can reduce the instance of preterm delivery and low birth weight deliveries, and subsequently reduce infant mortality.

SPM#10 *The percentage of infants screened by Healthy Start.* This objective relates to outcome measures number 3, 4, and 5, related to neonatal, postneonatal and perinatal mortality. The infant screen has proven to be a valid and reliable instrument for predicting postneonatal infant mortality. During FY1999, 75.13 percent of infants born in Florida were screened for Healthy Start, exceeding our objective of 73 percent. The screening rate has remained relatively stable over the past three years. Approximately 12 percent of infants were identified as at-risk, having scored 4 or more on the instrument. Analysis performed in subsequent years suggests that half of the infants who died postneonatically would have been identified with this screen. The screen captures a caseload that can be targeted for risk reduction services.

2.5.D.2: Services for Children

NPM#12 *Percent of children without health insurance.* In FY1998, data from Florida Healthy Kids was used to report the number of children enrolled in Title XXI Child Health Insurance Programs. As of FY1999, data on enrollment in all Florida KidCare programs including Medicaid was available, and a total of 917,975 children were enrolled in Florida KidCare as of December 1999. During the report period, efforts were made to increase access to care for uninsured children, and to increase the number of children who become insured. This was accomplished through: implementing and managing a statewide, toll-free hotline; performing various public information activities such as television, radio, and outdoor advertisements; and strengthening local outreach efforts by funding Regional Outreach Projects that deliver targeted outreach activities specific to the community. This has an impact on other outcome measures related to the death rate of children, as those with health insurance are more likely to get needed preventive and acute health care than those who are uninsured.

NPM#13 *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.* The percentage of children eligible for services who actually received a service increased to 86.7 percent. Receiving any service from a Medicaid provider increases the likelihood that preventative services and health screenings are delivered in a timely manner. Early intervention in the management of childhood health problems decreases poor outcomes. Increasing

the number of Medicaid-eligible children who receive a Medicaid service will impact measure 6, related to the child death rate.

NPM#16 *The rate (per 100,000) of suicide deaths among youths 15-19.* During FY1999, a variety of activities helped the Comprehensive School Health Services Projects achieve a statewide rate of 4.7 suicides per 100,000 6th – 12th grade students. These activities included 6,890 mental health interventions, 2,138 classes on mental health, 98 suicide interventions, 352 suicide prevention classes, and 3,368 referrals for mental health services. The suicide rate for youths 15-19 in the general population decreased from 9.3 per 100,000 in FY1998 to 5.0 in 1999. Decreasing the rate of suicide deaths among youths 15-19 will have a direct impact on outcome measure number 6 related to child death rate.

SPM#8 *The percentage of low-income children under age 21 who access dental care.* Data for 1999 are not yet available. Increasing access to dental care for children below 200 percent of poverty improves the overall health of low-income children through the prevention and treatment of the disease, thereby reducing the dental caries morbidity rate for children through age 18. Although reducing dental caries morbidity for children improves their general health, it does not affect the outcome measures adopted for this application and annual report. The legislature has increased funding to increase access to dental care for children and adults through the Medicaid and KidCare programs. In addition they increased funding to \$1m in 1999 for dental programs to increase access for non-Medicaid children and adults.

2.5.D.3: Services for Children With Special Health Care Needs

NPM#11 *Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.* During FY1999, all children enrolled in Children's Medical Services were funded for primary and specialty care services by Medicaid, CHIP or through state general revenue funding. For the uninsured, the underinsured and during "ineligible" months, state general revenue provides gap coverage for these services. Assuring that all CSHCN in the state program have funding for primary and special care impacts upon outcome measures number 1, 3, 4, and 5 related to infant, neonatal, postneonatal and perinatal mortality.

NPM#14 *The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.* While Florida fell short to some degree in meeting their goals in relation to enhancing family participation, parent involvement did impact several of the outcome measures. The part-time parent consultant position and the three family resource specialists were instrumental in assisting staff and the program in their efforts related to outcome measures 1, 3, 4, and 5 related to infant, neonatal, postneonatal and perinatal mortality.

Contributions to meet the outcomes included participation in public awareness, advocacy on behalf of the families served, participation on decision making workgroups, development of outreach material for families and their children, and assisting other state agencies in understanding the needs of CSHCN and their families to enable them to better provide them with services and support.

III. REQUIREMENTS FOR APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

Staff from the Office of Maternal and Child Health 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 also gathered from Healthy Start Coalition service delivery plans, FIMR and PAMR annual reports, and from the Center for Prevention and Early Intervention Policy at Florida State University study of racial disparity in infant mortality. Staff conducted a survey of key informants across the state, to assess the level of progress made on issues raised in the needs assessment survey conducted five years ago and to identify new areas of concern. Key informants included recognized MCH providers or provider organizations and advocates from across the state, Healthy Start Coalition directors, and Healthy Start coordinators at the county health departments.

Much of the data used in the needs assessment came from the Public Health Indicators Data System (PHIDS), which is a function of the Department of Health Office of Planning, Evaluation and Data Analysis. Vital statistics data was provided through the department's Office of Vital Statistics, and PRAMS data came from the department's Bureau of Epidemiology. Data collection for the needs assessment for each of the pyramid levels was conducted in the same way.

Data limitations mostly involve the use of provisional data for 1999, as final data will not be available until after the application deadline. However, in past years, provisional rates and data collected are usually very close to the final numbers calculated.

We will use the information gathered through this needs assessment to reestablish our priority needs, and address whether we should adopt any new state performance measures. We will also use this information to adjust our annual targets for both the state and national performance measures, and in the development of new plans to assure those targets are met.

Other agencies and organizations supplying information included the Agency for Health Care Administration, the Medicaid Program Office, the Florida Department of Education, the Florida State University Center for Prevention and Early Intervention, the Healthy Start Coalitions, and the March of Dimes. Citizen and family member involvement is provided through the Healthy Start Coalitions in the development of their annual plans, and through involvement in committees related to SIDS and maternal and fetal death reviews. Personnel involved in identifying needs, establishing measures, setting targets, and developing plans do so by analyzing data, reviewing local assessments, collaborating with other agencies, and relying on their personal expertise and observations gleaned from on-site quality assurance or technical assistance visits. Resources are allocated based on a number of variables, the main one being high-risk. Through tools such as the Healthy Start risk screening instruments, populations and areas in greatest need can be identified, and resources can be allocated accordingly.

Information on children with special health care needs was collected through the Family Voices survey, a collaboration between Family Voices and the Heller School at Brandeis University, with state Title V programs randomly selecting 200 families and 100 families selected by Family Voices. The survey offers a method to compare Florida's information with national information. The Family Voices survey had a 27 percent respondent rate with 63 respondents. Although this initially caused concern about the data being representative, comparison with the data from the Florida KidCare Program Evaluation Report suggests that the data is in fact representative. The Florida KidCare survey had contact with 4,254 families, 553 of those were identified as CMS families. In terms of demographics, both surveys found similar information about the children with special health care needs and their families.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population Status

During the past decade, the population of Florida has increased at a fairly steady rate of approximately 250,000 per year, going from a total of 13,256,873 in 1991 to a projected total of 15,588,134 in 2000. Approximately 84 percent of the population is white, a percentage that has remained fairly constant throughout the 1990s. Of the total population, 51 percent are female.

Health Status of Pregnant Women, Infants and Children

Florida's health indicators for the MCH population suggest that overall there have been slight gains in health outcomes since the completion of the 1995 needs assessment. The percentage of children through age 2 who have received recommended immunizations has continued to increase over the past few years, from 81.6 in 1996 to 86.2 in 1999. The birth rate for teens 15-17 has continually declined, going from 40.9 per 1,000 in 1996 to 33.8 in 1999. The number of mothers who breastfeed has increased 12 percent over the past three years. The percentage of children who do not have health insurance has dropped from 23.4 percent in 1997 to 13.4 percent in 1999. Slight gains have been made in the number of potentially Medicaid-eligible children who receive a Medicaid service, the percentage of very low birth weight babies who are delivered at high-risk facilities, and in the percentage of women who receive prenatal care in the first trimester. Subsequent births to teens 15-19 decreased from 15.5 percent in 1996 to 13.8 percent in 1999. The percentage of women who report tobacco use during pregnancy went from 12.2 in 1996 to 10.2 in 1999.

In 1997, Florida's infant mortality rate dropped to 7.06 per 1,000 live births, the lowest rate ever achieved in Florida. The rate rose slightly in 1998 to 7.24 per 1000. Preliminary data shows a slight decline in the overall rate for 1999, but there was a 15 percent increase in the infant mortality rate for non-white infants.

INFANT MORTALITY

| rate per 1,000 live births | 1995 | 1996 | 1997 | 1998 | 1999 |
|----------------------------|-------|-------|-------|-------|-------|
| Infant mortality all | 7.44 | 7.42 | 7.06 | 7.24 | 7.1* |
| White infant mortality | 5.92 | 5.77 | 5.60 | 5.83 | 5.4* |
| Non-white Infant mortality | 12.07 | 12.44 | 11.41 | 11.35 | 13.2* |

* provisional data

The percentage of women who deliver babies who have a low or very low birth weight has increased slightly each year since 1995. This increase is even greater in the white population, as the non-white rate has remained fairly steady. Our recent inability to generate further decline in the percentage of low weight births may be due to a number of factors. A level may have been reached that requires serious modification of behaviors before further improvements can be made. Medical advancements may also be a factor, as premature or otherwise underdeveloped babies receive better care.

LOW BIRTH WEIGHT

| weights/race | 1995 | 1996 | 1997 | 1998 | 1999 |
|----------------------|--------|--------|--------|--------|--------|
| under 2500 grams all | 7.69% | 7.86% | 8.04% | 8.08% | 8.15%* |
| under 2500 white | 6.39% | 6.56% | 6.76% | 6.81% | n/a |
| under 2500 non-white | 11.68% | 11.82% | 11.84% | 11.78% | n/a |
| under 1500 grams all | 1.46% | 1.51% | 1.54% | 1.61% | 1.63%* |

| | | | | | |
|----------------------|-------|-------|-------|-------|-----|
| under 1500 white | 1.07% | 1.13% | 1.19% | 1.25% | n/a |
| under 1500 non-white | 2.67% | 2.64% | 2.58% | 2.66% | n/a |

The percentage of pregnant women who enter prenatal care during the first trimester has remained at or near 83 percent over the last five years. The percentage of pregnant women who have no prenatal care has also remained fairly constant, at or near 3.3 percent. A number of factors affect the timing of a women’s entry into prenatal care. The most significant of these factors include: financial barriers, limited availability of providers, lack of transportation/child care, personal attitudes, and cultural barriers. We hope that planned interventions such as expanded outreach and simplification of the eligibility process will begin to have a positive affect on these indicators.

ENTRY INTO PRENATAL CARE

| | 1995 | 1996 | 1997 | 1998 | 1999 |
|---------------------------------|-------|-------|-------|-------|-------|
| 1 st Trimester Entry | 82.6% | 82.3% | 83.1% | 83% | 83.2% |
| No Prenatal Care | 3.39% | 3.34% | 3.14% | 3.49% | n/a |

The strategies and interventions funded by the Title V MCH block grant have supported many of the previously mentioned gains in MCH outcomes. Data trends, coupled with MCH research, suggest that future gains in these same areas will become more difficult to achieve as we encounter the underlying factors related to the most difficult health problems, many of which we are only beginning to understand.

For Florida, the data reflects significant disparity in health outcome indicators for racial and ethnic minority populations. Community Integrated Service Systems (CISS) funding (through the use of unobligated funds carried forward) is enabling Florida to contract for initial work in this area. Activities will include a comprehensive analysis of existing literature, a survey with key stakeholders, and regional forums with service providers and consumers to elucidate factors related to the disparity in outcomes. The department received CDC funding through a REACH grant to address the factors related to racial and ethnic disparities specifically impacting low birth weight. In addition, a racial and ethnic disparity bill entitled “Closing the Gap” will provide approximately \$5m of general revenue funding to address racial and ethnic disparities in health outcome indicators. Future interventions and strategies will need to be supported by evidence of their effectiveness on these vulnerable populations. The issues of immigration, undocumented citizenship, and cultural diversity (and its impact on health behaviors) compound the challenge to create comprehensive systems of care for the entire population.

In 2000, the Florida State University Center for Prevention and Early Intervention Policy conducted 13 focus groups with minority women in four geographically and demographically diverse counties in Florida: Alachua, Gadsden, Hillsborough, and Palm Beach. The purpose of their study was to examine issues related to racial disparity, in an effort to determine possible causes behind the higher incidence of infant mortality within the black population. Their findings suggest that a number of psychosocial and social economic factors may play a role in why black infants have a mortality rate that is twice as high as white infants.

The focus group report cited stress as a major factor. Black women in the focus groups perceived stress as being detrimental to their health and that of their babies. They cited discrimination in the workplace and health care settings, as well as difficulties with transportation, as being major sources of stress in their lives. They reported feeling looked down upon as black women, especially while pregnant, and felt they received less respect from health care providers because of their race/ethnicity. This perceived lack of respect often discouraged them from taking full advantage of available services. The Center suggested that interventions to address racism-induced stress during the perinatal period should include training health professionals to: understand the special risks faced by black women; recognize the signs of stress in black clients; communicate with their clients in a more culturally sensitive manner; and alter their approach to perinatal care so to improve access to services. They also noted that improving the diversity among health care providers by increasing the number of minority professionals may also help address this issue. They felt their race/ethnicity limited the quality and access to prenatal and postnatal care services they had received. They also indicated they felt intimidated by the setting in which their care was provided.

Consumers attending the focus groups suggested more parenting classes be made available for parents of all ages focusing on preconceptional health, prenatal and postnatal care, as well as basic parenting skills. Culturally-sensitive education is required to address this lack of knowledge at the individual, family or community level. It cannot be assumed those most in need will be willing or capable of actively seeking help. Thus, programs must identify those individuals most at risk and reach out to them based on their profile rather than their expressed interest.

Women in the focus groups repeatedly spoke of a feeling of isolation during pregnancy and a lack of support from male figures, family, health care providers, and community. To address

this issue, they proposed the availability of emotional support groups, as well as initiatives to educate fathers, involve them in the pregnancy, and encourage them to participate in their children's lives. Programs that provide medical care, child-care, financial and educational assistance, or other support need to be visible and accessible to all at-risk women irrespective of race or ethnicity. These direct assistance programs should be initiatives designed to increase community and family involvement in child rearing.

The report also notes a strong correlation between poverty and complications of pregnancy including low birth weight/preterm delivery and infant mortality for all women regardless of racial/ethnic affiliation. Being at a socioeconomic disadvantage is associated with poor access to quality health care, lower level of education, exposure to environmental hazards, poor nutrition, and exposure to high levels of stress and violence. The higher incidence of poverty in certain racial/ethnic groups and the associated higher infant mortality rates support the notion that this relationship may be a factor. If this is the case, eliminating socioeconomic disparities may be the most direct means of eliminating disparities in infant mortality and other complications associated with pregnancy.

Possible medical reasons for racial disparities in infant mortality cited by the report include higher incidences of bacterial vaginosis, sexually transmitted infections, and periodontal disease within the black population. There is a higher incidence of bacterial vaginosis in black women, and some research suggests the fact that douching is a much more common practice among American black women than in any other racial/ethnic group may be a factor. Focus group participants also stated they douched much more often than the general population. Sexually transmitted infections have been shown to increase the incidences of premature delivery, low birth weight, birth defects, and infant death, and black women have the highest rates for these infections of any racial or ethnic group among 15-19 year-olds. Women with periodontal disease have higher rates of preterm delivery and low birth weight, the main factors contributing to infant mortality. Periodontal disease is more common among members of disadvantaged socioeconomic groups due to poor nutrition and a lack of access to good dental care.

New findings related to maternal and infant health must be implemented in a manner that is responsive to the unique characteristics of Florida's MCH population. This will continue to be a key factor in policy and decision making related to issues such as the education, prevention

and interventions needed to address topics such as bacterial vaginosis, folic acid, and infant brain development.

The major causes of deaths for children and young adults from birth to 24 have remained fairly consistent over the past decade. During that time, Florida has made remarkable progress in reducing both the number of deaths and the rate, both overall and for nearly every major cause. The chart below illustrates this achievement.

| Resident Deaths for Leading Causes and Rates Per 100,000 Population, by Age Group, Florida, 1988 and 1998 | | | | | | | |
|---|---------------------------------|------|--------|--------|------|--------|-------|
| Age | Cause of Death | 1988 | | | 1998 | | |
| | | Rank | Deaths | Rates | Rank | Deaths | Rates |
| <1 | ALL CAUSES | - | 1,949 | 1096.8 | - | 1,415 | 728 |
| | Perinatal Conditions | 1 | 928 | 522.3 | 1 | 685 | 352.8 |
| | Congenital Anomalies | 2 | 379 | 213.3 | 2 | 264 | 136.0 |
| | Sudden Infant Death Syndrome * | 3 | 256 | 144.1 | 3 | 118 | 60.8 |
| | Unintentional Injury (accident) | 4 | 60 | 33.8 | 4 | 57 | 29.4 |
| | Heart Disease | 5 | 39 | 21.9 | 5 | 37 | 19.1 |
| 1-4 | ALL CAUSES | - | 459 | 67.6 | - | 304 | 39.9 |
| | Unintentional Injury (accident) | 1 | 198 | 29.2 | 1 | 151 | 19.8 |
| | Homicide and Legal Intervention | 2 | 30 | 4.4 | 2 | 25 | 3.3 |
| | Congenital Anomalies | 3 | 52 | 7.7 | 3 | 24 | 3.1 |
| | Malignant Neoplasm (Cancer) | 6 | 17 | 2.5 | 4 | 16 | 2.1 |
| | Heart Disease | 5 | 19 | 2.8 | 5 | 9 | 1.2 |
| 5-14 | ALL CAUSES | - | 441 | 29.0 | - | 427 | 22.2 |
| | Unintentional Injury (accident) | 1 | 209 | 13.8 | 1 | 176 | 9.2 |
| | Malignant Neoplasm (Cancer) | 2 | 52 | 3.4 | 2 | 57 | 3.0 |
| | Heart Disease | 5 | 16 | 1.1 | 3 | 32 | 1.7 |
| | Homicide and Legal Intervention | 3 | 26 | 1.7 | 4 | 27 | 1.4 |
| | Congenital Anomalies | 4 | 24 | 1.6 | 5 | 23 | 1.2 |
| 15-24 | ALL CAUSES | - | 2,106 | 124.4 | - | 1,521 | 84.3 |
| | Unintentional Injury (accident) | 1 | 985 | 58.2 | 1 | 707 | 39.2 |
| | Homicide and Legal Intervention | 2 | 435 | 25.7 | 2 | 225 | 12.5 |
| | Suicide | 3 | 222 | 13.1 | 3 | 199 | 11.0 |
| | Malignant Neoplasm (Cancer) | 4 | 75 | 4.4 | 4 | 81 | 4.5 |
| | Heart Disease | 5 | 48 | 2.8 | 5 | 40 | 2.2 |

* Sudden Infant Death Syndrome, ICD9: 798.0

Florida has made remarkable strides over the past two years in reducing the incidence of tobacco use by children and teenagers. In 1998, some of the funds received in a tobacco

settlement helped establish a Tobacco Pilot Program that developed prevention activities and media campaigns aimed at reducing tobacco use by young people. Reported current cigarette use (within the past 30 days) declined by 54 percent among middle school students and by 24 percent among high school students from 1998 to 2000. During the same period, cigar use was reduced by 46 percent in the middle school population, and by 21 percent among high school students. Smokeless tobacco product usage also decreased tremendously, by 54 percent among middle school students and 19 percent among high school students. The two-year decline in cigarette use alone represents 79,760 fewer youth smokers in 2000 compared to 1998, which translates to approximately 26,630 fewer premature deaths attributable to smoking if these youths had become and remained regular smokers. (Source: Florida Youth Tobacco Survey.)

Needs Assessment Survey Results

The MCH office disseminated an electronic key informant survey to 67 local CHD Healthy Start care coordinators, 30 Healthy Start coalitions, and to 56 other key informants. The survey generated a total of 43 responses. Of that total, 32.5 percent were from county health departments (Healthy Start coordinators), 25.6 percent were from Healthy Families Florida (HFF) staff, 23.3 percent were from other key informants, 11.6 percent were from Healthy Start coalitions, and 7 percent were from unidentified sources. The survey instructions encouraged informants to recruit responses from other key informants as deemed appropriate. A total of 12 of the 67 county health departments surveyed responded, and two counties sent in two separate responses, for a total of 14. Of the 11 responses received from HFF staff, seven were from one county. There were five responses from the 30 coalitions surveyed. Of the 56 other key informants surveyed three responded, one of which submitted two responses and another submitted seven from additional recruited responses, for a total of 10 responses from key informants. Three responses were not identifiable.

Survey participants were asked to assess the progress made on certain issues identified in the 1995 assessment. The issues were graded on a scale of 1-4, with “1” representing great improvement, “2” for somewhat improved, “3” for very little improvement, and “4” being no improvement. The highest scored item was the issue of single parent homes with an average of 3.4. Other issues rated 3.0 or higher included inconvenience of scheduling public transportation (3.3), lack of dental health services (3.3), lack of personal vehicle (3.2), lack of public transportation (3.1), low-literacy level (3.1), lack of social workers or counselors (3.1), clients living in crises (3.0), limited resources for basic material needs (3.0) and transient nature of

many families (3.0). Additional issues scoring nearly as high include: the perception by Medicaid clients that they are looked down upon, delays in the Medicaid eligibility process, the lack of school-based fluoride treatment programs, and the unavailability of child care services. Issues in this category that scored well (between 1.7 and 2.0) included: lack of awareness of importance of early prenatal care, negative stigma about breastfeeding, lack of family planning instruction and advice, insufficient public information on maternal child health services, fear of immunization side effects, and lack of parenting education.

Survey participants were also asked to assess barriers to care, again on a scale of 1-4 with “3” being very little improvement and “4” being no improvement. The issues listed as the greatest barriers to care (3.3 average score) included: transportation, psychosocial problems, mental health issues, overburdened families, lack of funds for medication, and inadequate funds. Domestic violence, no source for respite care, and lack of affordable acute care services all scored 3.1. Barriers scoring 3.0 included pediatric specialists needed, lack of parental participation, inadequate daycare, inadequate insurance, lack of HMO availability for 24-hour service, and lack of occupational therapy. Other barriers cited with slightly lower scores included: lack of specialists who accept Medicaid, long clinic waiting times, lack of physical therapy, cultural issues, lack of eye and hearing services, and limited school health. Barriers that showed some improvement with a score of 2.4 included: duplication of services, poor quality assurance, lack of protocols for chronic diseases, lack of coordination of services.

The survey listed priority health issues for various age groups, which had been identified in the 1995 assessment. Survey participants were asked to indicate which issues should still be considered a priority. For children age 1-4, parenting was the issue cited by the most responders (38 out of 43). Other issues cited by 30 or more responders included: abuse/neglect, dental care/prevention, family support, emotional/behavioral disorders, child development, and substance abuse in utero. Issues cited by 25-29 responders included: bonding, child care, mental health, nutrition, developmental difficulties, and home safety.

Abuse/neglect was the most listed priority issue for children age 5-11, cited by 34 of the 43 responders as an issue that should still be a priority. Other issues cited by 28-30 responders included: dental health, mental health, school health, and violence. Issues for this age group cited by 20-23 of the survey participants were: substance abuse, family-focused emphasis, obesity, ADHD, screening/follow-up, asthma, and accident prevention.

Survey participants cited a number of issues that should still be considered a priority health issue for children age 12-18. A total of 39 of 43 responders cited teen pregnancy as a priority issue, closely followed by illegal drugs (38), alcohol/tobacco (37), mental health (36), and STDs/HIV/AIDS (34). Other issues cited by 24-31 responders included: violence, dental treatment, sense of self, suicide, nutrition, and eating disorders.

While abuse/neglect is obviously a priority issue for children, it should be noted that 25 percent of the survey responses were from HFF staff, whose mission is the prevention of child abuse. This may have skewed the results slightly in favor of making this issue a higher priority in the categories above for children 1-4 and children 5-11.

The 1995 needs assessment identified certain issues as barriers to health care for the migrant population. Survey participants were again asked to grade these issues on a scale of 1-4, with “1” representing great improvement, “2” for somewhat improved, “3” for very little improvement, and “4” being no improvement. The highest scoring issue related to migrant health was finances at 3.5. Housing, dental care, food stamps, Medicaid, TANF, transportation, and family planning were all issues that rated 3.0 to 3.3, or judged to be showing very little improvement. Additional priorities cited were safety issues, wellness, education, day care, and nutrition.

Health Services Gaps for Pregnant Women, Infants and Children

Healthy Start Coalition service delivery plans identify the need for more rural birthing centers across the state. ACOG guidelines recommend a travel time to the nearest birthing center of 30 minutes or less. Travel to delivery centers from many rural areas in Florida is 60 minutes or more (Calhoun, Liberty, and Taylor counties, for example). Neonatal intensive care is even less accessible. Expanding the availability of birthing facilities would provide more continuity of care, with the provider of prenatal care also assisting in the delivery. There would also be fewer transportation problems. In Florida, 37 of the 67 counties are officially designated as rural and experience problems with access to care. The lack of a public transportation system in many parts of the state is a major factor affecting families who lack personal transportation or who only have use of a vehicle after regular office hours. Despite a major effort in many areas to co-locate services, health care and social service providers are still not centrally located, compounding the transportation problems for many clients.

Many people remain uninsured in Florida, but much progress is being made in reducing their numbers. Lack of insurance leads to inappropriate use of hospital emergency rooms, which become the only source of care. The uninsured are less likely to receive preventive care, delay seeking care until medical problems worsen considerably, and end up in the most expensive care settings when they seek care. In 1999, the Florida Health Insurance Study reported that while Florida's population has increased steadily throughout the 1990s, the number of uninsured people in Florida has fallen from 2.6 million (RAND 1993) to 2.1 million (FHIS 1999). This represents a drop from 18.5 percent of the total population being uninsured in 1993 compared to 16.8 percent in 1999. Factors that determine the likelihood that a person is uninsured include income, employment status, ethnicity, and region of the state they live in (certain areas have higher incidence). Following are the most common reasons given in the Florida Health Insurance Study as reasons for not having insurance:

- Too expensive/premium too high = 74.1%
- Don't need insurance/usually healthy = 4.0%
- Medical problems/pre-existing conditions = 2.5%
- Don't believe in insurance = 1.8%
- Not employed = 2.3%
- Free or inexpensive care available = 0.7%
- Waiting for coverage = 4.0%
- Transient status = 2.0%
- Employer doesn't offer = 3.0%
- Other = 5.6%

The Maternal And Child Health Office conducted a prenatal care survey in June 1999, asking both Healthy Start Coalitions and county health departments questions regarding prenatal care in their local communities. The survey found that nearly all respondents reported that there were personnel dedicated to assisting women with obtaining presumptive eligibility for Medicaid. A majority of the respondents (two-thirds of the counties and half the coalitions) reported that 75 percent or more of their PEPW clients were eventually determined to be eligible for Medicaid. A total of 48 of 64 respondents reported that it takes 7-14 days to get into prenatal care after initial contact, with another 13 reporting a wait of 15-21 days, with only three reporting a wait of 28 days or longer. Most respondents (62 out of 68) reported that the current system of care meets the needs of the community. Reasons cited for delays in receiving

care or why the system of care did not meet needs included: inadequate transportation, lack of providers, lack of money for unfunded women, patient backlogs, and lack of care in rural areas.

System Constraints for Pregnant Women, Infants and Children

There are a number of system constraints that affect this particular population. There are considerable financial constraints, such as inadequate insurance and lack of Medicaid funds to purchase care. For many women and families, their personal income affects their ability to access care, as items such as food and housing take priority. There is a shortage of transportation and childcare services, adversely affecting even those who can afford or have coverage for medical services. There is a limited availability of maternity care providers willing to serve economically disadvantaged or high-risk pregnant women and their children. There is inadequate funding for maternal and child health services in sites routinely used by high-risk populations, such as public health departments and community health centers.

Coalition service delivery plans also cited insufficient outreach, particularly towards women with experiences, attitudes, and beliefs that make them less likely to seek prenatal care for themselves or pediatric care for their children. There is a need for more community awareness/education activities to increase support for maternal and child health care.

Other barriers to care cited include: services and classes are not held in convenient locations, offices and clinics are not open at convenient times, limited classes in Spanish, limited availability of drug counselors and treatment, and the inability of many clients to read necessary forms. Many social service agencies have no bilingual staff. In general, the number of bilingual staff is inadequate for the Spanish-speaking population.

Family planning programs are the only way many low-income women access primary health care. In 1998, 62 percent of county health department family planning patients served had incomes at or below 100 percent of poverty level. These women are the most likely to be negatively affected by an unintended pregnancy and the least likely to have the resources necessary to provide for additional children.

Family planning services reduce unintended pregnancies and poor birth outcomes. A 1999 PRAMS study of births in Florida reported that 47.8 percent of births in 1996-97 were unintended. The study also found that the women who were most likely to have an unintended

pregnancy were also the women most likely to have unhealthy behaviors, problems with their pregnancies, or unhealthy babies.

There are 352 publicly supported family planning clinics in Florida. County health departments served over 200,000 clients statewide last year. Of the estimated 623,154 women who needed subsidized family planning services in Florida, county health departments and other providers were able to serve only 32 percent of the “women in need” population. “Women in need” is defined as sexually active women age 13-44 who are not sterile and who are not pregnant or trying to become pregnant. An additional defining standard includes women who are age 20-44 with incomes below the federal poverty level plus all women younger than 20 regardless of income.

However, two-thirds of all women who are at risk of unintended pregnancy and are in need of subsidized family planning services are not receiving them. Despite the efforts of various private and public organizations, the need for family planning services continues to exceed available resources. In an effort to reduce the number of unintended pregnancies and births paid by Medicaid, the Agency for Health Care Administration and the Department of Health submitted a waiver application to the Health Care Financing Administration requesting the extension of family planning services to 24 months after a pregnancy-related service. The waiver application was approved in the summer of 1998 for the period of September 1, 1998 through August 31, 2003. From September 1998 through June 1999, 14,781 women were provided family planning services under the extended coverage. As more women utilize the extended family planning coverage under the Medicaid program, more Title X funds may be available to provide family planning services to low-income women who are eligible for family planning services under Medicaid.

Strengths and Weaknesses of System for Pregnant Women, Infants and Children

Language, childcare, telephone and transportation issues persist in many areas of the state. Many social service agencies have no bilingual staff. In general, the number of bilingual staff is inadequate for the Spanish-speaking population in some areas. During the season from October to May, the influx of migrants creates a peak need for services such as housing, food, clothing, and financial assistance.

Time, distance and difficulty in arranging for childcare can lead women to postpone or cancel health care appointments. Childcare facilities for infants are minimal in some areas, especially subsidized childcare. A need exists for childcare settings that will accommodate parents working “non-traditional” hours like weekends, evening and early mornings, and for facilities that provide short term, drop-in-care.

Health care and social service providers are not centrally located to the client population. Residents residing in distant locations have to travel many miles to access services. There is no regular public transportation in some of the counties. Lack of public transportation also limits employment options, and availability of services for consumers.

Positive strides have been made over the past decade in increasing participation in the WIC program. In 1990, 161,759 people participated in the WIC program, approximately 31 percent of the eligible population. By 1999, participation had increased to 337,860 people, or 65.7 percent of the eligible population.

Health Status of CSHCN Segment of the MCH Population

The Family Voices survey reflects the following demographics. It is interesting to note that the age and gender percentages are within (+/-) 5 percent of the national demographics reported for children served by Title V. However, the national percentages for the White/Caucasian group was 71 percent, for the Black/African American group was 10 percent and for Hispanic group was 9 percent; this represents a significant difference in ethnicity for Florida and the resultant need to address cultural issues affecting those children and their families. Financially, there was also disparity in the low-income levels; Florida is serving a larger group of children from lower income families. The national percentage for less than \$10,000 was 15 percent and for the \$10,000 to 19,000 group was 17 percent.

(K=KidCare data)

| | | | |
|----------------------|--|-------|--------|
| Age: 0 to < 4 = 13 % | Ethnicity: White/Caucasian | =51 % | 78.6%K |
| 4 to < 7 = 17 % | Black/African American | =24 % | 10.4%K |
| 7 to < 11= 32 % | Asian/Pacific Islander/SE Asian | = 2 % | |
| 11 to <15= 25 % | Hispanic/Latino/Latina/Spanish | =17 % | 11.1%K |
| 15 to <19=11 % | Native Amer./Amer. Indian/ Aleut/Eskimo | = 0 % | |
| | Multiracial | = 6 % | |

(Other KidCare 11.0%)

Gender: Male=63 % (52.4% in the demographics for Florida KidCare New Enrollees)

Female=37 % (47.6% in the demographics for Florida KidCare New Enrollees)

| Income Levels (Household Pre-Tax Income for 1997) | |
|--|-------------|
| Less than \$10,000 | =27 percent |
| \$10,000 to \$19,000 | =21 percent |
| \$20,000 to \$29,000 | =11 percent |
| \$30,000 to \$39,000 | =14 percent |
| \$40,000 to \$49,000 | =5 percent |
| \$50,000 to \$59,000 | =6 percent |
| \$60,000 to \$69,000 | =3 percent |
| \$70,000 or Greater | =10 percent |
| No Response | =3 percent |

The KidCare Survey looked at only two income categories, 150 percent below the Federal Poverty Limit (\$25,050) and 150 percent above the Federal Poverty Level. The percentage above was 62.7 percent and below was 37.3 percent which appears to support the thought that the Family Voices data is representative for Florida.

Thus, it is clear that children with special health care needs are of all ages, races, ethnic backgrounds and income levels, which presents a broad spectrum of issues when attempting to meet the health care needs of this special population.

When looking at the medical conditions of these children, the Family Voices survey provides percentages for 35 specific conditions plus a percentage for additional conditions/other. The percentages exceed 100 percent because many children have multiple conditions. Conditions represented that affect 15 percent or more of these children were:

| | |
|-------------------------------------|------------|
| Allergies or Sinus Trouble | 29 percent |
| Asthma | 24 percent |
| Behavior Problems | 32 percent |
| Cerebral Palsy or other | |
| Neuromuscular Condition | 16 percent |
| Developmental Delay | 32 percent |
| Digestive/Gastrointestinal Disorder | 17 percent |
| Mental Retardation | 19 percent |
| Orthopedic or Bone Problems | 27 percent |
| Seizure Disorder | 17 percent |
| Additional Conditions/Other | 25 percent |

These conditions demand effective planning and collaboration across program and agency lines, which demands a dynamic and collaborative health care system.

The families of these children reported very positive information in regards to the stability and overall health of their children. Families indicated that 75 percent of these children are usually stable or are changing once in a while. Changing all the time accounted for the description of 21 percent of the children. Only 13 percent were described as technologically dependent. Over 42 percent reported that their child's health was excellent or very good. Another 54 percent reported their child's health was good or fair. Only 3 percent reported that their child's health was poor. This suggests that despite the diversity of their conditions, their health care needs are being met in a manner that is maintaining acceptable levels of wellness.

Health Services Gaps for CSHCN

Tremendous changes have taken place in Florida's health care system over the last 24 months. Legislation and the tobacco lawsuit have ushered in a period in which the state focused on finding a means to extend health care coverage to a larger number of children. While building the policies and framework to implement this coverage, Children's Medical Services has undertaken reorganization and re-definition of its functioning. Thus, many of the areas identified as "gaps" by the Family Voices survey done in 1997, are indeed areas that have been "built in" as the implementation has progressed.

Seeing that children with special health care needs have a primary care provider, a written health care plan and a case manager are important features of our efforts. Of the families surveyed by Family Voices, 11 percent did not have a primary care provider and 10 percent were concerned about the skill of the physician. The KidCare Evaluation report reflected that 15 percent of the families did not have a "usual source of care." However, they rated their children's primary physician skills as an 8.9 on a scale of 10. Thus it is important to continue increasing the number of primary care provider physicians and efforts to credential and bring into the CMS Network physicians with the skills needed to serve these children.

Of particular concern were Family Voices Survey responses that children did not have written health plans (46 percent did not while 25 percent didn't know or were not sure) or did not have a case manager (38 percent did not while 19 percent did not know or were not sure). Children's Medical Services continues to require that their nurse case managers develop family support

plans that are written with the family to ensure that their priorities, concerns and resources are considered while providing medically necessary health care to their children.

Although over three-fourths of the families surveyed by Family Voices reported receiving specialty care services, 14 percent indicated they experienced problems. However, 6 percent stated they needed services but did not receive them. Only 14 percent received mental health services, but of that group 44 percent reported having problems. Another 5 percent needed services but did not receive them. Other services that drew significant percentages (>20 percent) of “problem reports” were physical therapy, speech therapy, occupational therapy, home health care services, and prescription medications

In the focus groups held by the Institute for Child Health Policy regarding the Florida KidCare Program a number of areas of parents’ concern were identified:

- Having to switch providers when enrolling in Florida KidCare
- Having a different provider for each child in a family due to the various eligibility requirements
- Access to dental care is limited
- Getting personalized help, face to face
- Waiting period after submitting application
- Clarity of application and outreach materials

The outreach component of the KidCare program has made applications available at over 5,500 sites throughout the state. These include schools, county health departments, doctor’s offices and public assistance offices. Over a million flyers, brochures, posters and promotional items have been distributed. Media campaign components included 2,800 television and 3,400 radio advertisements, 250 outdoor boards, 1,150 bus placards, and a Web site with a downloadable application. This extensive outreach by the KidCare Corporation and the addition of a toll-free number manned by the Department of Health has provided live assistance and information for people with enrollment questions and application requests in hopes of addressing the concerns. Although the KidCare evaluation reported that children served by CMS had the highest percentage when compared to Medicaid children regarding having seen a dentist in the last six months (45 percent CMS, 38 percent Medicaid), it appears to be generally recognized that dental care represents a gap in services. Currently several bills before the state legislature propose expanded dental care for children.

System Constraints for CSHCN

As reflected above, there are areas of the system needing to be strengthened. A major thrust of the state's efforts has been to implement a system of primary care for children with special health care needs. However, in some rural areas, assuring access to a primary care provider within a 30-minute drive from the family home has presented a challenge. In the focus groups held by the Institute of Child Health Policy, concern was expressed about providers in the network being scattered over the geographical area, often requiring a drive of an hour or longer to get to an appointment. Florida issued an Intent to Negotiate to seek these and other necessary services throughout the state.

In some areas of the state, availability and accessibility varies with the county of residence. After using their initial allocation of 500 slots, the county is currently required to raise the required local match for additional slots and there has to be a provider network in the area. Another issue is that the programs are restricted to paying providers at the Medicaid rate. A number of providers have indicated that they are not willing to provide service at that rate.

The KidCare program has a complex administrative system. The financial eligibility requirements that determine which part of the program the child will be enrolled in are based on age. The intake system for each component has different administrative requirements. If the child has special health care needs, the child will enter the Children's Medical Services Network. The existing different financial eligibility criteria, provider networks, and payment rates in the various components create the potential that as a child's eligibility factors change, the child may have to change components of KidCare and possibly experience a change in providers or benefits.

Efforts continue to integrate all aspects of the KidCare program. The Florida KidCare Coordinating Council provides the partner agencies with recommendations to ensure the success of the program. Appointed and chaired by Robert G. Brooks, M.D., Secretary of the Department of Health, the council is responsible for overseeing all aspects of Florida KidCare and acting as an advisory body for agencies and elected officials. The council is comprised of 32 members from state agencies and numerous community businesses, advocacy groups, and organizations. The council receives input and guidance from eight appointed task forces

covering specialized areas of concern including but not limited to Community Health, Early Childhood, Rural Health, Special Populations and Welfare to Work.

Specialty care providers have been recruited, credentialed and made a part of the service network. Steps have been taken to implement behavioral health services within the network. A limited number of slots are available for these services. There has been some delay in moving ahead with this effort as the initial guidelines regarding diagnosis appeared to be too restrictive. A closer look suggests that the screening process needed to screen children in as opposed to screening them out. Changes have been made to the screening process and the diagnoses included.

Of note is the fact that 54 percent of the children in the Family Voices survey had state Medicaid as the payer of their primary health care. A patchwork of insurance was employer or family and employer supported (24 percent) and the rest were paid for by the family alone (14 percent). The concerning issue is that these plans typically have significant limits on the services available to the child. When those limits are exhausted, the child frequently cannot qualify for other coverage. However, the advent of KidCare in Florida has offered new avenues to coverage for these children.

Strengths and Weaknesses of System in Serving CSHCN

The Family Voices survey looked at five issues related to family satisfaction with their primary health plan. Below are only the percentages of families indicating an “excellent” rating on the issue, in Florida and nationally.

| Issue | Florida | National |
|---|------------|------------|
| Paying for second opinion | 13 percent | 9 percent |
| Paying for services or Equipment outside network | 19 percent | 10 percent |
| Approving emergency care | 41 percent | 27 percent |
| Approving specialty care | 35 percent | 23 percent |
| Out of pocket costs: Deductibles, co-pays, etc. | 27 percent | 19 percent |

Florida compares very favorably with the national ratings. Other issues such as paperwork, clear information about what services are covered and how to get them as well as knowing how to file a complaint also achieved higher ratings than the national responses. Overall, 78 percent of Florida's respondents indicated they were somewhat satisfied (30 percent) or very satisfied (48 percent). In the Florida KidCare survey, families reported their satisfaction with the issues below. The choices of responses were always, usually, sometimes and never.

- child was given an appointment as soon as they wanted:
Always 75.9 percent or Usually 1.9 percent
- child was seen as quickly as the parent wanted:
Always 71.3 percent or Usually 20.5 percent
- child was treated with respect and courtesy:
Always 90.6 percent or Usually 5.6 percent
- child's doctor or health care providers listened carefully to the parent:
Always 81.2 percent or Usually 13.3 percent
- child's health care provider explained things in a way you could understand:
Always 83.7 percent or Usually 10.3 percent
- child's health care provider showed respect for what you had to say:
Always 79.5 percent or Usually 15.8 percent
- child's health care providers spent enough time with your child:
Always 75.5 percent or Usually 14.6 percent

These ratings reflect a high level of satisfaction with how families are treated in the Florida KidCare programs.

In view of the higher percentage of low-income families represented in Florida's Family Voices sample, the percentage of respondents who indicated that there had been negative impacts on their family as a result of having a child with special health care needs is of concern. Families reported that this situation had caused financial problems (49 percent), caused them to cut down on work to care for this child (44 percent) or that they had stopped working to care for this child (33 percent). Also, 58 percent reported that they need additional income to cover the child's medical expenses. Thus, there remains a need to address ways to support families in their efforts to provide medically necessary care to their children.

3.1.2.2 Direct Health Care Services

Combined with enabling services below.

3.1.2.3 Enabling Services

Access to health care and health-related services remains a priority for the provision of direct health care and enabling services. Title XXI is helping to address access to care in the child health population through the Florida KidCare Child Health Insurance Program. A continuing challenge for the state remains the assurance of universal and continuous access, as well as early entry into prenatal care for all women.

Citizenship status may preclude many women in Florida from seeking prenatal care. This is compounded by cultural differences in the many cultures that represent Florida's immigrant population. These women are often difficult to reach and to serve. Often members of this population reside in rural agricultural areas of the state. Many rural areas in Florida lack sufficient transportation, health care providers, and delivering facilities. It is also difficult to recruit and maintain staff in these areas who have the expertise necessary to deal with multi-lingual and multi-cultural populations.

Since 1997, all Medicaid-eligible recipients (except those who are in an institution, enrolled in the Medicaid medically needy program, or eligible for both Medicaid and Medicare) have been required to choose an HMO or MediPass provider. The MediPass program was implemented in many county health departments and other providers across the state. The focus is to provide comprehensive, quality services to all Medicaid-eligible pregnant women, infants and children by assuring that a primary care home is available and is within a managed care setting to control costs. The Department of Health actively participates in the revisions of the state Medicaid prepaid health plan (managed care) contract on an ongoing basis to ensure that we maintain the availability of prevention and primary care services for the MCH population.

Welfare reform has resulted in a need for continual examination of and restructuring of the MCH service delivery system to meet the unique needs of the TANF population. Women are losing cash benefits, reentering the workforce, and finding it necessary to depend on both formal and informal child care networks. As a result, outreach, education, and services must be tailored to meet these new challenges. Health departments, clinics and private physicians must explore alternative methods to effectively deliver prenatal care, well-baby care, family planning and other health care services.

Title XXI provides funds to initiate and expand child health assistance to uninsured low-income children who are not eligible for Medicaid and have family incomes at or below 200 percent of the federal poverty level. The Florida KidCare Program consists of the following programs:

- MediKids, to provide services to children from birth to age 5 through existing Medicaid managed care plans or MediPass. MediKids offers Medicaid benefits, is not an entitlement, and will serve 23,000 kids in the first year.
- Florida Healthy Kids, for children age 5 to 19, will serve 162,000 children the first year.
- Medicaid coverage for teens age 15 to 19 will be expanded from 28 percent to 100 percent of the federal poverty level, serving an additional 30,000 children.
- Expansion of employee-sponsored group health insurance plans for children in families with access to dependent coverage.
- All CSHCN who have family incomes at or below 200 percent of poverty will be served through the CMS Network with a comprehensive package of Medicaid benefits and case management services.

The shift in Medicaid coverage over the last five years has affected financial barriers to care and services delivered by state and local public health agencies. Since fewer were eligible for services, these providers had less paying customers from Medicaid and thus less resources in that most individuals could not pay the full cost of services to make up for the loss in revenues. Data on the magnitude of this effect are difficult to come by. The effect of managed care has also reduced use of services by members of safety net providers when the prepaid plan does not contract with the provider. This can be problematic when the client shows up for services, but is not eligible for reimbursement.

In both cases there is no effect on Title V CHCSN services as Title V CHCSN clients eligible are served through a special network (unless they specifically opt out into MediPass) and are ineligible for prepaid services.

The effects of the Child Health Insurance Program (CHIP) on Title V are to increase continuity of coverage as the child will be served by the same network regardless of which program is reimbursing care. The CHIP network is the Title V network which is the same network used by Medicaid. Children not financially eligible for Title V can be served by Healthy Kids, a component of CHIP, at full pay.

Below are maps that illustrate counties that are medically underserved and that have a shortage of health care professionals. Counties are designated as medically underserved or as having a health care professional shortage as either shortages across the whole county, within special areas of the county, or within special populations. Here is a more detailed explanation of the designations used on the following maps:

C = whole county geographic designation (insufficient number of primary care physicians for county population)

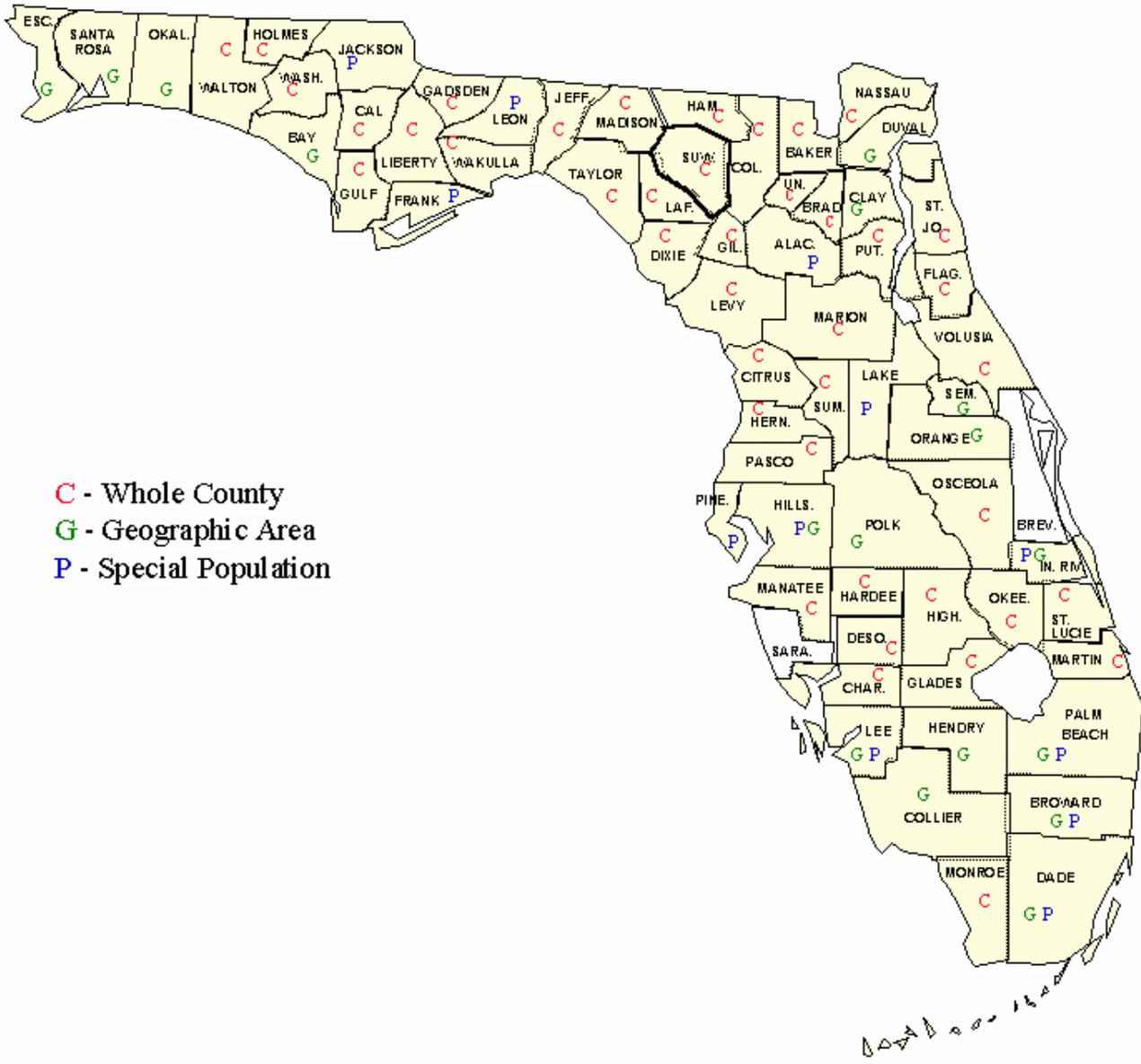
G = geographic designation for part of the county (insufficient number of primary care physicians for subcounty population)

P = either whole or partial county designation for special population (insufficient number of primary care physicians serving the special population, generally the low income below 200 percent of FPL, and migrant farm workers)

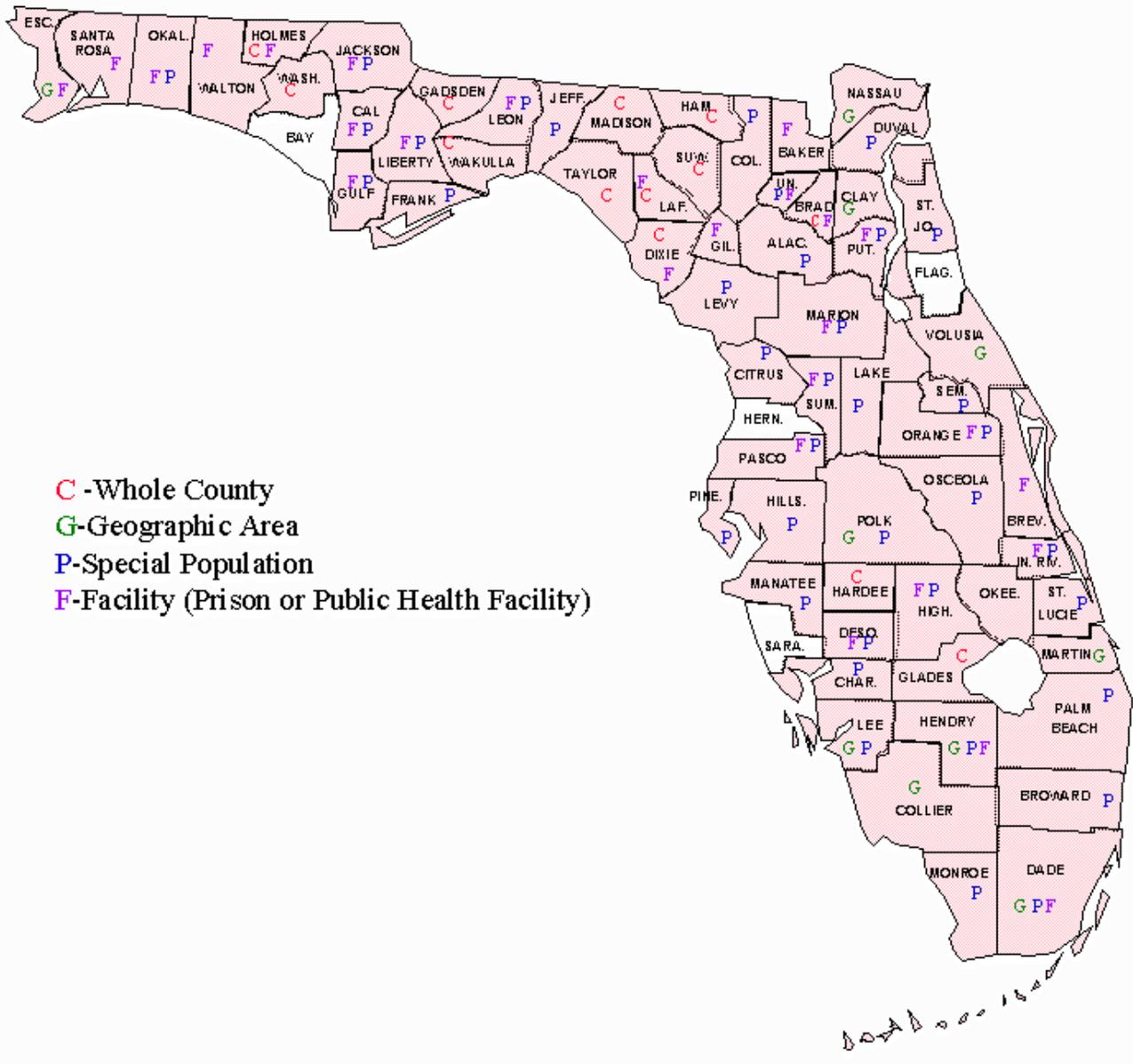
F = health care professional shortage in either a prison or a public health facility

MEDICALLY UNDERSERVED AREA

Medically Underserved Population



PRIMARY CARE Health Professional Shortage Area Designations



3.1.2.4 Population-Based Services

Florida’s universal prenatal and infant screening process continues to operate as a key point of entry for the MCH population. Data collected from the screening instruments assist in the immediate assessment of service needs for the individual as well as in the development of a comprehensive data base for health research and planning. As the data becomes more useful to local communities, the difficult issues related to maintaining confidentiality and information security become more important. Key state health office staff continue to work with the

department's legal staff to respond to the data needs of local communities while assuring that client confidentiality is maintained.

Florida's Pregnancy Associated Mortality Review (PAMR) has identified common themes in the recent year that will require follow-up from various work groups that have been formed to address the issues. The issues include: chronic illness and related risks in pregnancy (including obesity), substance abuse in the maternal health population, and the relationship of domestic violence and pregnancy. Once factors around these issues have been identified, interventions will be developed for local community implementation in an effort to positively impact the outcomes for all pregnant women.

Between 1997 and the first quarter of 1999, 106 pregnancy associated deaths were reviewed. In comparison to all women in Florida who had either a recorded live birth or a fetal death, PAMR women were less likely to be married, twice as likely to be black, less likely to have more than 12 years of education, and they were more likely to have been born outside the United States. Approximately 19 percent of the PAMR women whose death was pregnancy-related or possibly pregnancy related had inadequate prenatal care, compared to 9.7 percent for all women who had a delivery. Only 39 percent of the PAMR women whose death was pregnancy-related or possibly pregnancy related had adequate or better than adequate care, compared to 90.3 percent of the comparison population.

A chronic illness or condition was identified in 67 of the 106 reviewed PAMR cases. Of these cases, 37 were deemed pregnancy-related, 17 possibly pregnancy-related, and 13 not pregnancy-related. The main conditions identified were: hypertension, heart disease, anemia, asthma, and systemic lupus erythematosus. Obesity was also identified as an issue for pregnancy-related deaths. The body mass index (BMI) data of the reviewed cases were compared to BMI data for the 1997 Florida Prenatal Healthy Start Screen population using the National Heart, Lung and Blood Institute 1998 classification of overweight and obesity. A total of 45 percent of the women whose deaths were deemed pregnancy-related were classified as obese II or III (BMI >35), while only 6.9 percent of the reference population were classified as obese II or III.

Recommendations from the PAMR Executive Summary Report included additional community-based education on preconceptional health and how to access family planning services. The

report cited the need for better interagency linkages between prenatal providers and the need for interdisciplinary team meetings on high-risk cases. It called for better internal organizational practices for labor and delivery and an increased number of maternal autopsies. The need for more professional training and education was cited for preconception providers, as well as education on the importance of reproductive health care needs for women with chronic illnesses. It also called for strengthening the patient's knowledge and skills concerning the preconceptional period, and developmentally appropriate education for teens on pregnancy and risks.

Florida's Fetal and Infant Mortality (FIMR) process has already begun the implementation of local strategies to impact fetal and infant mortality rates. New efforts are being directed at reducing the number of infants whose deaths are attributable to sudden infant death syndrome (SIDS), specifically within childcare facilities. State health office staff are working together with the Department of Children and Families (who regulates childcare facilities) to increase awareness and implementation of the Back-to-Sleep campaign. The 1998 FIMR Annual Report notes that during 1997, 48 percent of infant deaths were attributed to perinatal conditions, 20 percent were congenital anomalies, 10 percent were SIDS, and 22 percent were other natural causes. The most frequently reported risk factors and their occurrence in FIMR cases reviewed for 1996-1997 were: tobacco exposure (57 percent); late prenatal care (51 percent); obesity and poor nutrition (39 percent); inadequate patient education (36 percent); and inadequate risk assessment (35 percent). FIMR reviews also confirm a possible relationship between vaginal infections during pregnancy and low birth weight deliveries, which may directly result in more fetal and infant deaths. Other needs identified through FIMR include increased need for service delivery improvements, patient/family education, professional education, and community awareness. The Department of Health has provided support and guidance to community FIMR projects since 1993, in an effort to improve local health care delivery systems and decrease both fetal and infant deaths. There are currently 13 FIMR projects, which cover 34 of the 67 counties in Florida.

Florida also continues its collaborative work with the Division of Environmental Health to focus attention on the necessity to address potential lead poisoning for Florida's children. Florida historically has provided lead screening as a part of the child health check-up services for Medicaid-eligible children. Recently, in response to new information provided by the CDC, the Division of Environmental Health and the maternal and child health unit within the

department have worked together to update develop an oral lead risk assessment, a lead follow-up protocol and a lead intervention protocol, to better meet the needs of the children in the state who are at risk for lead poisoning.

In 1999, the first Annual Report on Birth Defects was released. This report describes the causes, treatments, and prevention strategies for several types of serious birth defects. The following seven major categories of birth defects are addressed in the report: central nervous system, chromosomal, cardiac, gastrointestinal, genital and urinary, muscular and skeletal and oral clefts. Each category is the subject of a chapter that discusses the embryonic origin, health effects, treatments, causes and prevention strategies for birth defects in that category. The annual report also provides data on the frequency and rate of birth defects in Florida counties. The first Annual Report on Birth Defects in Florida contains provisional data for 1996 based on the Center for Disease Control (CDC) Birth Defects Reporting List. Ongoing efforts to identify and validate cases may result in minor adjustments in these figures. As other 1996 data sources are added and the validation studies (data quality procedures) are completed, the revised 1996 data will be considered final and combined with 1997 data in next year's report.

Addressing the need for adequate dental care continues to be a priority. The Florida Public Health Dental Program annually submits budget requests to the legislature to increase funding for dental health services. The 1999 Legislature allocated \$1 million from the tobacco settlement trust fund to increase access to county health department dental programs. This money will be used on treatment, prevention, and infrastructure building, depending on the needs in selected counties.

3.1.2.5 Infrastructure Building Services

The Maternal and Child Health unit developed extensive standards and guidelines for the provision of Healthy Start services. This document was distributed to all local county health departments and to all Health Start Coalitions. At the request of local providers, staff also developed and distributed a companion trainer's handbook for the standards and guidelines. State health office staff continues to provide technical assistance and training to local communities as requested. MCH staff have worked in concert with the program planning evaluation, and data unit to develop quarterly measures and goals in an effort to more effectively track program outcomes. Quality assurance continues to be provided through on-

site program review and/or review of data through a desk audit process using a health problem analysis approach.

Training from the MCH unit continues on specific priority topic areas such as risk appropriate care, data collection systems, and the Healthy Start prenatal and infant screening process. However, the need for a larger comprehensive training structure for MCH providers has been identified. The department is working with the University of South Florida, Lawton and Rhea Chiles Center for Healthy Mothers and Healthy Babies and the Florida State University Center for Prevention and Early Intervention to plan and develop statewide comprehensive training programs for MCH service providers.

The need to create a comprehensive review process for all deaths in the maternal and child health population continues to be an important need in Florida. There still is not a statewide system in Florida in which communities review cases of child deaths over the age of 1. We pursued funding through the legislative budgeting process for 1999, but the effort was not funded. The MCH unit will continue its review processes currently in place through PAMR and FIMR, though funding for a more comprehensive approach through a child death review process is still needed.

3.2 Health Status Indicators

3.2.1 Priority Needs

In summary, the five-year needs assessment indicates the priority needs in Florida include many issues that affect our main priorities, which are to improve pregnancy outcomes and reduce infant and child morbidity and mortality. One major issue evident in both the needs assessment and the health status indicator data is the need to reduce the incidence of low birth weight and very low birth weight deliveries. Factors that may affect this rate include reducing the incidence of vaginal infections during pregnancy, including bacterial vaginosis and sexually transmitted infections such as chlamydia. We must continue to address the rate of infant mortality, particularly in the non-white population. This could be positively affected by increasing the availability of maternity care providers willing to serve economically disadvantaged or high-risk pregnant women and their children.

We must continue to address the need for increased access to quality health care. In many rural areas, birthing centers are too distant, and there is a lack of neonatal intensive care. Although

we have made positive strides in reducing the number of people who are uninsured, we need to continue this effort. Access to care must also address the need for additional family planning services, as only 32 percent of women in need are currently being served. Participation in WIC should also be addressed, since approximately one-third of the eligible population is not being served.

Additional outreach activities are needed to increase awareness of the importance of prenatal care, particularly towards high-risk populations, as the percentage of women who receive care in the first trimester has remained at or near 83 percent for a number of years. Additional community awareness and education activities are needed to increase knowledge of and support for maternal and child health care. Additional parenting education is needed, particularly classes that target fathers and their role.

Our five-year needs assessment and performance indicator data has identified that dehydration in children is not the problem we felt it was when we first developed our state performance measures. We will be dropping this measure in next year's application, and replacing it with a measure we deem more important after further analysis of the needs assessment. Our list of priority needs (Form 14) has also been updated from the FY2000 application, to reflect new priorities revealed by this assessment.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of the Budget Forms

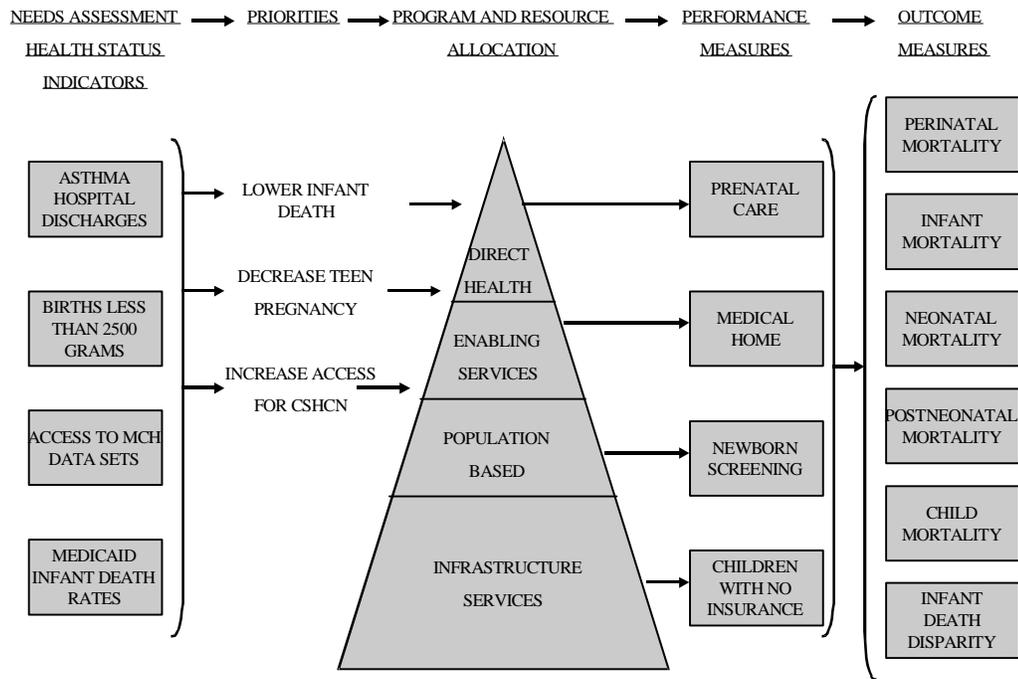
see forms 2, 3, 4 and 5

3.3.2 Other Requirements

The 1989 maintenance of effort amount for FY1999 was \$155,212,322. Sources of other federal MCH funds include \$192,412,120 for WIC; a \$50,000 CISS grant; CDC grants of \$986,888 for tobacco education and diabetes; \$2,207,883 for abstinence education; a \$100,000 SSDI grant; a USDA grant of \$69,763,025 for the Child Care Nutrition Program; and a \$6,766,959 Preventive Health Services Block Grant. The total state funds budgeted for FY2001 are \$279,787,306. The sources of these funds are general revenue (\$265,059,769) and CMS Donations Trust Fund (\$14,727,537). Other funds totaled \$32,256,448. The sources of other funds were the Federal Grants Trust Fund (\$27,948,010) and the Social Services Block Grant Trust Fund (\$4,308,438). This brings the total federal-state block grant partnership to \$331,555,590 for FY2001.

3.4 Performance Measures

Figure 3
TITLE V BLOCK GRANT
PERFORMANCE MEASUREMENT SYSTEM



3.4.1 National "Core" Five Year Performance Measures

3.4.1.1 Five Year Performance Targets

See form 11 and the national performance measure detail sheets.

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

See form 11 and the state performance measure detail sheets.

3.4.2.2 Discussion of State Performance Measures

SPM#1 *The percentage of Part C eligible children receiving service.* This measure was chosen because determining the percentage of potentially eligible children offered early intervention services is an excellent indicator of the effectiveness of our CSHCN system. The 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 a direct health care service related to outcome measures for reducing infant, neonatal, postneonatal and perinatal mortality.

SPM#2 *The rate per 1,000 of hospital discharges of children due to dehydration.* We chose this measure because hospital discharges for dehydration are an indication of the overall accessibility of routine preventive and primary health care and acute child health care. When children are able to obtain preventive and primary care services on an ongoing basis, they are less likely to require hospitalization for dehydration. The measure relates to the outcome measure of reducing the child death rate and to the priority need to decrease the incidence of child morbidity. This measure reflects the success of enabling services that help children access comprehensive, ongoing preventive and primary care and help their parents understand how to deal with their illnesses, such as outreach, facilitating access to health insurance coverage, case management, and health promotion education.

SPM#3 *The percentage of pregnant women reporting domestic violence on the PRAMS survey.* Chosen because the Department of Health wants to emphasize the significant effect domestic violence has upon maternal outcomes. This measure relates to the priority needs of improving pregnancy outcomes and reducing infant mortality. This measure is an enabling service related to outcome measures on reducing infant and perinatal mortality.

SPM#4 *The percentage of subsequent births to teens age 15 to 19.* Reducing subsequent births to teens was chosen because it will help reduce the infant mortality rate, and because teens with more than one child often face multiple social difficulties. This measure relates to the priority need of decreasing the rate of subsequent teen pregnancies, as well as reducing infant mortality and low birth weight. This measure is an enabling service, and the outcome measure it most affects is reducing the infant mortality rate.

SPM#5 *The percentage of women reporting tobacco use during pregnancy.* This measure was chosen because tobacco use during pregnancy has been shown to increase low birth weight deliveries. This measure relates to the priority needs of reducing low birth weight and reducing infant mortality. This measure is a population-based service that affects the outcome measures for infant mortality rate and perinatal mortality rate.

SPM#6 *The rate per 100,000 of reported cases of perinatal transmission of HIV.* Chosen because of the significant number of cases in Florida of perinatal transmission of HIV. This measure relates to the priority needs of reducing infant mortality and decreasing child morbidity. This measure is a population-based service that affects the outcome measures for infant mortality rate, perinatal mortality rate, and ratio of the black to white infant mortality.

SPM#7 *The rate per 1,000 of hospital discharges due to asthma in children age 0-14.* We chose this measure because hospitalizations for asthma are an indication of the overall accessibility of routine preventive and primary health care and acute child health care. When

children are able to obtain preventive and primary care services on an ongoing basis, they are less likely to require hospitalization for asthma. The measure relates to the outcome measure of reducing the child death rate and to the priority need to decrease the incidence of child morbidity. This measure reflects the success of enabling services that help children access comprehensive, ongoing preventive and primary care and help their parents understand how to deal with their illnesses, such as outreach, facilitating access to health insurance coverage, case management, and health promotion education.

SPM#8 *The percentage of low-income children under age 21 who access dental care.* This measure relates to the priority need of improving access to dental care for children below 200 percent of poverty in order to prevent and treat dental caries. It was chosen because dental caries is the most prevalent chronic disease of childhood, affects the quality of life for a vast percentage of the population and depletes considerable health care resources. This measure is an infrastructure-building service and will continue to be addressed through district workgroups developed in conjunction with the Statewide Dental Coordinating Council. Although this measure does not directly affect any of the outcome measures adopted for this application and annual report, dental caries greatly affect morbidity and the oral health of children.

SPM#9 *The percentage of pregnant women screened by Healthy Start.* We chose this measure because Healthy Start screening is the first step in assuring that all pregnant women get the services they need such as assessment and appropriate interventions that can reduce the instance of preterm delivery and low birth weight deliveries. This measure relates to the priority need of reducing infant mortality. This measure is an infrastructure-building service, and the measure affects the outcome measure for reduction of infant mortality.

SPM#10 *The percentage of infants screened by Healthy Start.* Chosen because the infant screen has proven to be a valid and reliable instrument for the prediction of postneonatal infant mortality. This measure relates to the priority need of decreasing the incidence of child morbidity and mortality. This measure is an infrastructure-building service that most affects the outcome measure of reducing neonatal, postneonatal and perinatal mortality.

3.4.2.3 Five Year Performance Targets

See form 11.

3.4.2.4 Review of State Performance Measures

To be conducted after application is submitted.

3.4.3 Outcome Measures

See form 12.

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

| Core Performance Measures | Pyramid Level of Service | | | | Type of Service | | |
|--|--------------------------|----|-----|----|-----------------|---|----|
| | DHC | ES | PBS | IB | C | P | RF |
| 1) 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. | X | | | | X | | |
| 2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. | X | | | | X | | |
| 3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home.” | | X | | | X | | |
| 4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined). | | | X | | | | X |
| 5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B. | | | X | | | | X |
| 6) The birth rate (per 1,000) for teenagers age 15 through 17 years. | | | X | | | | X |
| 7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth. | | | X | | | | X |
| 8) The rate of deaths to children age 1-14 caused by motor vehicle crashes per 100,000 children. | | | X | | | | X |
| 9) Percentage of mothers who breastfeed their infants at hospital discharge. | | | X | | | | X |
| 10) Percentage of newborns who have been screened for hearing impairment before hospital discharge. | | | X | | | | X |
| 11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care. | | | | X | X | | |
| 12) Percent of children without health insurance. | | | | X | X | | |
| 13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. | | | | X | | X | |
| 14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program. | | | | X | | X | |
| 15) Percent of very low birth weight live births. | | | | X | | | X |
| 16) The rate (per 100,000) of suicide deaths among youths 15-19. | | | | X | | | X |
| 17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. | | | | X | | | X |
| 18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. | | | | X | | | X |

| Negotiated Performance Measures | Pyramid Level of Service | | | | Type of Service | | |
|--|--------------------------|----|-----|----|-----------------|---|----|
| | DHC | ES | PBS | IB | C | P | RF |
| 1) The percentage of Part C eligible children receiving service. | X | | | | | X | |
| 2) The rate per 1,000 of hospital discharges of children due to dehydration. | | X | | | | | X |
| 3) The percentage of pregnant women reporting domestic violence on the PRAMS survey. | | X | | | | | X |
| 4) The percentage of subsequent births to teens age 15 to 19. | | X | | | | | X |
| 5) The percentage of women reporting tobacco use during pregnancy. | | | X | | | | X |
| 6.) The rate per 100,000 of reported cases of perinatal transmission of HIV. | | | X | | | | X |
| 7) The rate per 1,000 of hospital discharges due to asthma in children age 0-14. | | | X | | | | X |
| 8) The percentage of low-income children under age 21 who access dental care. | | | | X | | X | |
| 9) The percentage of pregnant women screened by Healthy Start. | | | | X | X | | |
| 10) The percentage of infants screened by Healthy Start. | | | | X | X | | |

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

4.1.A: Direct Health Care Services

4.1.A.1: Services for Pregnant Women, Mothers and Infants There were no national or state performance measures for direct health care services for this population group.

4.1.A.2: Services for Children There were no national or state performance measures for direct health care services for this population group.

4.1.A.3: Services for Children With Special Health Care Needs

NPM#1 *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.* During FY2000, the outreach initiative of the Florida KidCare Act is expected to identify children who are eligible for state plan Medicaid, but who are not currently enrolled. It is expected that some of these children will be eligible for SSI benefits. Information and referral will be provided to potentially eligible children and their families. Also resulting from the Florida KidCare Act is an expansion of eligibility criteria for referral of child SSI applicants to Children's Medical Services. In the past, only child SSI applicants with significant physical or medical impairments were referred to Children's Medical Services. In 1999, the agreement with the Office of Disability Determination

Services (DDS) was expanded to include the referral of all SSI applicants age birth to 3 years, and children age 3 to 16 years with childhood psychosis, emotional disorders or other mental impairments. Since March 1999, changes in the agreement with DDS have resulted in a 400 percent increase in the number of SSI transmittals being sent to CMS from DDS for review. It is expected that follow-up with the families of child SSI applicants and continued outreach of Florida KidCare will result in a gain of 2 percent during 2000 in the number of child SSI beneficiaries receiving services of CMS. During FY2001, CMS will provide rehabilitative services to 23 percent of the child SSI beneficiaries.

NPM#2 *The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.* In FY2001, CMS will continue to ensure all patients enrolled in the program receive any required specialty or subspecialty services required by their special health care needs.

SPM#1 *The percentage of Part C eligible children receiving service.* The increased involvement of a larger community constituency has positively impacted the program's ability to identify and serve more infants and toddlers who are eligible for the Early Intervention Program. The Local Planning Councils will continue their involvement in the ongoing development and implementation of the Early Intervention Program. The phase-in of local community plans will also support the effort to serve more of the Part C eligible children. Thus, during FY2001, CMS will serve 85 percent of the Part C eligible population of children.

4.1.B: Enabling Services

4.1.B.1: Services for Pregnant Women, Mothers and Infants

SPM#3 *The percentage of pregnant women reporting domestic violence on the PRAMS survey.* During FY2001, our plans for this measure include continuing to utilize the *Healthy Start Standards and Guidelines* to guide the care provided to the MCH population by placing emphasis on domestic violence as a priority. Training opportunities will continue to be provided for local county health department staff to improve domestic violence screening skills. The Department of Health will continue to provide at least two statewide domestic violence training opportunities per year for health care providers that serve the population of pregnant women. A tracking system is maintained for Healthy Start prenatal risk screening data to be analyzed in conjunction with the PRAMS data. The department will also modify the quality improvement process and technical assistance provision to reflect the importance of domestic violence issues. Furthermore, we will continue to work closely with the Florida Task Force on Domestic Violence Fatality Prevention and with the Florida Task Force on the Family Violence Prevention Fund's National Health Initiative on

Domestic Violence. Putnam and Pinellas county health departments have written action plans on how to develop and implement a domestic violence program and protocol for their individual facilities. These plans have led to the implementation of three domestic violence initiatives that collectively form the Violence Intervention and Prevention Program. First, the *Sexual Assault Intervention* component services adult and child victims of sexual assault, their families, and their friends with such services as: crises intervention, victim advocacy, and educational information to community resources. Secondly, the *Preventing Violent Pregnancies* initiative is targeted toward women who are pregnant and/or have a child up to age 1, who are experiencing or are at imminent risk for experiencing domestic violence. Types of services offered by this program include intensive therapy, Healthy Start case management, and assistance with filing crimes compensation claims. The third component, *Domestic Violence Intervention*, provides services to victims of domestic violence, with an emphasis on women and children. Services will also include safety assessment and planning, therapy or supportive counseling, and assistance in obtaining injunctions for protection. The Department of Health continues to provide technical assistance to the health departments as they expand services to this population. In addition, fatal and near fatal domestic violence related incidents will soon be under review in Florida, as recent legislation has established domestic violence fatality review teams. Members will review fatal and near fatal incidents of domestic violence and assess ways to prevent such incidents. Local teams must send data to the Florida Department of Law Enforcement, who will then prepare an annual report. Also established in the bill is a certified domestic violence center capital improvements grants program to be administered by the Department of Children and Family Services.

SPM#4 *The percentage of subsequent births to teens age 15 to 19.* In FY2001, our plan to reduce subsequent birth to teenagers age 15 to 19 to 11.96 percent includes the provision of family planning counseling and services in all of the 67 counties, health education and services at schools, Healthy Start services, and abstinence education targeted to 9 to 18-year-olds. On the local level, 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 teen births in their communities. The Department of Health is currently recruiting people to form a problem solving team to recommend strategies for reducing teen births, and we expect to implement the strategies they recommend in the coming years.

4.1.B.2: Services for Children

SPM#2 *The rate per 1,000 of hospital discharges of children due to dehydration.* During FY2001, we plan to continue to reinforce the policy and technical assistance guideline entitled *The Management of Acute Diarrhea in Children: Oral Rehydration, Maintenance, and Nutrition*

Therapy and to provide technical assistance as necessary. Current literature on dehydration in children will be reviewed, and the policy and technical guideline will be updated as indicated. Outreach activities for Florida's KidCare will be promoted to increase the number of children with access to preventative health care.

4.1.B.3: Services for Children With Special Health Care Needs

NPM#3 *The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."* CMS will continue to ensure that all children enrolled in the program are assigned to a "medical/health home."

4.1.C: Population-Based Services

4.1.C.1: Services for Pregnant Women, Mothers and Infants

NPM#9 *Percentage of mothers who breastfeed their infants at hospital discharge.* Our plan for FY2001 to increase the number of women who breastfeed includes: tracking and evaluating the number of clients receiving breastfeeding education and support at county health departments through the CIS system; collaborating with WIC regarding breastfeeding and coordination of Healthy Start; and collaborating with local community groups to promote breastfeeding.

SPM#5 *The percentage of women reporting tobacco use during pregnancy.* In FY2001, there will be ongoing monitoring through quality improvement activities and analysis of Healthy Start data to track the impact of the *Make Yours a Fresh Star Family* training program. A staff member of the Florida Department of Health is assigned to provide ongoing technical assistance and offer future trainings as they are needed. In addition, a small grant was acquired by one of the Healthy Start Coalitions in order for their service area to complete a biochemically verified evaluation of *Make Yours a Fresh Start Family*. The study is looking at the program's impact on pregnant women, and then following the women who quit for three months postpartum to see whether they maintain their non-smoking status. *Make Yours a Fresh Start Family* has the advantage of offering two separate magazines, one for pregnant women, and one for the mothers after they give birth. This study will be completed at the end of FY2001, and lessons learned from it will be applied throughout the state. It is believed that this comprehensive program will continue to positively impact the smoking rates in pregnancy.

SPM#6 *The rate per 100,000 of reported cases of perinatal transmission of HIV.* A number of activities are planned for FY2001 to help us reduce the perinatal transmission of HIV. Healthy Start liaisons will note compliance and provide technical assistance when data shows that fewer than 75 percent of women were offered testing. Validity of the data will be checked by sampling client records during quality improvement site visits to the county health departments. MCH will require Healthy Start Coalitions to monitor the records of prenatal care providers they contract

with. MCH will implement a clinical monitoring tool for coalition use in verifying compliance with the statute. We will continue to participate in the inter and intra-agency perinatal HIV transmission workgroup, which focuses on preventing vertical transmission of HIV. Other work efforts will include: increasing culturally appropriate outreach and education services to at-risk minority populations, teens and others at increased risk for HIV/AIDS; promoting early access to care for pregnant women; promoting a confidential HIV reporting, referral, partner elicitation and notification system; and increasing access to substance abuse treatment services in coordination with substance abuse programs of the Department of Children and Families and local public and private drug treatment providers. We will review and update existing policies to ensure that all Department of Health providers are offering the most up to date HIV counseling and testing to all women of childbearing age, and offering appropriate preventive treatment to pregnant women who test positive. The Partners Sharing Solutions Conference and other annual statewide conferences will include training on reducing vertical transmission of HIV. Successes learned from the Targeted Outreach for Pregnant Women Act programs will be communicated to other communities.

4.1.C.2: Services for Children

NPM#5 *Percentage of 2-year-old children who have completed age-appropriate immunizations.*

In FY2001, our plan to meet the goal of 90.0 percent of all 2-year-old children who are appropriately immunized includes: parent education activities; involvement of Healthy Start Coalitions and Kiwanis International; WIC and managed care organizations; identification of pockets of need for under-immunization; tracking immunizations in the health department; implementation of recall systems; implementation of the immunization registry in both the public and private sector, and continued implementation of the Vaccines for Children Program.

NPM#6 *The birth rate (per 1,000) for teenagers age 15 through 17 years.* In FY2001, our plan to meet the goal of 32.6 births to teenagers age 15-17 includes abstinence only education, family planning counseling, family planning services, comprehensive school health programs, and Healthy Start activities. The Abstinence Education Program anticipates awarding 18 new contracts to organizations to provide abstinence only education to 9 to 18-year-olds. In addition, the Abstinence Education Program will also continue statewide media/public awareness and social marketing activities promoting abstinence-only education for the prevention of pregnancy and sexually transmitted diseases. Local county health departments will continue activities to make easy access to services for teenagers and continue to collaborate with other community agencies in dealing with teen pregnancy prevention in their communities.

NPM#7 *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.* The Public Health Dental Program will continue to promote development

of school-based sealant referral programs through the departmental quality improvement process and coordination with school systems. New funding was allocated for prevention and treatment services through the county health departments, which would include sealants. The program will continue to pursue additional funding through oral health grants that would include surveillance, as they become available. The governor's budget this year includes funding to provide increased dental access for the CHIP population and to improve the Medicaid reimbursement rate.

NPM#8 *The rate of deaths to children age 1-14 caused by motor vehicle crashes per 100,000 children.* During FY2001, the Florida SAFE KIDS Coalition will continue its efforts to promote correct use of child car seats through educational campaigns, such as National Child Passenger Safety Week, National SAFE KIDS Week, and Buckle Up America Week. The coalition will continue to organize and participate in car seat check-up events throughout the state during these weeks and at other times of the year. The Florida SAFE KIDS Coalition will continue to promote car seat check-up events in areas of the state where currently there are not local SAFE KIDS Coalitions, as requested by the National SAFE KIDS Campaign. The Florida SAFE KIDS Coalition will also research the issue of transporting children with special needs, possibly providing training or resources on the subject to child passenger safety advocates and professional who work with children with special needs.

SPM#7 *The rate per 1,000 of hospital discharges due to asthma in children age 0-14.* During FY2001, the State Health Office will provide technical assistance to county health departments on the importance of early recognition and treatment of childhood asthma. The policy and technical assistance guideline for the management of asthma in children will be distributed to all county health departments. Additional activities include providing smoking cessation literature and training to county health department staff to help eliminate secondhand tobacco smoke as an asthma trigger. Department of Health School Health Program staff will continue to coordinate with the American Lung Association's regional directors and Integrated Therapeutics Group to promote asthma management and prevention programs to school-aged children. The state level interagency asthma workgroup, which includes the Office of Environmental Health, will continue to work towards promoting an asthma surveillance system and asthma preventative activities.

4.1.C.3: Services for Children With Special Health Care Needs

NPM#4 *Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).* In FY2001, Florida will continue screening all infants born in the state. Infants with positive results will have confirmatory testing and will be referred for treatment.

NPM#10 *Percentage of newborns who have been screened for hearing impairment before hospital discharge.* With the continuation of this initiative, it is expected that Florida's performance for FY2001 in this area will far exceed previous expectations, thus the annual performance objective for FY2001 is 55 percent of the newborns will be screened for hearing impairments before hospital discharge.

4.1.D: Infrastructure-Based Services

4.1.D.1: Services for Pregnant Women, Mothers and Infants

NPM#15 *Percent of very low birth weight live births.* In FY2001, our plan to maintain the rate of very low birth weight to 1 percent of live births was based on the standards set by Healthy People 2010. The following activities will help us maintain our goal: 1) Continue our focus on Healthy Start prenatal care and care coordination services to pregnant women identified at risk for poor birth outcomes. 2) Utilize the Periods of Risk Analysis, a World Health Organization approach to look at the proportional contribution of various "periods" to fetal and infant mortality as a tool for steering program emphasis within public health. 3) Apply the valuable knowledge gained from the Florida Birth Defects Surveillance System, including the Birth Defects Registry, to improve our system of care. 4) Increase the number of pregnant women offered the Healthy Start risk screening, improve outreach efforts to increase the percentage of women receiving prenatal care during the first trimester of pregnancy, and continue promotion of family planning services to increase birth intervals and to reduce teen birth rates. 5) Continue efforts in a statewide folic acid campaign in collaboration with the March of Dimes to promote preconceptional health and the importance of early entry into prenatal care. 6) Continue to use the valuable knowledge gained from FIMR projects to improve our system of care. 7) Increase collaboration among community providers and Healthy Start Coalitions to improve local systems of care for our maternal and child populations. 8) Study factors related to racial disparity from the work discussed in the overview of the maternal and child health population status section, 3.2.2.1. 9) Continue statewide interventions targeted at prevention and cessation of drug use during pregnancy. 10) Continue statewide interventions targeted at prevention of bacterial vaginosis and other infections in pregnancy.

NPM#17 *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.* Our plan for FY2001 to meet the goal that 90 percent of very low birth weight infants be delivered at facilities for high-risk deliveries and neonates includes working with the Agency for Health Care Administration (Medicaid) to ensure that low birth weight infants are delivered at appropriate facilities and ensuring that emergency transport is available for indigent clients for inter-facility transfer as appropriate.

NPM#18 *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.* In FY2001, our plan to reach the goal that 90 percent of all pregnant women will begin prenatal care in their first trimester was based on the standards set by Healthy People 2010. Activities to maintain our goal include the following activities: 1) Continue to expand the coverage of Presumptive Eligibility for Pregnant Women (PEPW) through outside providers in determined areas of need. 2) Expedite entry into prenatal care by initiating statewide a simplified eligibility process that will enable clients to have a mail-in Medicaid application. 3) Maintain a statewide folic acid campaign in collaboration with the March of Dimes that will promote preconceptional health as well as the importance of early entry into prenatal care. 4) Continue development of a plan for Florida to maintain the Healthy People 2010 goal of 90 percent of all pregnant women beginning prenatal care in their first trimester. Collaboration with the following partners will be included in the process: Healthy Start Coalitions, county health departments, researchers from major universities, the Agency for Health Care Administration, major insurers, advocates such as Florida Healthy Mothers/Healthy Babies Coalition, the March of Dimes Foundation, consumers and direct service providers. 5) Target counties with first trimester entry levels below the state average for special technical assistance and ask them to develop and implement strategies to improve access to early prenatal care. 6) Continue working through the Prenatal Care Workgroup to implement strategies to remove barriers to care and develop solutions for increasing the first trimester entry rate. 7) Continue collaboration with Targeted Outreach for Pregnant Women program to identify those women in need of services to allow early entry into prenatal care.

SPM#9 *The percentage of pregnant women screened by Healthy Start.* Many Healthy Start Coalitions have developed strategies to increase screening rates, including outreach activities and provider education training. The State Health Office will assist in training as needed, and will monitor and report on screening trends. Additional activities during FY2001 will include: 1) ongoing technical assistance to communities for Healthy Start screening issues; 2) coordination with Florida's Healthy Families Florida program to implement an integrated screening process; and 3) coordination with Federal Healthy Start to evaluate systems for exchange of prenatal care information among private and public health providers.

SPM#10 *The percentage of infants screened by Healthy Start.* During FY2001, the State Health Office will assist in the training of community liaisons and will monitor and report screening trends. Additional activities will include: 1) provision of ongoing technical assistance to communities for Healthy Start screening; 2) continued work with the Florida birth defects registry to analyze data related to the incidence of birth defects; 3) collaboration with Healthy Families Florida on infant

screening forms; and 4) evaluation of linked information from hospital discharge data sets, and child abuse data sets to identify infants at increased risk of morbidity.

4.1.D.2: Services for Children

NPM#12 *Percent of children without health insurance.* In FY2001, we plan to reduce the number of uninsured children through collaboration and coordination with existing activities of State Title V programs and new outreach efforts of the Florida KidCare Program. The outreach plan will include: continuing the toll-free hotline number; performing a targeted media campaign to those populations identified as needing health insurance such as welfare-to-work families; providing Florida KidCare information (such as brochures and fact sheets) and incentives (such as toothbrushes); and continuing the aggressive community-based outreach campaign performed at the state level - but much more effectively through the Regional Outreach Projects - that will facilitate access to existing service delivery systems, increase the capacity to inform families about Florida KidCare, and assist families in applying for KidCare. These efforts are in addition to working collaboratively with other local agencies' activities such as statewide meetings, conferences, and health fairs to provide Florida KidCare information and incentives to participants. Legislatively, the potential expansion of Florida KidCare to cover an additional 81,182 children, to expand dental coverage, provide Florida KidCare benefits to non-citizen children, and provide presumptive eligibility for Medicaid, will further the goal of insuring all children in Florida and will increase the need for targeted outreach activities performed at the state and local levels.

NPM#13 *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.* Activities in FY2001 to increase to 87.7 percent the number of potentially Medicaid-eligible children who will receive a service paid by the Medicaid Program include a simplified child health insurance application process and an intensive multi-media outreach campaign aimed at parents of children who are uninsured or underinsured for health care services. Florida KidCare will continue outreach to families through statewide and media campaigns. KidCare regional coordinators will continue to provide outreach to community leaders and families across the state. Additionally, the Department of Health will develop, in collaboration with key child health partners, a strategic plan for improving child health services and will pilot a Community Medical Home project in three communities. The Community Medical Home project implements a "gold standard" of child health care in at-risk communities. These efforts should increase parents' use of Medicaid services for their children. The Department of Health will continue to collaborate with the Medicaid program on the *Child Health Check-up Campaign*.

NPM#16 *The rate (per 100,000) of suicide deaths among youths 15-19.* For FY2001, the goals, objectives and activities as stated in the forthcoming Suicide Prevention Plan to be created by the

Task Force on Adolescent Suicide will be implemented. The plan will encompass potential activities that can be carried out by various state agencies, non-profit organizations and local communities. The Comprehensive School Health Services Projects will continue to provide a continuum of suicide prevention activities, including classes and interventions on suicide and mental health issues, and referrals to community-based mental health providers. The eight participating schools for the Centers for Disease Control Infrastructure grant also provides a focus on building skills for staff and students to recognize potential problems and provide referral or intervention for students with social and mental health issues that may contribute to suicide. During 2000, the Florida Department of Education is convening statewide workshops in response to the nationwide upswing in school-based violence, including suicide. The Department of Health's School Health Program is a participant in these workshops, and will be a key player in assisting schools to implement violence and suicide prevention activities.

SPM#8 *The percentage of low-income children under age 21 who access dental care.* We plan to meet future objectives through the coordinated, integrated efforts of public and private sectors to increase awareness of dental issues, to actively seek funding to expand public programs and to increase participation in volunteer programs. During FY2001, the Public Health Dental Program will also provide quality improvement activities for county health department programs to develop high quality, cost-effective programs, and will monitor these activities. The Public Health Dental Program's advocacy for inclusion of dental benefits in the KidCare insurance package failed during the 1999 legislative session; however, it was included in the governor's proposed budget for 2000. The dental program will continue to advocate for the necessary additional general revenue to increase access to dental care for low-income children during the FY2001 legislative session and will continue to pursue grant funding opportunities.

4.1.D.3: Services for Children With Special Health Care Needs

NPM#11 *Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.* In FY2001, Florida will continue to ensure that funding for primary and specialty care is available for CSHCN enrolled in the CSHCN program. As a result of the passage of Title XXI and the Florida KidCare Act of 1998, uninsured children under age 19 receive low-cost insurance coverage up to 200 percent of the federal poverty level. All CSHCN will be enrolled in the CMS Network, where they will receive a comprehensive Medicaid benefit package and specialized case management services.

NPM#14 *The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.* Activities for FY2001 include plans to: 1) Assist ICN, once contracts are executed, in establishing functional family resource specialists (FRS) throughout

the state with an assurance that their duties, responsibilities, and expectations will be carefully delineated and a consistent approach to their supervision and evaluation established through technical assistance from other national and state family leaders. 2) CMS will work in collaboration with Family Voices-Florida and the Family to Family Health Information Center to identify and facilitate shared roles, responsibilities, and lines of accountability in assisting families of CSHCN throughout the state in accessing appropriate, affordable, and adequate health care. Title V/CSHCN will take a lead role, but its success will be dependent upon collaboration and partnership with the Department of Children and Families, the Agency for Health Care Administration, and the statewide provider networks. 3) CMS will provide family leaders throughout the state with timely information and opportunities to participate in the planning and implementation of programs and services by utilizing Family Voices-Florida as a vehicle for information dissemination and leader identification. 4) CMS will identify resources and support measures to enable CMS FRS and families opportunities for leadership training that will enhance their exposure to educational initiatives and increase their capacity to become leaders and partners with other community leaders, administrators, and policy makers to initiate necessary systems changes.

4.2 Other Program Activities

Direct Health Care Services and Enabling Services

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 information while minimizing cultural, geographic and financial barriers to care.

Staff Development, Education and Training: MCH staff develop 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.

Outreach Childbirth Education and Parenting Project: Assures accessibility to quality childbirth education and parenting education for low-income, low-literacy families. The project prepares low-income pregnant women and their families for the experience of childbearing and the responsibilities of child rearing.

Community Resource Mothers and Fathers: Paraprofessionals representative of the clients they serve visit at-risk pregnant women, infants, toddlers, preschool children and their parents. Services such as in-home parent support and education and linkage with health and social services are provided to improve MCH and developmental outcomes.

Shaken Baby Syndrome: The Department of Health staff participates on the advisory committee of the statewide Shaken Baby Syndrome campaign and distributes consumer and health care provider brochures to county health departments and others upon request.

Population–Based Services and Infrastructure-Building Services

Fetal and Infant Mortality Review: An information-gathering process that can 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.

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 the Back-to-Sleep campaign among health providers and secondary caregivers especially childcare providers. Additional awareness activities include incorporating the message “This Side Up When Sleeping” for safe sleep into a variety of programs that serve young families, and targeting child care and professionals with the message. The department used baby t-shirts that said “This Side Up When Sleeping” (on the front) as an incentive for our Child Health Insurance Program (Title XXI) outreach program. The Department of Health is represented as a Florida SIDS Alliance board member, and the Bureau Chief for Family and Community Health is the representative for the Association of Maternal and Child Health Programs (AMCHP) on the National SIDS and Infant Death Program Support Center Advisory Board.

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.

Pregnancy Risk Assessment Monitoring System: The PRAMS project conducts population-based surveillance of selected maternal behaviors that occur during pregnancy and early infancy. Information gathered helps MCH program staff plan and evaluate prenatal health programs.

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.

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. Education is ongoing for providers across the state concerning lead levels and where, when and how toxic levels must be reported.

Family Planning Waiver: The Department of Health collaborated with the Agency for Health Care Administration, to submit an application to the federal Health Care Financing Administration for a Medicaid family planning 1115(a) waiver during 1998/99. The waiver extends eligibility for family planning services from 60 days to 24 months for all women in Florida with incomes at or below 185 percent of poverty level who have received a pregnancy related service paid for by Medicaid.

Other Requested Information:

The Family Health Line, the toll-free hotline in Florida, 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. Trained counselors answer calls from 8:00 a.m. to 11:00 p.m. Monday through Friday and from 10:00 a.m. to 7:00 p.m. Saturday and Sunday.

The Title V MCH program collaborates with other federal grant programs in many ways. Coordination with WIC includes collaboration regarding breastfeeding initiatives, coordination of Healthy Start, addressing nutrition issues such as folic acid to prevent neural tube defects, and general nutrition guidelines for inclusion in our Healthy Start standards. Coordination with the Family Planning Program includes work on reducing teen pregnancy, reducing subsequent births to teens and abstinence education. Coordination with other grant programs administered outside of the Department of Health includes working with Florida's federal Healthy Start projects in selected counties, Special Projects of Regional and National Significance (SPRANS) 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 FSU Center for Prevention and Early Intervention, and CISS grants related to reproductive health and child abuse and neglect prevention.

Statutory requirements for coordination agreements with Title XIX at state and local levels are provided for in Chapter 411, Florida Statutes, the Florida Prevention, Early Assistance and Early Childhood Act. This statute requires the Department of Health, the Department of Children and Families and the Department of Education to assure intra-agency and interagency planning, policy, program development, and coordination to enhance existing programs and services and to develop

new programs and services for high-risk pregnant women, high-risk preschool children, and their families.

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 the state's Carnegie Starting Points grant, 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.

In 1990, the Department of Education and HRS (the former agency of the Department of Health) signed an interagency agreement that formed the basis for several school health initiatives. This agreement specifies the collaboration on all matters relating to school health, the implementation of targeted legislation for children from birth to age 5, dropout prevention, developmentally appropriate day care for the children of teen parents, AIDS, public/private partnerships, and parent education and involvement programs. The Department of Health collaborates with the Department of Education in a Centers for Disease Control Cooperative Agreement to improve the infrastructure necessary to support coordinated school health programs.

In an effort to increase health care access for the indigent population, the 1996 Florida Legislature established the Primary Care for Children and Families Challenge Grant. The intent of this program is to provide matching funds to county governments to stimulate the development of coordinated primary health care delivery systems for low-income children and families. The program emphasizes volunteerism, cooperation and broad-based participation by public and private health care providers. It functions as a partnership between state government, local government and private sector health care providers.

Ryan White grantees across the state have worked closely with the Department of Health to reduce the perinatal transmission of HIV. Local AIDS community-based organizations and consortia have formed collaborative relationships with Children's Medical Services offices to ensure that affected pregnant women, infants and children have access to integrated services and a coordinated system of care. There has been increased testing of pregnant women for HIV, and the vast majority of

HIV-infected women are on combination therapy, including AZT, to reduce vertical transmission. Through the help of Ryan White, more providers are getting the message that all pregnant women should be tested for HIV, and that early testing provides a good chance of preventing perinatal transmission.

In Florida, AHEC has worked closely with the Department of Health on a number of issues. Representatives from AHEC participate on a Maternal and Child Health Task Force with representatives from the Department of Health, the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, and Healthy Start. AHEC provided CEUs for a school health nurse certification, and is helping the department determine how to best certify school health nurses. AHECs across the state have conducted teleconferences on a number of MCH issues such as child abuse and domestic violence.

Community Health Centers also play an important role in Florida's health care delivery system, with over 90 sites across the state. 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.

4.3 Public Input

Public input into planning for the maternal and infant population begins with the Healthy Start Coalition local needs assessment process and service delivery plan development and implementation. Not only are consumers required to be represented on the board of directors of these coalitions, consumer experience surveys and focus groups are heavily relied on for needs assessment, plan development and ongoing implementation. Headquarters MCH staff review and evaluate coalition needs assessments, service delivery plans, and implementation reports and use this information in planning MCH programs. Though Healthy Start Coalitions are limited to plan development for pregnant women and infants up to age 3, input from consumers spans other childhood concerns as well, such as availability and accessibility of health care, child care and other supportive services. Public input on our five-year needs assessment will be solicited through the use of surveys.

Section 505 of the Title V legislation requires that the application be made public within the state in such a manner as to facilitate comment by any person during the development and after its

transmittal. To comply with this requirement, an advertisement was placed in the Florida Administrative Weekly soliciting input. An additional advertisement in the Florida Administrative Weekly will announce its availability to the public. Copies of the block grant will be distributed to county health departments and Healthy Start Coalitions. We will also make the block grant available over the Internet. The block grant for FY2000 is currently available on the Internet by going to the Department of Health Web site at www.doh.state.fl.us. From there, go to the “click here to view subject choices” pull-down menu and click on maternal and child health. From there, scroll down the page, and you will see a link for available block grants. FY2001 will be added after the document is reviewed and approved by MCHB.

4.4 Technical Assistance

At this time, Florida is not requesting any technical assistance from MCHB. The Department of Health is collaborating with the University of South Florida Lawton and Rhea Chiles Center to develop a maternal and child health workforce development initiative, and we may request technical assistance from MCHB related to project design and curriculum development. Other potential technical assistance needs might include cultural competence from the National Center for Cultural Competence, racial disparity work, low birth weight, and child death reviews.

V. SUPPORTING DOCUMENTS

5.1 Glossary

Adequate prenatal care - Prenatal care where the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [Title V Sec. 501(b)(3)]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. (Title V Sec. 501(b)(4))

Children - A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (For planning and systems development) - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.
2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.
3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services,

outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, “Why should the State address this risk factor (i.e., what health outcome will this result support)?”

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State’s required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State’s Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State’s Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or postpartum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State’s Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant’s* funds (carryover from the previous year’s MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO’s, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under “Infrastructure Building,” “Population Based Services,” “Enabling Services” and “Direct Medical Services.”

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect.

3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction sub-agreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification

and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to

file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

- 5.3 Other Supporting Documents**
No other supporting documents.
- 5.4 Core Health Status Indicator Forms**
See page SD 1.
- 5.5 Core Health Status Indicator Detail Sheets**
See page SD 6
- 5.6 Developmental Health Status Indicator Forms**
See page SD 17
- 5.7 Developmental Health Status Indicator Detail Sheets**
See page SD 29
- 5.8 All Other Forms**
See page SD 46
- 5.9 National “Core” Performance Measure Detail Sheets**
See page SD 90
- 5.10 State “Negotiated” Performance Measure Detail Sheets**
See page SD 110
- 5.11 Outcome Measure Detail Sheets**
See page SD 120