II. Needs Assessment

A. Needs Assessment Process

Overview of Needs Assessment Methodology

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

IMRH contracted with the Florida Government Performance Survey Research Center at Florida State University (FSU) to perform surveys regarding the health needs of the maternal and child population. (The cumulative report resulting from these surveys will be referred to as "the FSU survey" throughout this needs assessment report). Three groups were surveyed: key stakeholders, consumers, and direct service providers.

Key stakeholders included directors/administrators for a variety of public agencies, including the Agency for Health Care Administration, county health departments, the Department of Children and Families, the Department of Juvenile Justice, the Florida Department of Education, Healthy Start coalitions, and the Medicaid Program Office. Key stakeholders also included county administrators, state senators, state representatives, and representatives of advocacy groups concerned with maternal and child health, such as the Florida Association of Community Health Centers, the March of Dimes, and the Florida Pediatric Society. The total number of key stakeholders who responded was 112 out of 208, for a response rate of 54.9 percent.

Consumers were defined as clients of the state's 67 county health departments and 31 Healthy Start coalitions. Convenience sampling was used to select participants. In all, 1,194 out of 2,115 consumers completed surveys, for a response rate of 59 percent.

Direct service providers were physicians and nurses likely to treat the maternal and child population, including physicians in family practice, obstetrics and gynecology, and pediatrics, and nurses practicing in the fields of family nurse practitioner, nurse midwifery, women's health, pediatric nurse practitioner, and neonatal nurse practitioner. Potential participants were selected proportionally, by region and by size of community, to mirror the percentage of the state's population in each size of community (small <50,000, medium 50,000 – 250,000, and large >250,000) in each region (south, central, northeast, and northwest). The response rate for direct service providers was 149 out of 602 (25.9 percent). Further details regarding all aspects of the FSU survey may be

obtained by reviewing the copy of the entire report prepared by the Florida Government Performance Survey Research Center, which will be posted on the department's website along with the FY2006 application.

In November 2003, Florida's Title V programs undertook a Capacity for State Title V (CAST-5) evaluation. Representatives from DOH programs serving the needs of pregnant women, infants, children, and CSHCN; community partners; key stakeholders; consumer and family advocates; and Florida's Association of Healthy Start Coalitions took part in the three-day process. Relevant results will be discussed later in the report, where we examine MCH program capacity by pyramid levels.

Data Limitations

Data limitations for the quantitative data used in this needs assessment include the frequent use of 2003 data as the most recent data available. Limitations also exist regarding the response rates of the various survey groups within the FSU study, especially the 25.9 percent response rate for direct service providers. Unfortunately, final results for many of the surveys currently being undertaken to ascertain needs of the CSHCN population will not be available until after the due date for this report. Results will be used on an ongoing basis to evaluate program priorities and resource allocation.

Process of Collaborative Analysis and Goal-Setting

A multidisciplinary Needs Assessment Advisory Committee, representing both the public and private sector, was convened in order to ensure input from a wide range of programs, disciplines, and professionals to help identify needs and, once the needs were identified, prioritization of those needs so resources will be directed to ensure needs are met most effectively. Membership on the Needs Assessment Advisory Committee included representatives from the Department of Health (DOH) Bureau of Family and Community Health, Federal Healthy Start, DOH IMRH unit, Florida Association of Healthy Start Coalitions, Florida's PAMR team, DOH Child and Adolescent Health unit, DOH Division of Environmental Health, DOH Public Health Dental Program, the Chiles Center at the University of South Florida, DOH Office of Planning, Evaluation and Data Analysis, DOH Bureau of Epidemiology, Florida Department of Children and Families, FSU School of Nursing, DOH Bureau of Immunization, DOH Bureau of Chronic Disease Prevention and Health Promotion, DOH Division of Children's Medical Services, Florida March of Dimes, University of Florida, DOH Bureau of STD Prevention and Control, DOH Sexual Violence Prevention Program, DOH Office of Injury Prevention, DOH Bureau of HIV/AIDS, Florida's Agency for Health Care Administration, Florida Institute for Family Involvement (FIFI), and DOH Office of Health Professional Recruitment.

The advisory committee met formally three times. The purpose of the first meeting was to discuss the needs assessment process, receive feedback from members, and allow members to provide input on additional areas in which IMRH should target assessment activities. The second meeting was used to report on progress and identify further areas of exploration that may have been missed. At the final meeting, the discussion centered on data collected through the process, and members came to a consensus on how to prioritize identified needs.

Although three formal meetings by members of the Needs Assessment Advisory Committee took place specifically to inform this needs assessment, the members who came together to form the advisory committee interact with each other on an ongoing basis regarding maternal and child health issues. After this needs assessment has been submitted, members of the advisory committee will continue to interact, both formally and informally, in order to continually monitor progress and evaluate performance measures and resource allocation based upon status of performance measures and in response to emerging issues. Locally, regionally, and on a statewide basis, this process ensures resources are being directed in the most efficient means possible.

In addition, it is important to note that the Secretary of the Florida Department of Health goes to great lengths to promote an environment in which decisions regarding programmatic goals and resource allocation include input from key government agencies, private organizations, and consumer groups as an ongoing part of departmental strategic planning and development of performance objectives. Every program within the Department of Health, IMRH included, is expected to understand how its programmatic objectives interface with other programs' objectives, and collaboration grows from this expectation. For example, staff from IMRH and the Bureau of HIV/AIDS Perinatal HIV Program meet at least quarterly to review current program goals and progress toward the goals, as well as the impact of emerging issues. Thanks to these regular communications, both programs ensure efforts and resources are not duplicated in addressing perinatal HIV prevention strategies. Collaborative relationships such as this one exist across all related programs that affect the health of infants, mothers, children, adolescents, and children with special health care needs. While a five-year Title V needs assessment is an important exercise, it is part of a larger, ongoing cycle of needs assessment, program planning, resource allocation, evaluation, and reassessment that occurs within the Florida Department of Health among all public health programs.

Needs Assessment Partnership Building and Collaboration

As described above, partnerships among key stakeholders concerned with maternal and child health, both within and outside of DOH, are part of DOH daily operations. Staff from IMRH and Children's Medical Services (CMS) attempt to have interdisciplinary representation on all committees and workgroups, including staff from other related DOH programs, local county health departments, Healthy Start coalitions, representation from consumer groups when appropriate, representation from other key private and public entities when appropriate (such as medical schools, professional associations, nursing schools), and staff from other governmental agencies. Standing meetings exist between related programs for a wide variety of issues. For example, staff from the IMRH data and evaluation team meets monthly with PRAMS staff to discuss pertinent findings, possible ongoing data evaluation projects, and future revisions of state-specific questions for the PRAMS questionnaire.

Several of the specific activities undertaken to inform this needs assessment, such as the CAST-5 evaluation and the Needs Assessment Advisory Committee, have enhanced collaboration related to analyzing the needs of the MCH population. New relationships forged as a result of these processes will be cultivated and will help strengthen future collaborative efforts regarding capacity assessment and program implementation related to the needs of the MCH and CSHCN populations.

B. Five Year Needs Assessment

Health Status of Pregnant Women, Mothers, and Infants

Although there have been several positive trends related to the health status of this group, one of the findings of most concern is the continued presence of racial and ethnic disparity in health outcomes. For almost every indicator examined, black women and babies have worse health outcomes than whites.

Prenatal Care Entry: The percentage of women in Florida who entered prenatal care during the first trimester has increased from 83.9 percent in 1999 to a 10-year high of 85.8 percent in 2003. Although the percentage of black women with first trimester entry increased from 73.6 percent in 1999 to 78 percent in 2003, there remains great racial disparity in this indicator; for white women, the corresponding percentages were 87.1 percent in 1999 and 88.2 percent in 2003. The percentage of Florida women with no prenatal care has remained fairly constant between 1999 and 2003, at or near 1 percent. The percentage of black women with no prenatal care decreased from 2 percent in 1999 to a 10-year low of 1.6 percent in 2003. Despite this improvement, black women are twice as likely as white women to have no prenatal care. The percentage of white women with no prenatal care remained around 0.7 percent between 1999 and 2003. In 2003, 20 percent of black birth mothers reported receiving prenatal care later than the first trimester of pregnancy (2^{nd} and 3^{rd} trimesters), which was 1.8 times higher than white birth mothers that reported prenatal care later than the first trimester of pregnancy (11 percent). A total of 10,178 black women who gave birth in 2003 either received no prenatal care or received late prenatal care, representing 21.6 percent of black resident live births and 4.8 percent of the total resident births that year. (Florida DOH Vital Statistics 2003 Annual Report) The FSU survey found the perception of the importance of prenatal care as an unmet health care need for pregnant women and newborns ranked fourth overall (after reducing teen pregnancy, dental care, and helping pregnant women to quit smoking). Responses varied widely by respondent group. Prenatal care was perceived as the second highest need by direct service providers, but was ranked fourth by key stakeholders and seventh by consumers.

Teen Pregnancy: The birth rate for teens age 15 to 17 has continued to decline in Florida, going from 31.8 per 1,000 in 1999 to 22.4 in 2003. The birth rate for black teens 15 to 17 decreased from 54.0 per 1,000 in 1999 to 37.7 in 2003. The birth rate for black teens remains more than twice that of whites, as the rate for white teens decreased from 25.5 per 1,000 in 1999 to 18.3 in 2003. The birth rate for children age 10 to 14 has also decreased from 1.1 per 1,000 in 1999 to 0.7 in 2003. For white children age 10-14, the birth rate has decreased from 0.7 per 1,000 in 1999 to 0.4 in 2003, and the rate for black children has decreased from 2.6 per 1,000 in 1999 to 1.7 in 2003; this rate is also more than twice that of whites. The percent of repeat births to teens age 15-19 increased from 14.8 percent in 2002 to 15.2 percent in 2003; however, there has been an overall general decline since 1994, when the percentage was at a 10-year high of 16.6 percent.

Florida PRAMS data for 2001-2002 found that preterm births are more prevalent among women 19 and younger (11.9 percent) than among women 20 to 24 (10.2 percent), 25 to 34 (8.8 percent), and 35 and older (10.5 percent). PRAMS data on teen mothers and their infants between 2001 and 2003 also showed that compared to women 20 and older, teenage women with live births experienced a higher prevalence of many negative health impacts for themselves and their babies, including low birth weight (10.2 percent

vs. 7.2 percent), very low birth weight (2.0 percent vs. 1.4 percent), infants requiring neonatal intensive care (17.1 percent vs. 13.6 percent), infants exposure to secondhand smoke for at least one hour per day (13.2 percent vs. 6.6 percent), and maternal hypertension during pregnancy (22.5 percent vs. 18.3 percent).

The FSU survey found that *reducing teen pregnancy* is an extremely important need in the minds of direct service providers, key stakeholders, and consumers. It was the highest ranked item overall when respondents were asked about the most important unmet health care needs for pregnant women and newborns. Direct service providers and consumers both ranked it as their top choice, and it was second for key stakeholders (after reducing the number of low birth weight babies.)

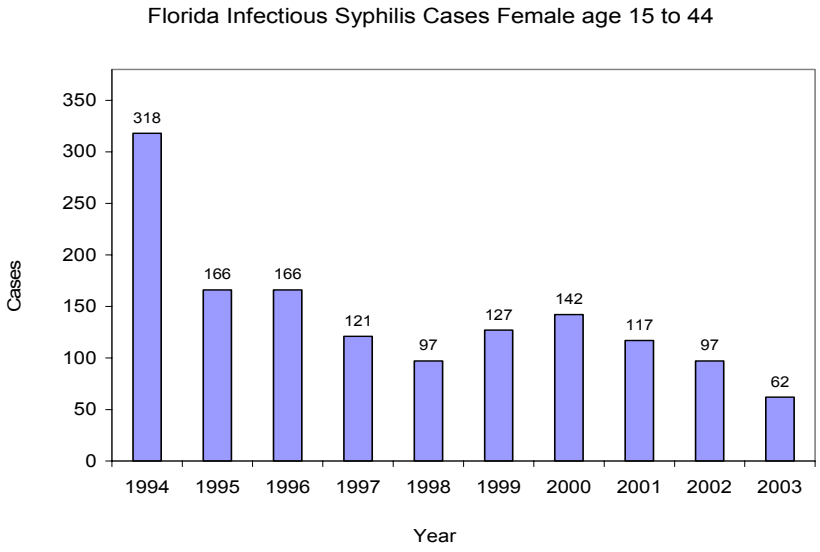
HIV Burden for Pregnant Women/Mothers: In 1996, the percentage of mothers of HIV-infected children who knew their HIV status prior to birth was 41 percent (18 of 44 births). The percentage increased to 82 percent in 2003 (9 of 11 births). In 1996, 10 of the 18 (55 percent) mothers who delivered an HIV-infected infant and knew their HIV status prior to birth received ZDV and/or other antiretroviral drugs at some point in their pregnancy or delivery. In 2003, six of the nine (67 percent) mothers who delivered an HIV-infected infant and knew their HIV status prior to birth received ZDV and/or other antiretroviral drugs at some point in their pregnancy or delivery. It appears that as the number of pregnant women who know their HIV status has increased and the number of cases of perinatal transmission has decreased, the perception of the importance of this issue has decreased. The FSU study found that overall, *reducing perinatal (around the time of birth) transmission of AIDS* ranked 10th out of 11 in the ranking of the most important unmet health care needs for pregnant women and newborns. PRAMS data for 2001-2002 found that the prevalence of being tested for HIV among pregnant women in Florida was higher among women with health insurance before pregnancy (92.1 percent) than among those who were uninsured before pregnancy (85.8 percent). Additionally, PRAMS data found that the prevalence of being tested for HIV among pregnant women was higher among women with whom a health care provider discussed HIV during a prenatal visit (91.3 percent) than among women who had not had such a discussion (65.2 percent).

Overall death rates for HIV/AIDS reached a high in 1995 when there were 4,336 deaths and the rate per 100,000 population was 33.5. When further examined by gender, the death rate in 1995 was 3.1 for white females, 73.6 for black females, and 11.7 for Hispanic females. In contrast, in 2003, there were only 1,742 deaths and the overall death rate decreased to 10.9 per 100,000 population. The death rates for women during 2003 were 1.3 per 100,000 for white females, 35.5 per 100,000 for black females, and 1.9 per 100,000 for Hispanic females. In 2002 HIV/AIDS was the fourth highest cause of death among all races for persons age 25 to 44. However, among blacks, HIV/AIDS was *the* leading cause of death in 2002. These data show that even though the number of deaths and death rates have decreased substantially since 1995, there are still large disparities in the risk of death from HIV/AIDS across race and gender categories. For example, in 2003, the death rate for black females was 27.3 times the rate for white females.

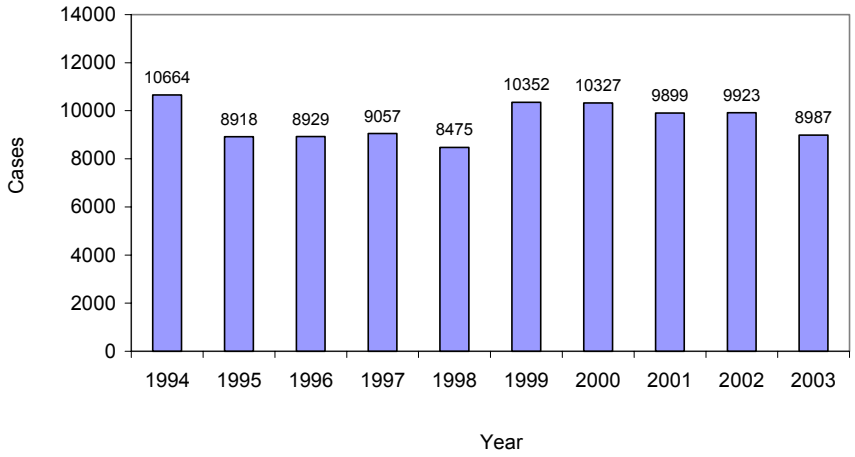
Other Significant STDs: Sexually transmitted diseases continue to affect the health of women age 15 to 44. According to the Florida Department of Health 2004 *Annual Report on Sexually Transmitted Disease Reporting*, “STDs continue to significantly impact the health status of Floridians, especially women. During 2004, approximately 3

percent of all infants born in the state were delivered to women who either had an STD during pregnancy and/or at delivery. Eighty percent of chlamydia cases reported were in females, with 76 percent being identified in females 15-24 years of age." Additionally, there were 16 cases of congenital syphilis in Florida in 2004.

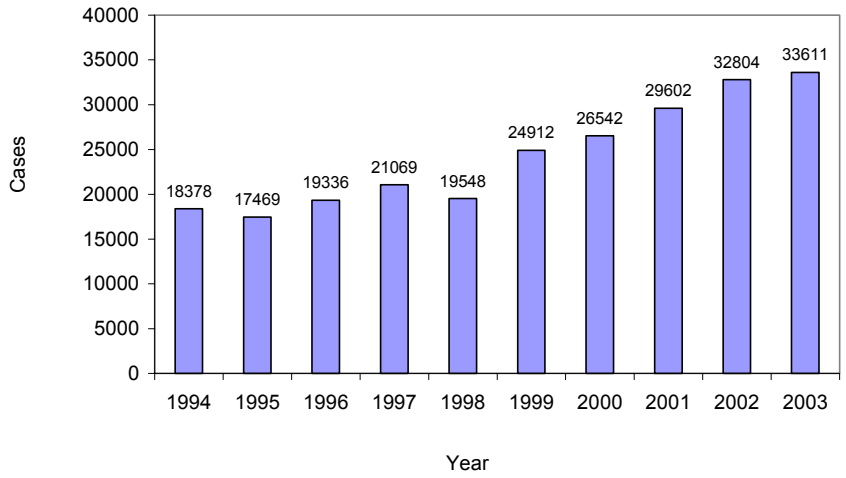
The graphs below show the number of cases of syphilis, gonorrhea, and chlamydia for females age 15 to 44 by year. These graphs show that syphilis cases have declined from 318 cases in 1994 to 62 cases in 2003. Gonorrhea cases have varied across the years 1994 to 2003, but have not shown a clear trend up or down. Chlamydia has increased from 18,378 cases in 1994 to 33,611 in 2003.



Florida Gonorrhea Cases Female age 15 to 44



Florida Chlamydia Cases Female age 15 to 44



The FSU survey found that when respondents were asked about the *most important other health care problems facing mothers and children*, sexually transmitted diseases

ranked third overall, behind domestic violence, and lack of dental care. Among all consumers surveyed, it ranked second after domestic violence.

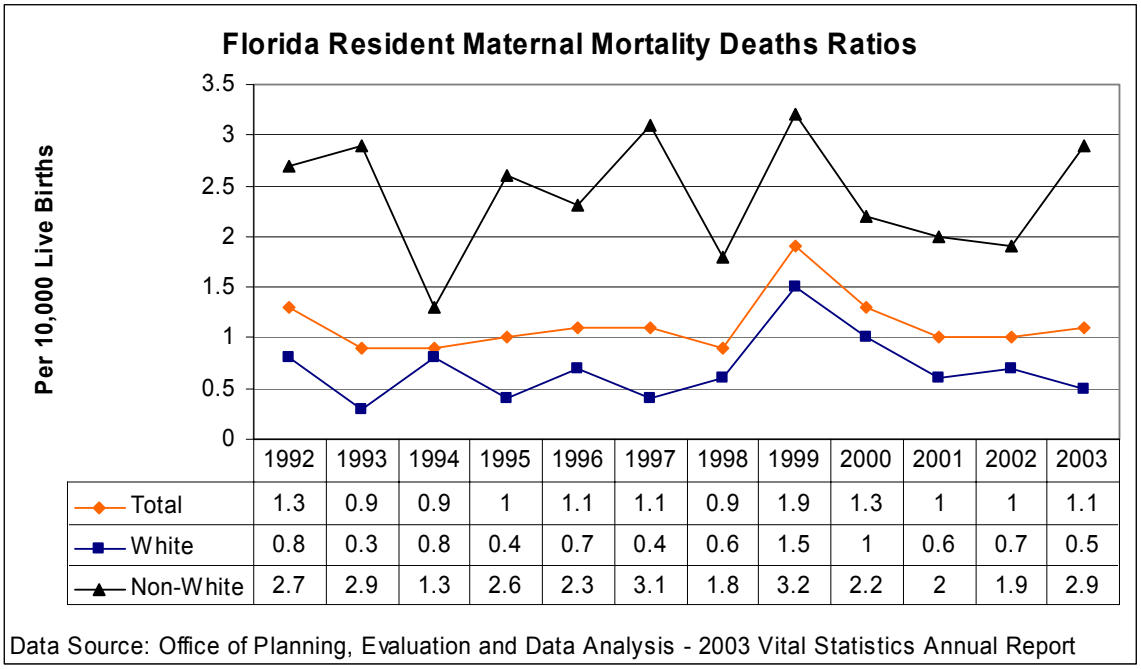
Oral Health: As mentioned previously, the FSU survey found that lack of dental care was the second most commonly cited response overall for the question about *most important other health care problems facing mothers and children*. Additionally, it was also the second most common response overall (after reducing teen pregnancy) when respondents were asked about the *most important unmet health care needs for pregnant women and newborns*. Florida has limited data related to the burden of dental disease throughout the state. The state has yet to implement a statewide dental health surveillance system. Most Florida-specific oral health data comes from five sources: the Florida Cancer Data System, the Florida Birth Defect Registry, the 2000 Florida Behavioral Risk Factor Surveillance System (BRFSS), the Florida Medicaid Management Information System, and the Florida County Health Department Clinic Management System. The Florida Cancer Data System only provides data on oral cancer. The Florida Birth Defect Registry collects information on the number of cleft lips and palates per live birth. The 2000 Florida BRFSS provided limited information on health-related risk factors, such as alcohol and tobacco use, and only covered three issues directly related to oral health: the percentage of adults who have had their teeth cleaned within the past year, the percentage of adults who visited a dentist within the past year, and the percentage of adults with no teeth removed. The Florida Medicaid Management Information System and the Florida County Health Department Clinic Management System provide some data on the dental disease burden among Floridians. However, the data from these systems is limited in that Medicaid and the county health departments primarily provide services to low income individuals. There are currently no data points to measure the status of oral health or access to oral health services for pregnant women or mothers.

Domestic Violence: As previously mentioned, domestic violence was the top ranked choice in the FSU survey among all respondents who were asked about the *most important other health care problems facing mothers and children*. The percentage of pregnant women reporting domestic violence on the PRAMS survey has been between 4.4 percent and 4.9 percent during the years 2000–2003. A PRAMS special report titled *Health Care Provider Discussions about Physical Abuse with Women Who are Pregnant in Florida, 2000-2001* found that health care providers discussed physical abuse with less than half (40.9 percent) of pregnant women.

Smoking in Pregnant Women: The statewide percentage of resident live births in Florida to mothers who smoked during pregnancy decreased steadily from 10.2 percent in 1999 to 8.1 percent in 2003. For white births, the percentage dropped steadily from 12.2 percent in 1999 to 8.2 percent in 2003. The overall percentages were less and also showed decreasing trends for black and Hispanic women; percentages decreased from 4.7 percent in 1999 to 3.9 percent in 2003 for blacks, and from 2.4 percent in 1999 to 1.6 percent in 2003 for Hispanics. The FSU survey found that overall, helping pregnant women to quit smoking ranked third when respondents were asked about *the most important unmet health care needs for pregnant women and newborns*. However, when broken down into individual groups, the ranking of this need varied greatly. Consumers listed it as the third most important, but providers and key stakeholders each ranked it as the sixth most important need.

Alcohol Use During Pregnancy: Florida PRAMS data for 2000-2002 found that less than four out of every 100,000 babies born in Florida had fetal alcohol syndrome at the time of birth. Further, 5 percent of pregnant women in Florida consumed alcohol during their most recent pregnancy. These findings are interesting when compared with the perceptions of direct service providers, key stakeholders, and consumers, who ranked alcohol abuse/alcoholism as the number one *most important substance use and abuse* problem for mothers and youth, ahead of illegal drug use and tobacco use.

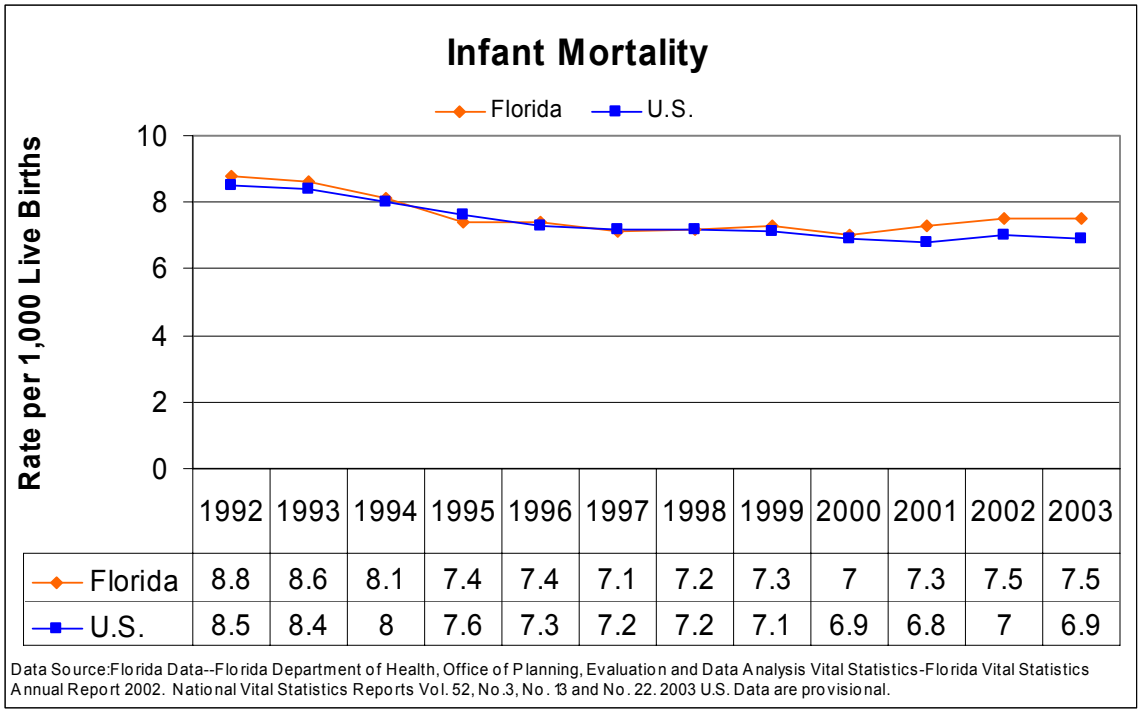
Maternal Mortality: Florida's maternal mortality rates for 1992-2003 are illustrated in the graph below. While the overall maternal mortality rate has remained fairly constant over the past three years, non-white mothers are dying at a greater rate than white mothers. In 2003 the non-white rate was 2.9 per 10,000 live births and the white rate was 0.5 per 10,000, which indicates that non-white women are 5.8 times as likely to die a maternal death compared to white women. In addition, data for Florida's Pregnancy Associated Mortality Review showed the maternal mortality ratio was higher for women 35 and older and for women who were overweight or obese.



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Total	1.3	0.9	0.9	1	1.1	1.1	0.9	1.9	1.3	1	1	1.1
White	0.8	0.3	0.8	0.4	0.7	0.4	0.6	1.5	1	0.6	0.7	0.5
Non-White	2.7	2.9	1.3	2.6	2.3	3.1	1.8	3.2	2.2	2	1.9	2.9

Data Source: Office of Planning, Evaluation and Data Analysis - 2003 Vital Statistics Annual Report

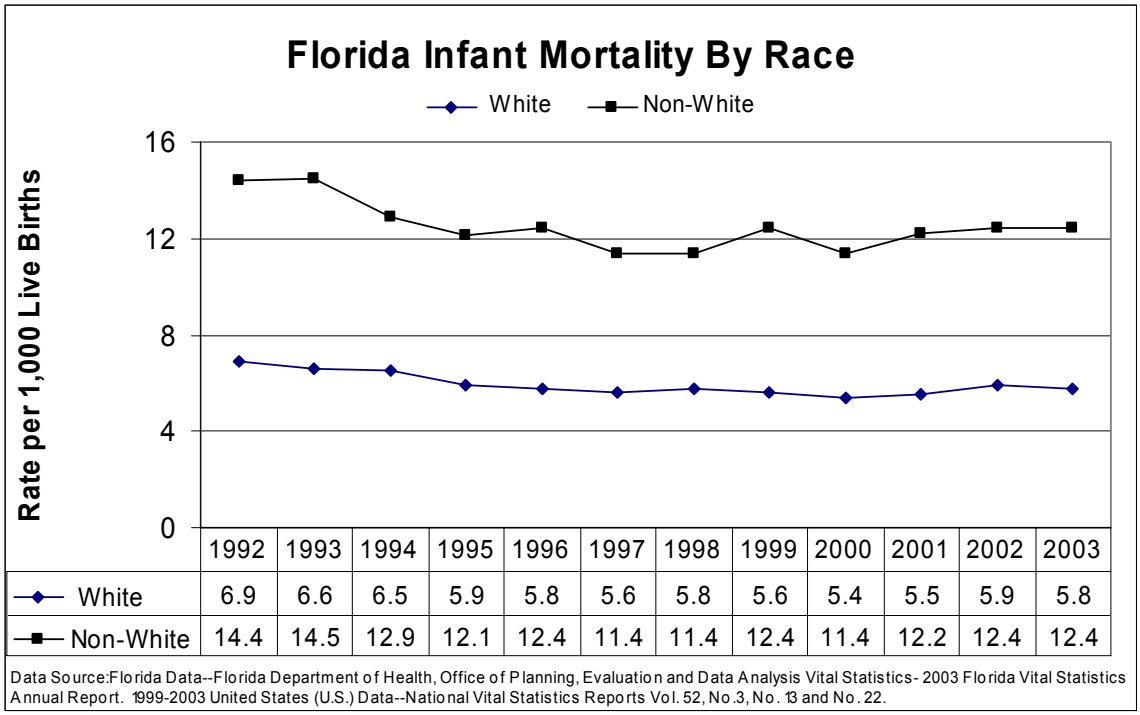
Infant Mortality: Florida's infant mortality rate has been similar to the national infant mortality rate until around 2001, when the U.S. infant mortality rate continued to decline (6.8 per 1,000 live births) to the lowest rate ever recorded, while Florida's rate began to rise as shown in the below chart. The 2003 infant mortality rate in Florida was 7.5 per 1,000 live births. Although the rate in Florida has shown recent increases, since 1992, there has been an overall 14.8 percent decrease in the infant mortality rate in Florida.



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Florida	8.8	8.6	8.1	7.4	7.4	7.1	7.2	7.3	7	7.3	7.5	7.5
U.S.	8.5	8.4	8	7.6	7.3	7.2	7.2	7.1	6.9	6.8	7	6.9

Data Source:Florida Data--Florida Department of Health, Office of Planning, Evaluation and Data Analysis Vital Statistics-Florida Vital Statistics Annual Report 2002. National Vital Statistics Reports Vol. 52, No.3, No. 13 and No. 22. 2003 U.S. Data are provisional.

The following chart shows Florida's infant mortality by race. In 2003, the non-white infant mortality rate was 12.4 per 1,000 live births, more than twice the white rate of 5.8 per 1,000 live births. Both groups have seen an overall decline in infant mortality. The white mortality rate has decreased 15.9 percent from 1992 to 2003 while the non-white rate has decreased 13.9 percent during the same period.



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	6.9	6.6	6.5	5.9	5.8	5.6	5.8	5.6	5.4	5.5	5.9	5.8
Non-White	14.4	14.5	12.9	12.1	12.4	11.4	11.4	12.4	11.4	12.2	12.4	12.4

Data Source:Florida Data--Florida Department of Health, Office of Planning, Evaluation and Data Analysis Vital Statistics- 2003 Florida Vital Statistics Annual Report. 1999-2003 United States (U.S.) Data--National Vital Statistics Reports Vol. 52, No.3, No. 13 and No. 22.

The chart above notes the differences between white and non-white infant mortality rates. For black infants, the infant mortality rate is even greater than the overall non-white population. The infant mortality rate for black infants was 13.7 per 1,000 black live births.

A total of 28 of the 67 counties in Florida are below the state 2003 infant mortality rate of 7.5 per 1,000 live births. These counties are listed in the table below. Counties with no infant deaths for 2003 are included; these are small counties with a low number of births. Of the 39 counties over the state rate, 10 counties were statistically significantly higher than expected after adjusting for maternal race, marital status, and education. The 10 counties were Alachua, Bay, Clay, Columbia, Duval, Hillsborough, Leon, Marion, Putnam and Wakulla.

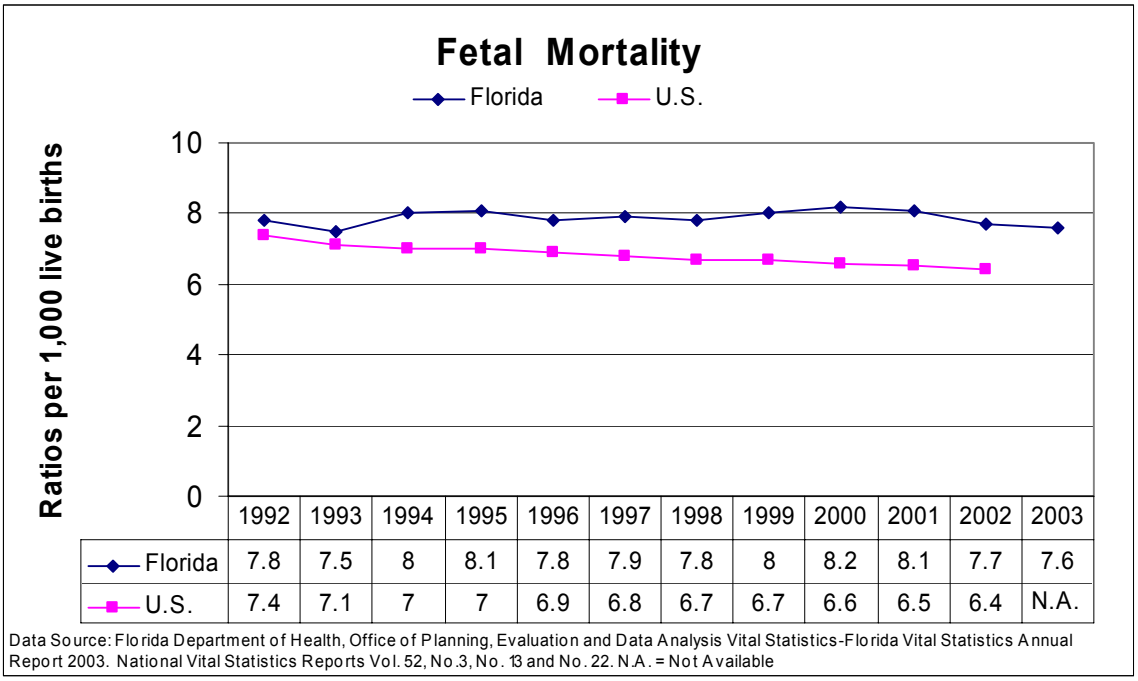
Florida Counties Below the 2003 State Rate of 7.5 per 1,000 live births					
1	Saint Johns	7.4	15	Lake	5.6
2	Hendry	7.2	16	Highlands	5.6
3	Flagler	7.2	17	Citrus	5.6
4	Calhoun	7.2	18	Seminole	5.4
5	Monroe	7	19	Lee	5.1
6	Martin	6.8	20	Volusia	5
7	Broward	6.4	21	Brevard	5
8	Sarasota	6	22	Osceola	4.8
9	Manatee	6	23	Saint Lucie	4.5
10	Dade	6	24	Desoto	4.4
11	Indian River	5.8	25	Union	0.0
12	Pasco	5.7	26	Liberty	0.0
13	Nassau	5.7	27	Lafayette	0.0
14	Okeechobee	5.6	28	Hardee	0.0

The following table lists the causes of infant death for Florida in 2003. Certain conditions originating in the perinatal period continue to be the leading causes of infant death; types of perinatal conditions are listed in the next table. Symptoms, Signs and Ill-Defined Conditions include 92 Sudden Infant Death Syndrome Cases. Of the 92 SIDS deaths, 60 were white (40 boys and 20 girls) and 32 were non-white (15 boys and 17 girls).

Florida Resident Infant Deaths, 2003		
Cause of Death	**Number of Infant Deaths**	**Percent of Infant Deaths**
Certain Conditions Originating in the Perinatal Period	783	49.4%
Congenital Anomalies	290	18.3%
Symptoms, Signs and Ill-Defined Conditions	158	10.0%
External Causes	103	6.5%
Diseases of the Circulatory System	54	3.4%
Diseases of the Respiratory System	45	2.8%
Diseases of the Digestive System	45	2.8%
Infections and Parasitic Diseases	43	2.7%
Diseases of the Nervous System and Sense Organs	30	1.9%
Diseases of the Genito-urinary System	10	0.6%
Diseases of the Blood and Blood-Forming Organs	9	0.6%
Endocrine, Nutritional and Metabolic Diseases	9	0.6%
Neoplasms	2	0.1%
Ear & Mastoid Process Diseases	1	0.1%
Skin and Subcutaneous Tissue Diseases	1	0.1%
Diseases of the Musculoskeletal System & Connective Tissue	1	0.1%
Total	1584	100%

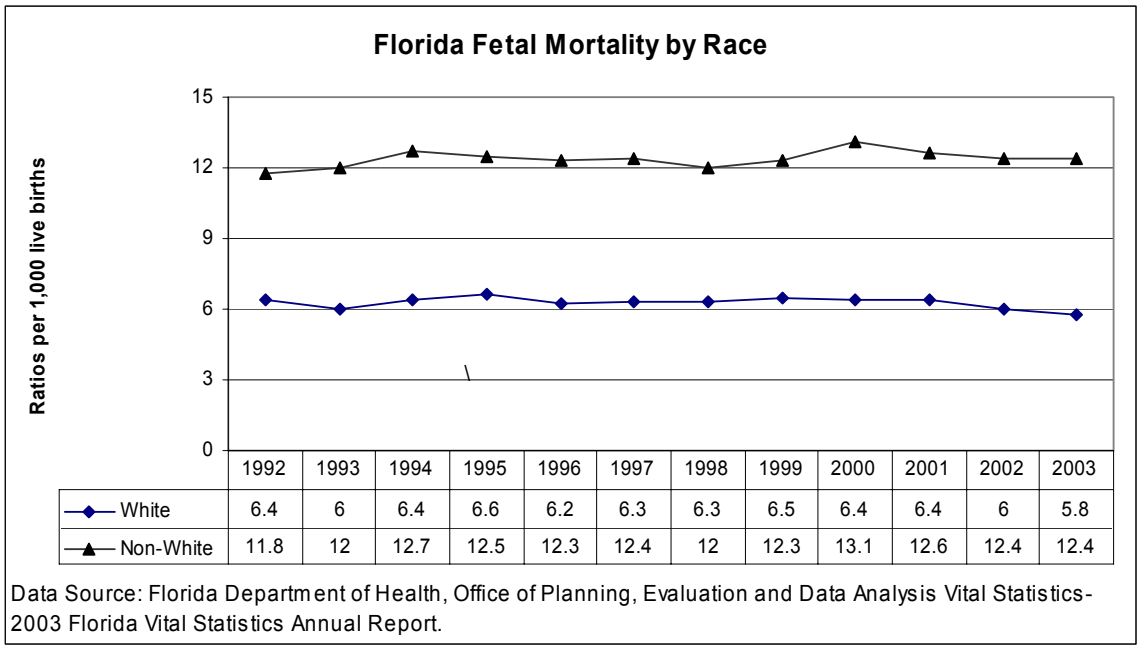
Types Conditions Originating in the Perinatal Period
Late infant, not heavy-for-dates
Fetus or newborn affected by material conditions which may be unrelated to present pregnancy
Fetus or newborn affected by maternal complications of pregnancy
Fetus or newborn affected by complications of placenta, cord, and membranes
Fetus or newborn affected by other complications of labor and delivery
Slow fetal growth and fetal malnutrition
Disorders relating to short gestation and unspecified low birth weight
Disorders relating to long gestation and high birth weight
Birth trauma
Intrauterine hypoxia and birth asphyxia
Respiratory distress syndrome
Other respiratory conditions of fetus and newborn
Infections specific to the perinatal period
Fetal and neonatal hemorrhage
Hemolytic disease of fetus or newborn, due to isoimmunization
Other perinatal jaundice
Endocrine and metabolic disturbances specific to the fetus and newborn
Hematological disorders of fetus and newborn
Perinatal disorders of digestive system
Conditions involving the integument and temperature regulation of fetus and newborn
Other and ill-defined conditions originating in the perinatal period

Fetal Mortality: From 1992 to 2002, the national fetal death ratio decreased 13.5 percent, while Florida's ratio only decreased about 3 percent, as shown below. In 2003, the non-white fetal mortality rate (12.4 per 1,000 live births) is more than twice the white rate (5.8 per 1,000 live births). The white fetal mortality rate decreased 9.4 percent between 1992 to 2003, while the non-white rate has seen a percent increase of 5.1 percent.



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Florida	7.8	7.5	8	8.1	7.8	7.9	7.8	8	8.2	8.1	7.7	7.6
U.S.	7.4	7.1	7	7	6.9	6.8	6.7	6.7	6.6	6.5	6.4	N.A.

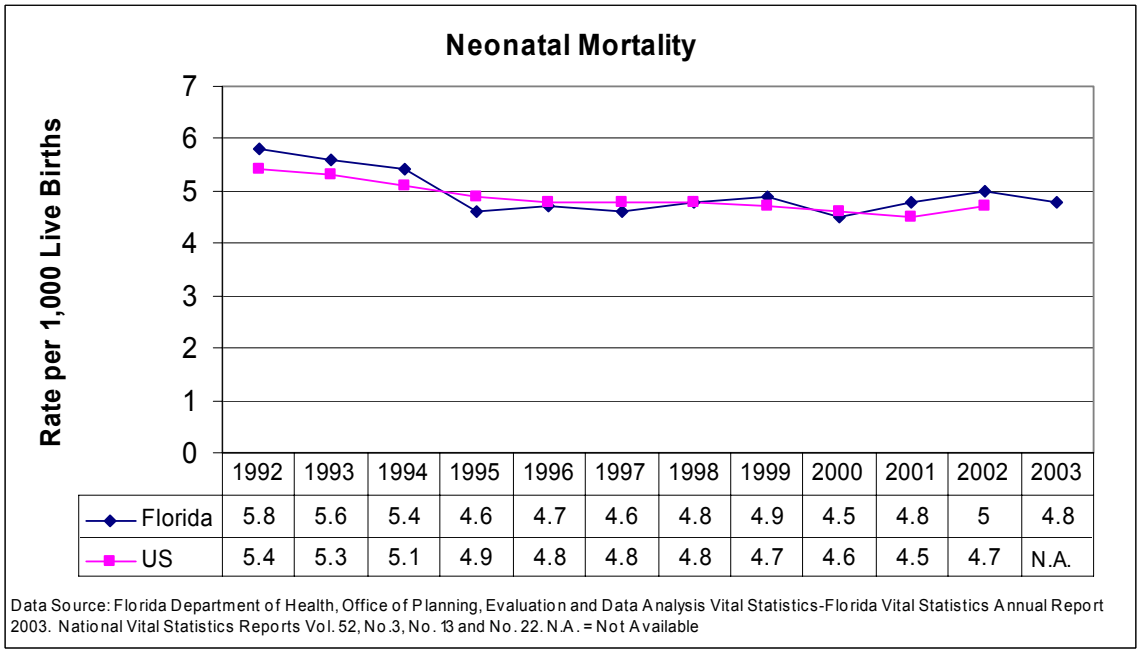
Data Source: Florida Department of Health, Office of Planning, Evaluation and Data Analysis Vital Statistics-Florida Vital Statistics Annual Report 2003. National Vital Statistics Reports Vol. 52, No.3, No. 13 and No. 22. N.A. = Not Available



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	6.4	6	6.4	6.6	6.2	6.3	6.3	6.5	6.4	6.4	6	5.8
Non-White	11.8	12	12.7	12.5	12.3	12.4	12	12.3	13.1	12.6	12.4	12.4

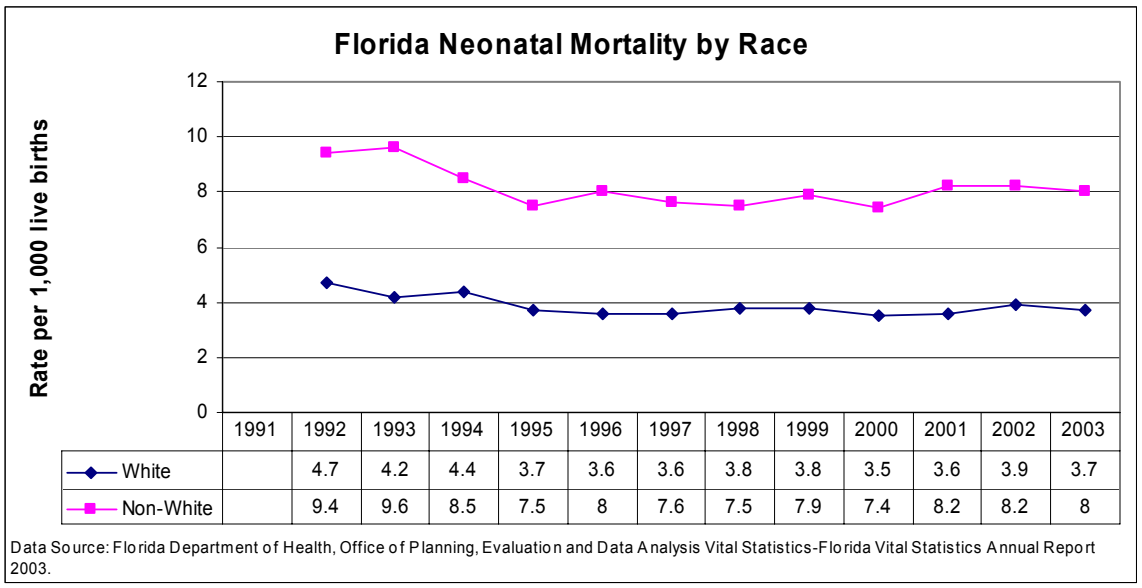
Data Source: Florida Department of Health, Office of Planning, Evaluation and Data Analysis Vital Statistics-2003 Florida Vital Statistics Annual Report.

Neonatal Mortality: From 1992 to 2002, the U.S. saw about a 13 percent decrease in the neonatal mortality rate. When comparing 1992 to 2003, Florida has seen a percent decrease of 17.2. In 2003, the non-white rate (8.0 percent) was more than twice the white rate (3.7 percent). Since 1992 the white neonatal mortality rate has decreased 21.3 percent, while the non-white rate only decreased 14.9 percent.



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Florida	5.8	5.6	5.4	4.6	4.7	4.6	4.8	4.9	4.5	4.8	5	4.8
US	5.4	5.3	5.1	4.9	4.8	4.8	4.8	4.7	4.6	4.5	4.7	N.A.

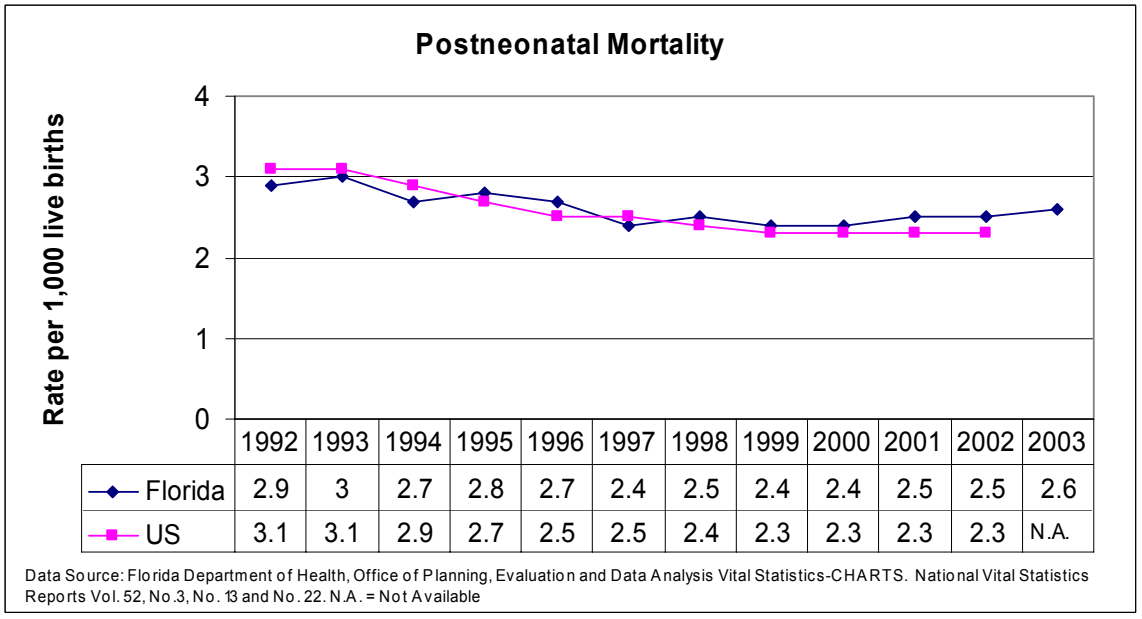
Data Source: Florida Department of Health, Office of Planning, Evaluation and Data Analysis Vital Statistics-Florida Vital Statistics Annual Report 2003. National Vital Statistics Reports Vol. 52, No.3, No. 13 and No. 22. N.A. = Not Available



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White		4.7	4.2	4.4	3.7	3.6	3.6	3.8	3.8	3.5	3.6	3.9	3.7
Non-White		9.4	9.6	8.5	7.5	8	7.6	7.5	7.9	7.4	8.2	8.2	8

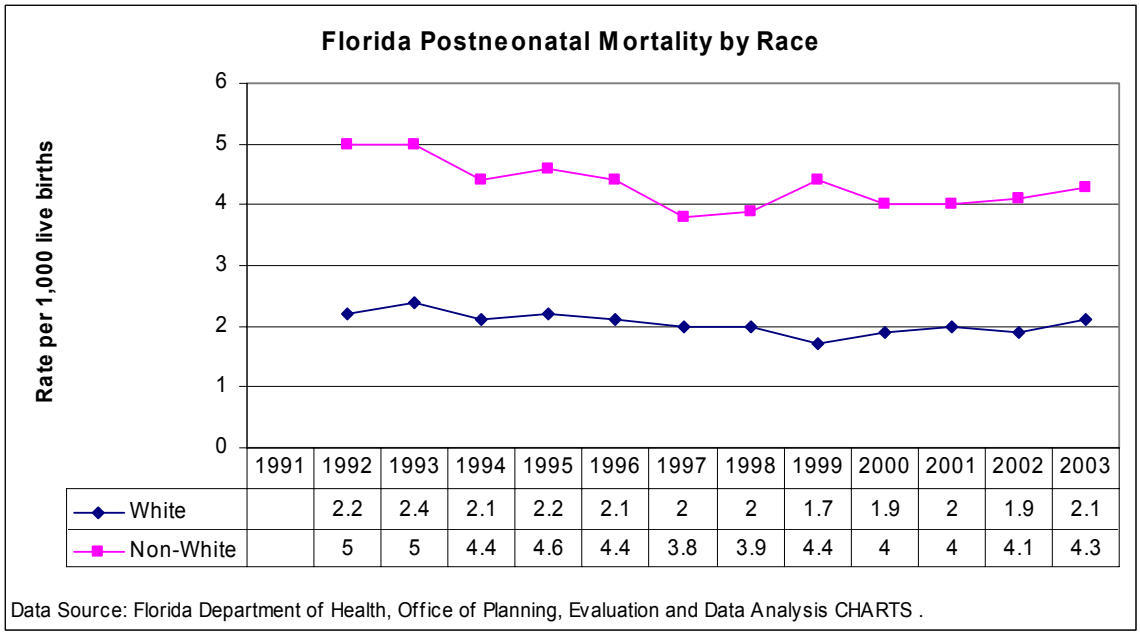
Data Source: Florida Department of Health, Office of Planning, Evaluation and Data Analysis Vital Statistics-Florida Vital Statistics Annual Report 2003.

Postneonatal Mortality: The national postneonatal mortality rate has decreased about 26 percent. Since 1997, the postneonatal mortality rate in Florida has remained relatively stable. Then in 2003, the rate increased slightly, about 4 percent; however, from 1992 to 2003 there was a 10 percent decrease in postneonatal deaths. The non-white postneonatal mortality rate is about twice the white rate. When comparing 1992 to 2003, Florida's white race has seen a 4.5 percent decrease and the non-white race has seen a 14 percent decrease.



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Florida	2.9	3	2.7	2.8	2.7	2.4	2.5	2.4	2.4	2.5	2.5	2.6
US	3.1	3.1	2.9	2.7	2.5	2.5	2.4	2.3	2.3	2.3	2.3	N.A.

Data Source: Florida Department of Health, Office of Planning, Evaluation and Data Analysis Vital Statistics-CHARTS. National Vital Statistics Reports Vol. 52, No.3, No. 13 and No. 22. N.A. = Not Available



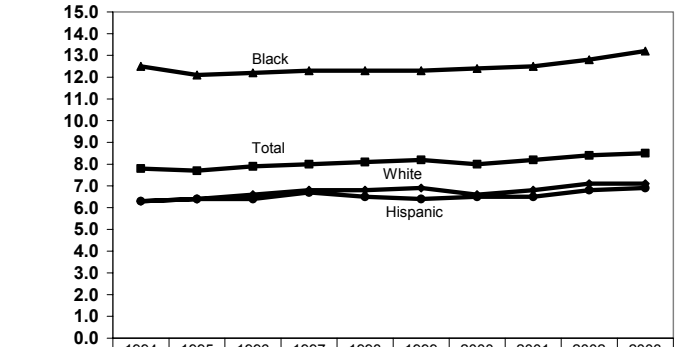
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White		2.2	2.4	2.1	2.2	2.1	2	2	1.7	1.9	2	1.9	2.1
Non-White		5	5	4.4	4.6	4.4	3.8	3.9	4.4	4	4	4.1	4.3

Data Source: Florida Department of Health, Office of Planning, Evaluation and Data Analysis CHARTS .

Birth Defects: As in the rest of the United States, birth defects are a leading cause of childhood morbidity and infant mortality in Florida. In 1999, more than 5,000 babies were born with birth defects, affecting approximately 1 in every 43 live births. During 2000, 272 of the 1,423 infant deaths were attributable to birth defects, accounting for 19 percent of all infant deaths. Florida PRAMS data for 2000-2001 found that during prenatal care visits, health care providers discussed screening for birth defects with 81 percent of women.

Low Birth Weight Infants: The percentage of births below 2500 grams (LBW) has increased from 7.8 percent in 1994 to 8.5 percent in 2003. This trend is the same for white, black and Hispanic births. The graph below shows the trends in LBW births from 1994 to 2003.

PERCENTAGE OF BIRTHS WEIGHTING LESS THAN 2500 GRAMS



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
All Races	7.8	7.7	7.9	8.0	8.1	8.2	8.0	8.2	8.4	8.5
White	6.3	6.4	6.6	6.8	6.8	6.9	6.6	6.8	7.1	7.1
Black	12.5	12.1	12.2	12.3	12.3	12.3	12.4	12.5	12.8	13.2
Hispanic	6.3	6.4	6.4	6.7	6.5	6.4	6.5	6.5	6.8	6.9

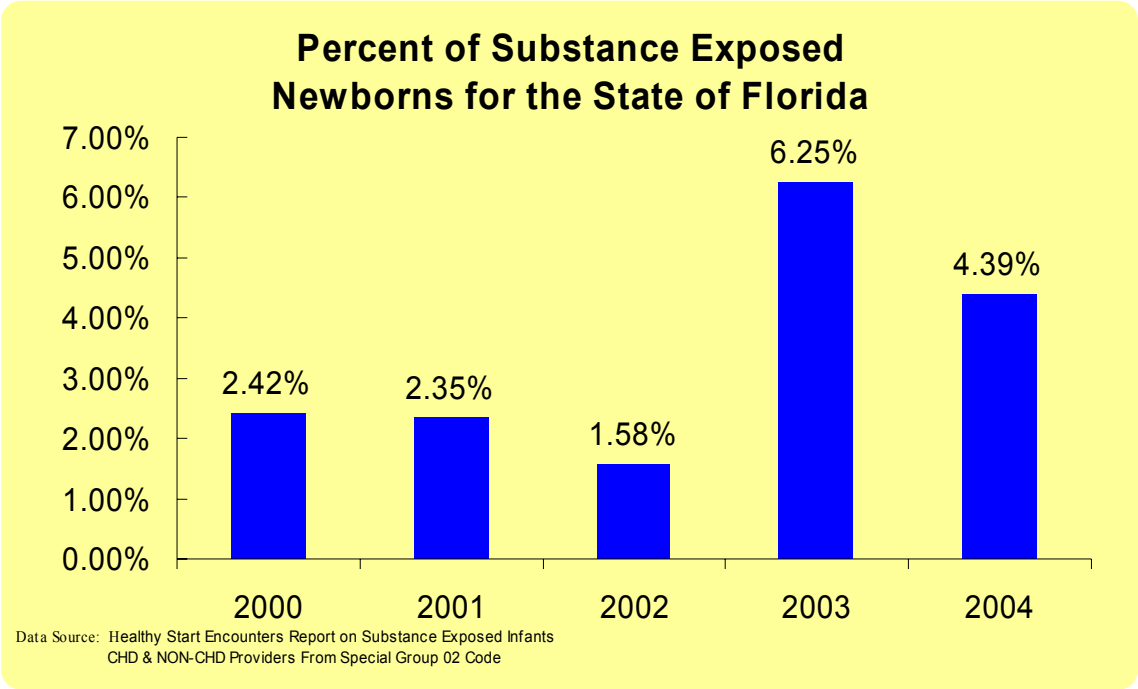
Being born LBW and premature often go hand-in-hand. Not surprisingly, Florida PRAMS data from 2001-2002 found that preterm infants have a much higher likelihood of being LBW than full-term infants (52.3 percent vs. 2.6 percent). Financial costs associated with prematurity are often crippling for both families and the health care system as a whole. Agency for Health Care Administration data for 2003 showed that newborns classified as immature, born prematurely or experiencing respiratory distress (DRGs 386, 387, 388) had an average cost per stay of $47,770.

The FSU survey yielded interesting results regarding this indicator. When respondents were asked about the *most important unmet health care needs for pregnant women and newborns,* key stakeholders ranked reducing the number of low birth weight babies as the top need. However, direct service providers and consumers felt very differently. Direct service providers ranked it as the sixth most important need, and consumers ranked it as the ninth.

Very Low Birth Weight Infants: The percentage of very low birth weight (VLBW) infants in Florida has changed very little over the past 10 years, fluctuating between 1.5 percent and 1.6 percent. For both whites and Hispanics, the percentage has fluctuated between 1.1 percent and 1.2 percent between 1999 and 2003. Between 1999 and 2003, the percentage of VLBW infants for blacks fluctuated between a low of 2.8 percent and a high of 3 percent (more than twice the percentage for whites and Hispanics). Similar to findings for LBW infants, Florida PRAMS data for 2001-2002 also found a definite relationship between prematurity and VLBW. A total of 14 percent of preterm babies were VLBW, compared to 0.1 percent of full-term babies.

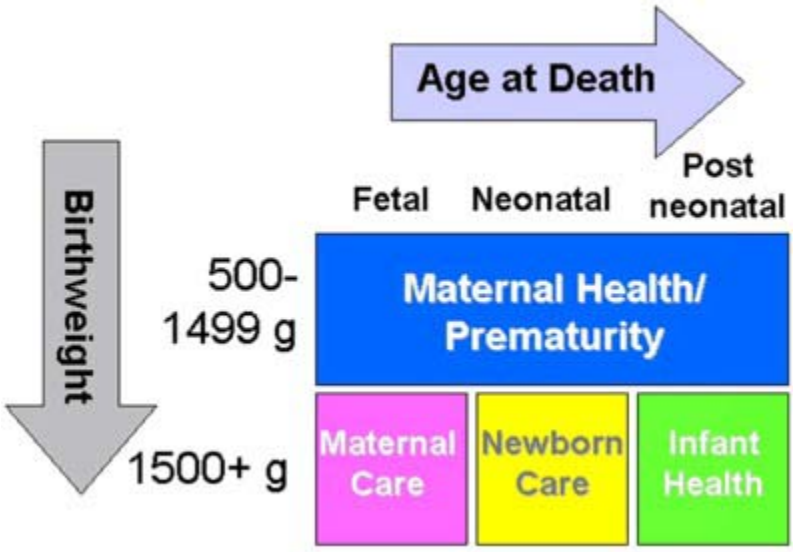
Substance-Exposed Newborns: The following graph shows the percentage of substance-exposed newborns in Florida between 2000 and 2004. There have been notable fluctuations in this number, from a low of 1.58 percent in 2002 to a high of 6.25 percent in 2003. It is almost impossible to discern if decreases and increases in the percentages are due to decreased and increased reporting or if there are actual drops

and increases in the number of substance-exposed newborns. Quite possibly, it is a combination of the two factors. Additionally, there have been data quality control issues due to one large county incorrectly coding ("over-coding") numbers of substance-exposed newborns. This has skewed the data in such a way that the percentages are larger than they should be. DOH staff is actively working with this county to correct the data coding problem.



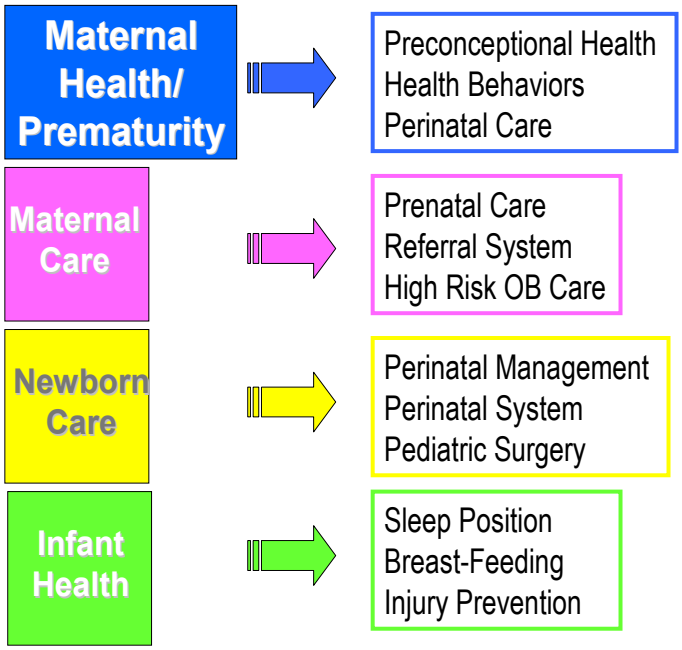
Florida Perinatal Periods of Risk Analysis 1998 through 2002: Perinatal Periods of Risk (PPOR) is an analysis method for infant and fetal death data that was developed by Dr. Brian McCarthy and the World Health Organization. PPOR classifies infant deaths and fetal deaths using four categories based age at death and birthweight. The basic idea is different factors influence the risk of death in each of the four categories. Also, the number of deaths in each category indicates where the biggest problems are. The four categories are illustrated in the diagram below.

PPOR Categories



In general, the risk factors associated with each category are listed below.

Risk Factors Associated with PPOR Categories



The Florida Department of Health Maternal and Child Health Evaluation unit performed the PPOR analysis for the years 1998 through 2002 using linked birth and infant death and fetal death records for Florida. Fetal deaths with gestational ages less than 24 weeks and infants with birthweights less than 500 grams were excluded from the analysis. In each of the four categories, the rates for 2002 were compared to the rates for 1998 and found to be not statistically significantly different. This indicates that within the PPOR categories, there has been no significant change in risk of death between 1998 and 2002. Table 1 below illustrates this point.

Table 1

Rate per 1000 Live Births Plus Fetal Deaths by Year

PPOR Category	1998	1999	2000	2001	2002	2002:1998 % Change	p Value for 2002:1998 % Change
Maternal Health	4.08	4.28	4.06	4.00	4.01	-1.6%	0.74
Maternal Care	2.38	2.56	2.42	2.55	2.38	0.3%	0.97
Newborn Care	1.27	1.35	1.40	1.35	1.37	7.8%	0.39
Infant Health	1.88	1.64	1.73	1.98	1.92	1.9%	0.80
Total	9.61	9.83	9.60	9.87	9.68	0.0%	0.81

Since there were no statistically significant changes in trends over the years 1998 through 2002, the PPOR analysis was done using the data for the entire time period 1998 through 2002.

One feature of the PPOR method is the comparison of the feto/infant deaths in each category to a reference group. The reference group is selected for comparison because the feto/infant death rates are better and it is a subset of the total population of births and fetal deaths. The rationale is since the reference group is part of the overall population, the goal of achieving the same rates for the entire population should be possible. In this analysis the reference group was defined as infants and fetal deaths born to mothers who were age 20 or above, race White, with at least 12 years of education. The difference between the rates for the reference group and non-reference group is considered the excess rate. Table 2 below gives the counts of fetal and infant deaths by PPOR category and reference group. These data are used to calculate the statistics in table 3 below.

Table 2

Infant Deaths Plus Fetal Deaths
Florida 1998 - 2002

	Reference Group	Non-Reference Group	Total
Maternal Health	1484	2634	4118
Maternal Care	1099	1379	2478
Newborn Care	626	731	1357
Infant Health	623	1222	1845
Total	3832	5966	9798
Live Births Plus Fetal Deaths	573605	434713	1008318

Table 3

Infant Death Plus Fetal Death Rates Per 1000 Births Plus Fetal Deaths
and Rate Ratios by PPOR Category and Reference Group
Florida 1998 - 2002

	Reference Group	Non-Reference Group	Non-Reference Group to Reference Group Rate Ratio	95% Confidence Interval	
Maternal Health	2.59	6.06	2.34	2.20	2.50
Maternal Care	1.92	3.17	1.66	1.53	1.79
Newborn Care	1.09	1.68	1.54	1.38	1.71
Infant Health	1.09	2.81	2.59	2.35	2.85
Total	6.68	13.72	2.05	1.97	2.14

Table 3 compares the reference group rates to the non-reference group rates. It can be seen that relative to the reference group, the Maternal Health and Infant Health categories have the largest difference.

Table 4 has the same rates as Table 3 but in table 4 the rates are subtracted to obtain the excess rates shown in the third column.

Table 4

Infant Death Plus Fetal Death Rates Per 1000 Births Plus Fetal Deaths and Difference (Excess) by PPOR Category and Reference Group Florida 1998 - 2002

PPOR Category	Reference Group	Non-Reference Group	Difference (Excess)	Percent Excess
Maternal Health	2.59	6.06	3.47	49.3%
Maternal Care	1.92	3.17	1.26	17.8%
Newborn Care	1.09	1.68	0.59	8.4%
Infant Health	1.09	2.81	1.72	24.5%
Total	6.68	13.72	7.04	100.0%

In Table 4, it can be seen that for every 1000 births plus fetal deaths in the non-reference group, there is an excess of 7.04 infant and fetal deaths. Almost half (49.3 percent) of the excess is in the Maternal Health category. The second highest category is the Infant Health category with an excess of 1.72 or 24.5 percent of the total 7.04 excess.

These results indicate that Maternal Health and Infant Health are the areas most in need of improvement in Florida. Referring to the figure above, improvement in these areas will require efforts in preconceptional health and health behaviors, and perinatal care for women, and sleep position, breast feeding and injury prevention for infants.

The Florida PPOR Practice Collaborative Project

The Florida Perinatal Periods of Risk Practice Collaborative was undertaken in 2002 to impact the Florida's maternal and child health system through engaging in three activities: identifying specific populations of pregnant women and babies with the greatest opportunity for improvement in key Florida communities; developing capacity and expertise within Florida's maternal and child health system to fully utilize the PPOR approach by expanding the number of professionals well versed in it's practical application; and to provide data to assist key figures in Florida's maternal and child health system to develop consensus regarding priorities and services, to identify public policy implications of findings, to identify joint assets and develop strategies, and to address identified needs at the state and local levels.

The purpose of Florida's PPOR Practice Collaborative was to implement a PPOR initiative in the seven largest counties in Florida in an attempt to bring about key changes in the maternal and child heath system. The membership of the Florida practice collaborative consisted of representatives from the seven counties in Florida with the highest number of births. These communities include: Dade, Broward, Palm Beach, Duval, Orange, Hillsborough, and Pinellas Counties. The selection of these communities was influenced by prior experience indicating improvements in the outcomes for these geographic areas impact the state's statistical data on health

indicators such as infant mortality. Each community had representation from the local county health department and a Healthy Start coalition. In addition to these partners, Florida's Department of Health played a key role. Representatives from the Florida Department of Health, Maternal and Child Health Research and Evaluation unit assisted with training and supporting local communities.

The project was a replication of a national practice collaborative in which three of the Florida partners had participated. The national offices of the March of Dimes, CityMatCH, and the Centers for Disease Control sponsored the national practice collaborative. The state chapter of the March of Dimes funded Florida's replication project. CityMatCH and the CDC provided technical assistance and support to Florida's project.

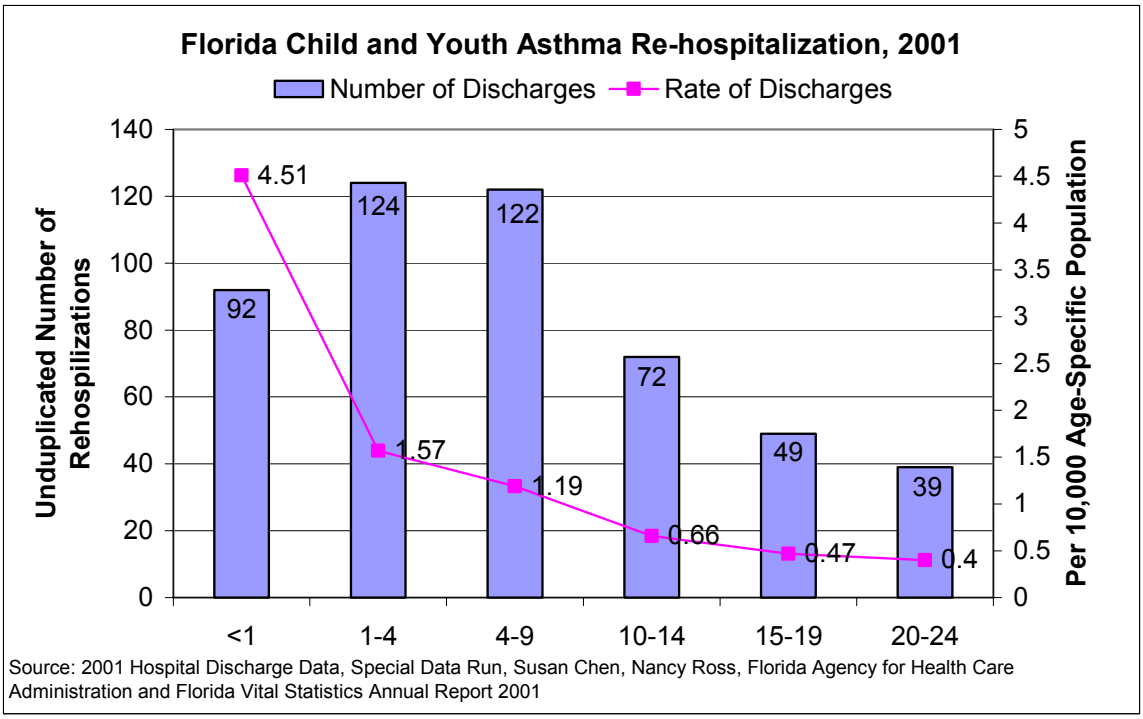
Approximately 25 participants met quarterly for a one year period from March 2002 to April 2003 for instruction and planning. Findings from the data analysis revealed Florida's greatest opportunity for improvement in birth outcome would be achieved by a greater focus on the health status of women prior to conception.

As a result of these findings, Florida's Department of Health implemented a number of changes designed to impact the health status of women prior to and between pregnancies. These activities included the development of a pilot project and subsequent protocol for services described as interconceptional education and counseling. In this model, 10 areas of risk are identified. These are defined as, poor nutrition (overweight or underweight, anemia etc), lack of physical activity, smoking, lack of routine health care (including but not limited to family planning), substance use or abuse, chronic high blood pressure, mental health issues, and environmental risk factors (exposure to chemicals). Two assessment tools have been used to develop educational intervention. These tools are a women's health questionnaire and the *Tell us About Yourself* form.

Health Status of Children and Adolescents

Immunization Rates for Infants: The percent of Florida 2-year-olds who are fully immunized went from a 10-year high of 86.6 percent in 2000 to a low of 79.4 percent in 2003, before rebounding to 85.3 percent in 2004. Public perception about the importance of childhood immunizations seems to be relatively low when compared to other childhood health indicators. The FSU study found that among all respondents, lack of immunization (not getting shots) ranked eighth out of nine possible responses for the question regarding the *most important health care problems for infants, children, and adolescents*.

Asthma: According to the Florida Agency for Health Care Administration inpatient discharge data in 2003, asthma accounted for 118,273 hospital discharges for all ages. Of the total discharges, 3,230 were less than 1 year of age and 23,455 were 1-24 years of age. The figure below shows the number and rate of rehospitalizations for asthma. Infants less than l year of age had the highest rehospitalization rate (4.51 percent). While this number has fallen, reports indicate that asthma hospitalizations increased in late 2004, possibly due to structural damage inflicted by the unprecedented 2004 hurricane season.



Source: 2001 Hospital Discharge Data, Special Data Run, Susan Chen, Nancy Ross, Florida Agency for Health Care Administration and Florida Vital Statistics Annual Report 2001

The following table displays Florida asthma deaths for years 1999-2003. The number of deaths to 0-24 year -olds was decreasing steadily until 2002 when the number of asthma deaths increased by almost 89 percent. According to the Agency for Health Care Administration, asthma related hospital discharges are on the rise. In 1999 there were 77,808 discharges and in 2003 there were 118,273 discharges for ages 0-24.

Florida Asthma Deaths		
Year	Total Asthma Deaths	Number of Asthma Deaths 0-24 Years of Age
1999	241	18
2000	224	14
2001	246	9
2002	232	17
2003	218	19

Lead Poisoning: Florida is home to an estimated one million children under 6 years of age. The state also has over 300,000 Medicaid-eligible children (indicating low income) under 6. These demographic statistics illustrate the distinct vulnerability of Florida's pediatric population to lead poisoning. Lead screening rates in Florida have increased over the years. In 2002, 79,295 infants and children under age 6 were screened, and 736 (9.3/1,000) were reported as lead poisoned. Although a greater number of lead poisoned children (n=877) were identified in 2003, the rate positive per child screened dropped 19 percent from 9.3 per 1,000 to 7.5 per 1,000. The FSU survey found that overall, respondents ranked lead exposure (in paint) as the least of the *most important health care problems for infants, children, and adolescents.*

Tobacco Use: The Florida Youth Tobacco Survey for 2002 indicated that 30.6 percent of Florida's public middle school students and 52.2 percent of Florida's public high school students had ever tried a cigarette. Moreover, 9.2 percent of public middle school students and 17.8 percent of public high school students currently used cigarettes, cigars, or smokeless tobacco products on one or more of the past 30 days in the year 2002. Data on spit tobacco from 1999 indicated that 1.2 percent of Florida's youths (2.4 percent of males and 0.1 percent of females) were current spit tobacco users.

From 1998 to 2002 in Florida, there has been a 30 percent decrease in middle school students and a 23 percent decrease of high school students who have ever tried a cigarette. The percentage of middle school students who are current smokers decreased by 50 percent (18.5 percent to 9.2 percent), while the percentage of high school students who are current smokers decreased 35 percent (27.4 percent to 17.8 percent). The percentage of middle and high school students who declared they are "committed never smokers" increased over this same time period – an increase of 45 percent for middle school students (38.9 percent to 56.2 percent) and 73 percent for high school students (25.0 percent to 43.2 percent). The FSU survey found that overall, when asked about the *most important substance use and abuse problems for mothers and youth*, respondents ranked tobacco use third out of five choices.

Oral Health: As previously mentioned, Florida has very limited data related to the burden of dental disease throughout the state. For the years 1999-2001, 71.4 percent of 15-year-old county health department patients (of all races and genders) had untreated tooth decay, while 21.4 of the same population had no decay. Moreover, 37.3 percent of 15-year-old Medicaid patients had untreated tooth decay. The DOH Public Health Dental Program and the Florida Medicaid Management Information System are the sources of the Florida-specific data on sealant use. This data records sealant placement on permanent molar teeth of 8-year-olds and 14-year-olds who were seen in county health departments or who are Medicaid-eligible. This data is limited in that it indicates the presence of sealants in mainly low-income children. For these children, 30 percent of 8-year-olds and 22 percent of 14-year-olds received dental sealants on their permanent molar teeth in 2000, and there has been a decreasing trend over the last few years.

Childhood Obesity/Poor Nutrition: The FSU survey found that overall, obesity was the second and poor nutrition the third most commonly cited response when respondents were asked about the *most important health care problems for infants, children, and adolescents*. Among direct service providers and key stakeholders, obesity was the highest ranked problem. The following data are taken from the Florida Youth Risk Behavior Survey (YRBS). This survey identifies a number of risk behaviors among youth and includes behaviors that put children at risk for developing overweight or obesity. The survey is conducted in public high schools across Florida. The survey addresses physical education class, TV viewing, and the eating of fruits and vegetables across different ethnic groups and ages of children. Results from the 2001 and 2003 administration of the survey are compared:

- Overall, 28.7 percent of students in 2001 and 29.1 percent of students in 2003 perceived themselves as slightly or very overweight. Girls were more likely than boys to perceive themselves as overweight (33.6 percent versus 24.1 percent in 2001; 32.6 percent versus 25.6 percent in 2003).

- Overall, 42.2 percent of students in 2001 and 43.8 percent of students in 2003 were trying to lose weight. Girls were much more likely than boys to try to lose weight (57.1 percent versus 28 percent in 2001 and 57.3 percent versus 30.6 percent in 2003).
- Overall, the percentage of students who ate at least five servings of fruits and vegetables per day was 20.3 percent in 2001 and 23.3 percent in 2003. Boys were more likely than girls to consume five or more servings of fruits and vegetables per day (22.6 percent versus 17.8 percent in 2001 and 23.3 percent versus 18.1 percent in 2003).
- Overall, 58.8 percent of students in 2001 and 60.8 percent of students in 2003 engaged in physical activity that made them sweat and breathe hard on three or more of the past seven days (regular physical activity). Boys were much more likely than girls to engage in physical activity on at least three of the past seven days (68.4 percent versus 48.8 percent in 2001 and 70.9 percent versus 50.6 percent in 2003).
- Overall, 44.9 percent of students in 2001 and 42.7 percent of students in 2003 watched three or more hours of TV per day on an average school day.
- Overall, 58.4 percent of students in 2001 and 54.4 percent of students in 2003 attended physical education classes on no days. Girls were more likely than boys to have no P.E. activity in school (66.3 percent versus 50.7 percent in 2001 and 60.7 percent versus 48.1 percent in 2003).

Child Abuse/Neglect Florida's Child Abuse Death Review team reviews the facts and circumstances surrounding child abuse and neglect deaths in which the Department of Children and Families, Florida Abuse Hotline accepted at least one prior report of abuse or neglect. The 2003 annual report of the Child Abuse Death Review team includes a summary of findings from reviews of 161 deaths that took place between 1999 and 2003. Noteworthy findings include:

- Neglect deaths occurred slightly higher at 52 percent, while abuse was at 48 percent.
- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 44 deaths caused by direct trauma, 21 of the children died from head trauma, seven from abdominal trauma, and 16 from beatings and multiple traumas.
- Twelve children died from trauma resulting from shaking/impact.
- Drowning was the leading cause of neglect deaths with 37 child deaths for the five-year period.
- Thirteen of the children died from a fatal gunshot wound, and nine were intentionally shot by an adult.
- Co-sleeping contributed to the deaths of four of the children under the age of 3 months.
- Fathers or male paramours were responsible in 83 (44 percent) of the deaths. Mothers were responsible in 68 (36 percent) of the deaths. Neglect was the primary cause of death in the majority of cases in which the mother was the only caretaker responsible. The majority of the deaths in which the father or male paramour was the sole caretaker responsible were caused by abuse.

Injuries: Since 1999 unintentional injury (accident) has remained the leading cause of death in Florida for children and youth between the ages of 1 to 24. The table below displays the leading causes of child and adolescent deaths for 2003. The second leading cause of death is different for each of the three age groups: 1-4 Congenital Anomalies, 5-14 Malignant Neoplasm, and 15-24 Homicide.

Florida Leading Causes of Resident Deaths, 2003				
Age		COD	# of Deaths	Rate per 100,000
1-4	1	Unintentional Injury (Accident)	151	18.7
	2	Congenital Anomalies	22	2.7
	3	Malignant Neoplasm	20	2.5
	4	Homicide	17	2.1
	5	Heart Disease	10	1.2
5-14	1	Unintentional Injury (Accident)	130	6.0
	2	Malignant Neoplasm	60	2.8
	3	Congenital Anomalies	17	0.8
	4	Homicide	15	0.7
	5	Chronic Lower Respiratory Dis	10	0.5
15-24	1	Unintentional Injury (Accident)	1,042	48.6
	2	Homicide	253	11.8
	3	Suicide	195	9.1
	4	Malignant Neoplasm	93	4.3
	5	Heart Disease	47	2.2

Based on 2003 data of the Florida Youth Risk Behavior Survey, 15.8 percent of Florida's public high school students seriously considered attempting suicide, and 12.6 percent made a plan about how they would commit suicide.

Health Status of Children with Special Health Care Needs (CSHCN)

The Florida Children's Medical Services Network (CMSN) and related programs served 99,457 infants, children, and youth in 2004. Of that total, 56,300 were enrolled in the CMSN, 40,554 in the Early Steps Program (Florida's early intervention program), and 2,603 had presumptive abnormal metabolic tests. Statewide enrollment of children with special health care needs (CSHCN) served in 2004 through the CMSN with Title XIX coverage was 38,757, or 68.84 percent; 12,508, or 22.22 percent with Title XXI coverage; and 13,727, or 24.38 percent in private/other (this figure includes children in the CMSN Safety Net). The number of children served in Title XIX, Title XXI, and private/other exceeds the total number of CSHCN served in 2004 by CMS because clients switch from one coverage to another during the calendar year and an unduplicated count is not available within the current data system.

The top 12 diagnostic groups in children served by the CMSN for the calendar year 2004 were:

Primary Diagnosis Group	***Percent of Children***

Congenital Anomalies	*15.74%*
Diseases of the Nervous System and Sense Organs	*12.27%*
Symptoms, Signs and Ill-Defined Conditions	*11.07%*
Diseases of the Respiratory System	*10.63%*
Mental Disorders	*10.55%*
Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders	*7.08%*
Certain Conditions Originating in the Perinatal Period	*5.32%*
Diseases of the Blood and Blood-forming Organisms	*3.10%*
Neoplasms	*2.51%*
Diseases of the Musculoskeletal System and Connective Tissue	*2.37%*
Injury and Poisoning	*2.37%*
Diseases of the Genitourinary System	*1.94%*

According to the National Survey of Children with Special Health Care Needs Chartbook 2001, the population of CSHCN in Florida had the following characteristics (all statistics are based on parental reports):

- Percent of Children with Special Health Care Needs: 13.1 percent (12.8 percent nationally)
- Percent of CSHCN whose conditions affect their activities usually, always, or a great deal: 28.1 percent (23.2 percent nationally)
- Percent of CSHCN with 11 or more days of school absence due to illness: 17.8 percent (15.8 percent nationally)
- Percent of CSHCN without insurance at some point in the past year: 14.0 percent (11.6 percent nationally)
- Percent of CSHCN with any unmet need for specific health care services: 24.5 percent (17.7 percent nationally)
- Percent of CSHCN with any unmet need for family support services: 5.3 percent (5.1 percent nationally)
- Percent of CSHCN needing specialty care who had difficulty getting a referral: 27.7 percent (21.9 percent nationally)
- Percent of CSHCN without a usual source of care (or who rely on an emergency room): 10.7 percent (9.3 percent nationally)
- Percent of CSHCN without a personal doctor or nurse: 13.9 percent (11 percent nationally)
- Percent of CSHCN without family centered care: 38.9 percent (33.5 percent nationally)
- Percent of CSHCN whose families pay $1,000 or more in medical expenses per year: 12.7 percent (11.2 percent nationally)
- Percent of CSHCN whose condition caused financial problems for the family: 25.9 percent (20.9 percent nationally)
- Percent of CSHCN whose families spend 11 or more hours per week providing or coordinating care: 15.7 percent (13.5 percent nationally)

- Percent of CSHCN whose condition affected the employment of family members: 37.2 percent (29.9 percent nationally)

MCH Program Capacity by Pyramid Levels

Role of Florida's Healthy Start Program: Collaboration between the Department of Health IMRH staff and the statewide network of Healthy Start coalitions ensures local and statewide needs are assessed and reassessed continually, including assessment of capacity at all levels of the pyramid, in order to allocate resources for the maternal and child health population most effectively. The Department of Health contracts with local Healthy Start coalitions, community-based nonprofit agencies located throughout the state whose purpose is to address the diverse needs of pregnant women and infants up to age 3. The coalitions conduct assessments of community assets and needs, identify gaps and barriers to effective service delivery, and develop a service delivery plan to address identified problem areas and issues. They also allocate available Healthy Start direct service dollars to local providers and monitor the Healthy Start system of care. Throughout this discussion of MCH program capacity by pyramid levels, Florida's Healthy Start program will continually be mentioned, as it is the backbone for coordination of services for the maternal and child health population in Florida.

CAST-5 Evaluation: As mentioned earlier in this report, Florida undertook a CAST-5 evaluation in November 2003. Relevant findings of the CAST-5 evaluation will be discussed under the appropriate subheadings throughout this section on MCH capacity by pyramid levels.

Direct Health Care Services and Enabling Services

Access: As previously mentioned in this report, access to health care services continues to be a major challenge for the most vulnerable among the maternal and child health population. A recent analysis of all of the Healthy Start coalition service delivery plans identified unmet needs related to access to primary care prior to pregnancy, access to comprehensive prenatal care, and identification and treatment of maternal infections and STDs. Also cited is a need for improved access to family planning services prior to hospital discharge, as well as a need for providers to ascertain access to a family planning method at the time of the postpartum visit. Lack of access to many enabling services was also noted, including lack of access to affordable and quality childcare, affordable and safe housing, job training and employment, and transportation. For black women, cultural sensitivity issues may be impacting their comfort level in accessing care. The plans suggest providers need to improve cultural competency by ensuring the racial makeup of staff is similar to that of their clients, and they should implement cultural sensitivity and customer service training to make services more user-friendly. Language barriers also continue to be an issue impeding access to care. It was recommended that bilingual staff need to be available on a consistent basis.

Several initiatives are in place to address the provision of culturally competent care for the maternal and child health population. An initiative is currently underway to institutionalize community inclusion as an integral part of all key MCH programs that target the elimination of disparities in pregnancy and birth outcomes. DOH staff is working with other key stakeholders on a community mobilization workgroup. One of the

key outcomes of this workgroup will be the inclusion of information on community mobilization in the department's *Healthy Start Standards and Guidelines* and technical assistance guidelines in the *County Health Department Guidebook*.

There are several other projects in Florida that specifically address racial and ethnic disparities in health outcomes. The department's *Racial and Ethnic Disparity: Closing the Gap* (RED) initiative provides funding for demonstration projects in local communities to target services to special populations. There are also five Federal Healthy Start Projects in Florida. Federally funded Healthy Start projects provide services and programs designed to reduce maternal and infant illness (morbidity) and enhance local systems of care. Projects are located in areas that traditionally experience a high rate of negative perinatal (around birth) outcomes with particularly high-risk populations. A major priority of the projects is reducing racial disparities in maternal and infant outcomes. Special projects focus on reducing the disparity between white and black infant mortality and reducing disparities in low birth weight, preterm delivery, and size for gestational age. Racial disparities are also addressed by increasing provider knowledge of and sensitivity to cultural beliefs and practices. The projects also work to increase access to health services and to promote healthy behaviors among the target population. They give infants a better opportunity for health by promoting good health for the mother before and between pregnancies. They help ensure women and infants receive the services they need through enhanced health and social service care coordination. Additional support is provided through special programs focusing on maternal depression, including services such as mental health assessment, treatment, and referral.

One of the CAST-5 competencies is the ability to inform and educate the public and families about maternal and child health issues. A well-informed and well-educated public is better able to access needed health services. Florida was generally rated as being "partially adequate" in terms of performing this function. Key weaknesses included:

- Need for public awareness campaigns
- Need for business plan for public awareness
- DOH Distribution Center (carries materials on health information) is not used by all due to cost
- No systematic way to collect & disseminate evaluative reports
- Evaluative reports are "under-resourced"

Another CAST-5 competency that relates to health care access is the ability to link women, children and youth to health and other community and family services, and ensure access to comprehensive, quality systems of care. In general, Florida was rated as being "partially" to "substantially adequate" for this indicator. Key opportunities for improvement included:

- Challenge: HIPPA, sharing client information between agencies
- Challenge: Updating technology
- Need for better coordination of progress/activities – CMS/DCF contract activities related to medical foster care
- Challenge: Health information that is multilingual/culturally competent/appropriate reading level

- For some populations, still major problems with service delivery (access-friendly)
- Incarcerated women in county jails – no system in place to assure quality health/prenatal care
- Florida lacks adequacy in tracking adolescents and children in out- of-home placements
- Challenge: Oral health needs
- Challenge: Tracking migrant population
- Challenge: Inadequate funding for uninsured/migrant populations
- No funding for dental care for pregnant women
- CSHCN need services that are not part of a "normal" health care package – e.g., behavioral services
- Not “up to par” in translation services
- No funding for examination of long term outcomes
- No evidence related to impact of Healthy Start on child abuse prevention
- Racial/ethnic disparities
- DOH website standards are not user-friendly
- Schools are a "mixed bag" related to public access to computers
- Need to coordinate & evaluate health-related hotlines
- Need for funding for external evaluation (MCH)
- Immunizations for 2-year-olds
- In Dade County, over 100 languages are spoken (presents challenges)
- Easier to address linguistic issues than cultural
- Ensuring individuals doing translation are doing so accurately and in a culturally sensitive manner
- Need for better integration with the Office of Minority Health
- Need for literacy promotion
- Need for better intra-agency agreements
- Need more of a safety net for high-risk women who fall out of care
- Case management/care coordination – needs improvement
- Academic institutions need to do a better job of disseminating research findings
- Challenges related to information sharing as more formerly “public” health services are privatized
- Waiting lists for Kid Care/CMS (life/death concerns)

Another CAST-5 competency related to access issues relates to Florida’s ability to ensure the competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs. In general, Florida was rated as “partially adequate” in terms of meeting this competency. Key opportunities for improvement noted were:

- Nursing shortage especially public health nurses
- Poor marketing of public health
- Lack of recognition and recruitment of other professionals (i.e. social workers)
- DOH does not have the authority for mental health - there is a disconnect between mental and physical health

- Malpractice insurance issue (caused MDs to leave/lack of support for medical professionals in the areas of medical malpractice issues)
- Challenges related to cultural competencies
- Lack of pediatric dentists
- Opportunity for telehealth, telemedicine to expand
- Opportunties for expanding early recrutiment and education of MDs, nurses, social workers, dentists, nurtritionists
- Need to Implement expansion of succession planning
- Need to expand reimbusement from Medicaid for medical services, including dental
- Challenges related to the privatization of public health
- Threat related to movement to reduce the responsibilities of nurse mid-wives and ARNPs

Financial Issues: The recent analysis of statewide Healthy Start coalition service delivery plans found there are still many financial issues that serve as barriers to accessing direct health care services. In many communities, women do not access care due to lack of insurance or insufficient funding. For women who do not qualify for Medicaid and do not have health insurance, there are often no options. The Chipola Study found that about half of the citizens interviewed cited lack of money and no health insurance as the major barrier to receiving health care.

The results of a telephone survey conducted for the 2004 Florida Health Insurance Study indicate 19.2 percent of survey respondents under 65 were uninsured. The findings also revealed Hispanic respondents had the highest uninsured rates at 31.8 percent, black respondents had the second highest uninsured rates at 22.6 percent, and 14.3 percent of the survey's white respondents were uninsured. The primary reason identified for not having health insurance was not being able to afford insurance.

The Centers for Disease Control and Prevention reports similar health insurance coverage figures for Florida during the three-year period 2001-2003: 35.7 percent of Hispanics are uninsured; 25 percent of blacks (non-Hispanic) are uninsured; and 17.8 percent of whites (non-Hispanic) are uninsured.

Concerns related to health care access for undocumented immigrants remain an important challenge for Florida. Citizenship status may preclude many women in Florida from seeking prenatal care. This is compounded by cultural differences in the immigrant population. These women are often difficult to reach and to serve. Members of this population often reside in rural agricultural areas. Many rural areas in Florida lack sufficient transportation, health care providers, and delivering facilities. In these areas, it is also difficult to recruit and maintain staff that has the expertise necessary to deal with multi-lingual and multi-cultural populations. The number of Medicaid emergency alien deliveries have grown dramatically over the past nine years, from 4,556 in 1996 (amount paid by Medicaid $10,547,190.50) to 16,281 in 2004 (amount paid by Medicaid $65,353,093.46).

One important initiative in Florida to help reduce financial barriers for maternal health care services is the Family Planning Waiver Program. The Agency for Health Care Administration and the Department of Health worked together to implement this program to extend Medicaid coverage for certain family planning services. The Family Planning

Waiver Program was developed to reduce infant deaths, unplanned pregnancies, and to help families get family planning services after delivering a baby or having a miscarriage. Without the waiver program, women who had only Medicaid to cover their pregnancy are dropped from Medicaid 60 days after the birth of a child or miscarriage. With the waiver program, women with a pregnancy-related Medicaid payment are provided limited family planning services for up to 24 months after loss of Medicaid coverage. The program will be in effect until November 30, 2006.

The Family Planning Waiver Program provides the following services:

- annual physical exams including a pap smear and interconceptional counseling and education,
- birth control supplies,
- pregnancy testing if indicated,
- limited treatment for sexually transmitted infections, and
- related medicines and lab tests.

Program eligibility:

- Women who have lost full Medicaid coverage and had a pregnancy-related Medicaid claim within the past two years would be eligible for this program.
- To qualify for this special Medicaid program, a woman must:
  - want to have family planning services;
  - not be pregnant;
  - not have had a hysterectomy or tubal ligation (tubes tied); and
  - have a household income less than or equal to 185 percent of the federal poverty level.

Another important collaborative effort between the Florida Department of Health, the Agency for Health Care Administration, and the Florida Association of Healthy Start Coalitions resulted in the 2001 implementation of a Medicaid 1915(b) waiver to include Healthy Start service provision as a part of the amended MediPass Waiver. The Healthy Start Medicaid waiver has a dual purpose:

1. To provide more intensive Healthy Start services to Medicaid-eligible women and infants at highest risk.

2. To make it easier for all Medicaid-eligible women between 150 percent and 185 percent of the federal poverty level (SOBRA eligibility) to access the prenatal care they need through the MomCare program. MomCare is a new component of Healthy Start, focusing on assisting all newly Medicaid-eligible pregnant women in getting the care they need.

During state fiscal year 2002–03 (July through June), the Medicaid waiver Healthy Start Services component “drew down” approximately $10,088,549 in federal funds for Florida’s at-risk pregnant women and children. With this additional funding, the Healthy Start program was able to provide more needed Healthy Start services to clients.

The waiver also provided $3,830,272 in funding during fiscal year 2002–03 for MomCare. Through MomCare, women who are eligible for Medicaid during pregnancy

receive assistance in selecting a health care provider; keeping medical appointments; and obtaining WIC, Healthy Start, and other services through outreach and care management. MomCare has become an integral part of the maternal and child health service delivery system, working efficiently to link women to the services they need. As part of the Healthy Start waiver, pregnant women in Florida are able to apply for Medicaid using a simple, one-page mail-in application. Any health care provider (private physicians, clinics, hospitals, and public health agencies) can request a supply of applications for distributing to patients. The state now uses a streamlined process to review completed Medicaid applications, which must include proof of pregnancy. In most cases, eligible women receive their final determination in less than two weeks. The Healthy Start Medicaid waiver efficiently increased services to those most in need by building upon the existing infrastructure.

Financial issues also impact children's access to direct health care services. According to statistics compiled by the Annie E. Casey Foundation, 16 percent of children under age 18 in Florida were without health insurance for at least part of 2001, compared to a national rate of 12 percent. The Medicaid program provides insurance coverage for children that qualify. Infants qualify for Medicaid if their families' incomes are below 200 percent of the federal poverty level. For children age 1 to 6 the cut-off is 133 percent and for children age 6 to 19 the cut-off is 100 percent of the federal poverty level. There are several programs funded under the federal title XXI grant, such as Kid Care and Healthy Kids, to provide insurance coverage for children. However, these programs are not entitlement programs and enrollment is capped and offered only on a space available basis. The total enrollment in these programs is approximately 1,500,000 children (in 2004 Florida had approximately 3,689, 000 children ages 1-17).

According to the 2004 Florida KidCare Program Evaluation Report, between 2 percent and 9 percent of families enrolled in Title XXI programs felt the premiums they were required to pay were too much. In July 2003, Florida increased the premium for families from $15 per-family-per-month to $20 per-family-per-month for those receiving subsidized premiums. The Centers for Medicare and Medicaid services later determined that $20 per-family-per-month exceeded federal cost-sharing limits (5 percent of family income) for some families at or below 150 percent of the FPL. In October 2003, Florida reduced the premiums to $15 for those at or below 150 percent FPL and kept the premiums at $20 for those above 150 percent FPL. Analysis of the impact of this premium increase showed that prior to the premium increases, about 2 percent of children disenrolled from the Healthy Kids program monthly. Disenrollment increased after the July 2003 premium change to 3.6 percent in August 2003 and to 4.7 percent of children in September 2003. When the premiums were reduced, a decline in disenrollment was observed. Families with incomes at or below 150 percent FPL were 36 percent more likely to disenroll in the post-premium change period when compared to the pre-premium change period. Families in rural areas were 6 percent more likely to disenroll after the premium change than families in urban areas, even after considering the children's health status and family income. The 2004 Florida KidCare Program Evaluation Report stated that "Families are very sensitive to premium price increases and the impact of these increases could be experienced most strongly by children residing in families below 150 percent of the FPL, those residing in rural areas. . . Families may choose to forego health insurance for healthy children if they cannot afford the premium leaving their children vulnerable to a lack of preventive care and prompt treatment of acute health care needs. Caution should be exercised when considering premium increases for families."

In August 2003, the Governor's Task Force on Access to Affordable Health Insurance for Floridians was created. Final recommendations of the task force included the following:

- The establishment of small-employer purchasing pools
- Promotion of evidence-based medicine and healthy lifestyles
- Encourage development of local health care programs for uninsured
- Medicaid restructuring using a Health Insurance Flexibility and Accountability waiver
- Protection of safety-net providers, such as Federally Qualified Health Centers
- Encourage enrollment in the KidCare program
- Creation of health plans for uninsurables and HIPAA eligibles

Proposed federal budget cuts to some of the most basic mandatory and discretionary programs that serve low-income people could create serious hardships both for Florida and its low-income people. Proposed cuts to programs such as the Food Stamp Program, Medicaid, Supplemental Security Income (SSI), the Earned Income Tax Credit (EITC), Temporary Assistance for Needy Families (TANF), the Social Services Block Grant, and Head Start, among others, could mean that more of Florida's most vulnerable families will face even greater financial hardships in accessing both direct and enabling health care services.

The aforementioned proposed federal budget cuts could also mean less federal assistance to states for subsidized child care. As previously mentioned, lack of affordable childcare was the top choice overall when respondents to the FSU survey were asked about the *most important health care problems for infants, children and adolescents*. Florida's recently established Voluntary Pre-kindergarten Program may help to fill some of the gaps for childcare, but the program only serves 4-year-olds and there are still large unmet needs for children under 4.

Emerging Issues: Obesity has been an emerging issue nationwide over the past several years. Analysis of the Healthy Start coalition service delivery plans yielded the suggestion that curricula need to be developed and implemented by schools and community groups serving children (K-12) on the importance of good nutrition and a healthy lifestyle. When appropriate, the impact of obesity on future pregnancies needs to be incorporated into this curriculum.

As linkages have been made between poor dental health and overall health status, including cardiovascular health and pregnancy outcomes, access to oral health services has also become an emerging issue over the past several years. The 2004 Florida KidCare Program Evaluation report found that dental care is the largest unmet need for children post-enrollment in the program. Although dental care is included in the KidCare benefit package, about 15 percent of parents are reporting their children need this care but are not getting it. In 2004, the Public Health Dental program undertook a collaborative effort with partners throughout the state to develop an Oral Health Improvement Plan for Disadvantaged Persons. Using background information provided by the Department of Health, the work group created the following recommendations for the plan:

Recommendation 1: Improve access to community and school-based preventive programs – Lead Entity: Florida Department of Health

Recommendation 2: Improve access to community and school-based education programs - Lead Entity: Florida Dental Association/Florida Dental Health Foundation

Recommendation 3: Increase public and governmental awareness of oral health issues - Lead Entity: Florida Dental Association/Florida Dental Hygiene Association

Recommendation 4: Improve state and county-based oral health surveillance and research - Lead Entity: DOH/UF Dental School/Nova Dental School

Recommendation 5: Improve access to care by ensuring a highly-trained, diverse, appropriately allocated dental workforce - Lead Entity: Florida Dental Association/Florida Dental Hygiene Association/DOH Volunteer Program

Recommendation 6: Improve access to care by ensuring adequate statewide, publicly focused infrastructure and support programs - Lead Entity: Nova Dental School/AHCA

Recommendation 7: Improve the integration of oral health prevention and education into general health - Lead Entity: DOH/Nova Dental School/UF Dental School

Another notable emerging issue is the rising Cesarean (C-section) rate in Florida. The statewide C-section rate has risen steadily from 23.5 percent in 1998 to 32.7 percent in 2003. This is of special concern for women with no or inadequate health insurance, as the length of hospitalization and associated costs are much higher for women who undergo C-section.

Recently there has been a rise in Cesarean section upon demand from the patient. The medical community stands divided on this issue. The C-Section rates can be affected by various issues such as the size of the hospital, the time of day or week a woman presents in labor, and medical liability influences. A recent study has shown a relationship between the rise of primary Cesarean sections to the changes in maternal characteristics (age, parity, prepregnancy weight, weight gain in pregnancy, and smoking status) as well as changes in obstetrical practice (labor inductions, epidural anesthesia, delivery by an obstetrician, and midpelvic forceps deliveries.)

Prematurity has also become an issue of increasing concern over the past several years. In February 2003, the March of Dimes launched a special campaign focusing on prematurity by holding the Florida Prematurity Summit in Tampa. The conference was attended by approximately 150 doctors, nurses, and other health care providers; policy makers; researchers; and prominent leaders in the field of maternal and child health. The 28 member advisory committee for the campaign includes four representatives from the Florida Department of Health, including one member who also serves on the editorial committee responsible for producing the proceedings of the summit. This has enabled the department to make a substantial and continuing contribution to Florida's role in this nationwide March of Dimes campaign.

Availability of Care: The analysis of Healthy Start coalition service delivery plans cited a lack of long-term mental health care services, substance abuse treatment services for pregnant women, family planning services during the interconceptional period, and well-

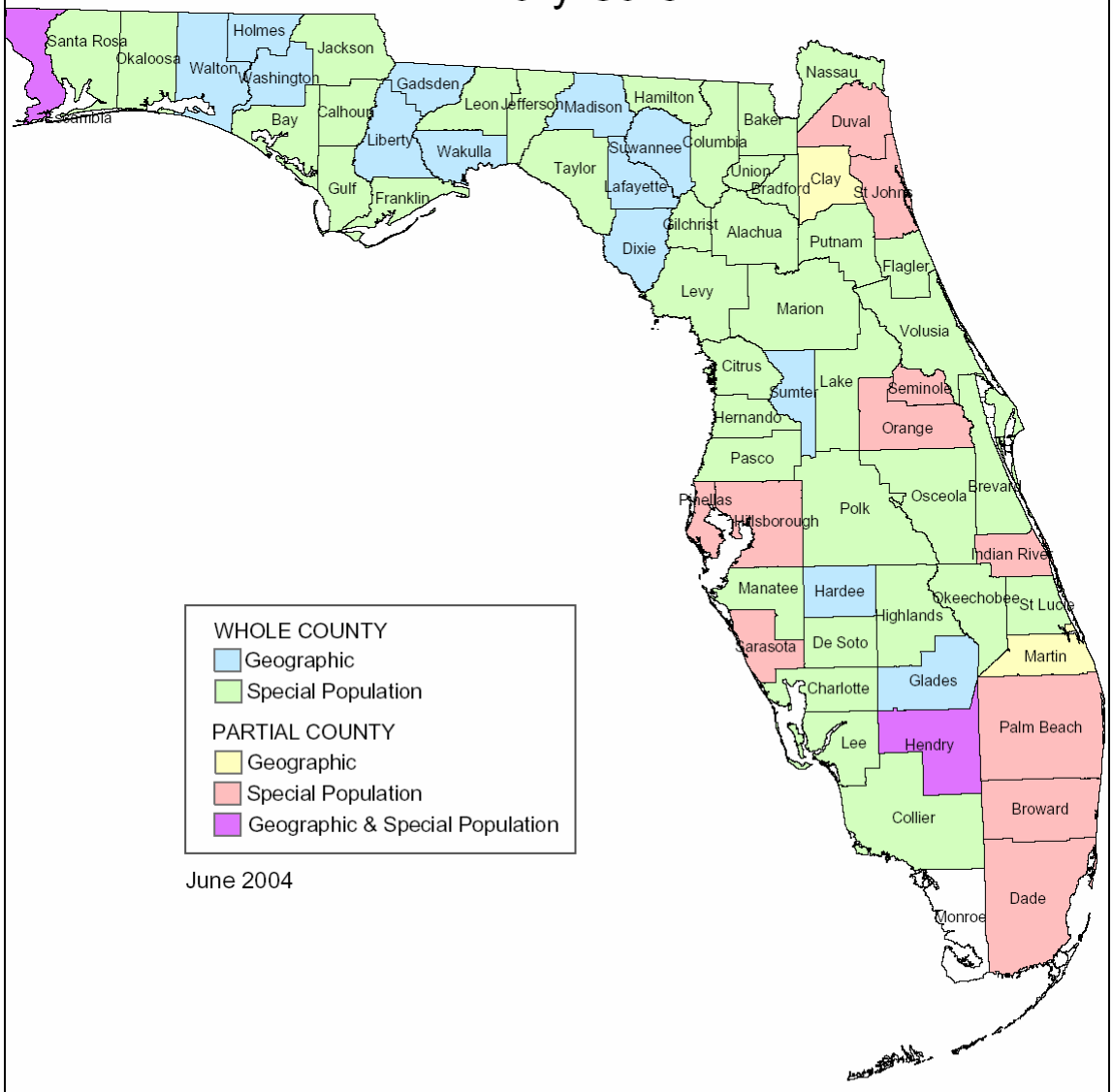
woman care during the preconceptional period. Reasons cited for these access issues include lack of providers and available staff, as well as limited clinic hours which make accessing care difficult for working mothers.

Access issues related to a lack of available providers and staff are especially acute in rural areas. In 2002, the Chipola Healthy Start Coalition conducted extensive interviews of local citizens, community organizations, physicians, and other providers. The coalition encompasses Calhoun, Holmes, Jackson, Liberty, and Washington counties, which are rural areas of the Florida panhandle. While the survey was conducted in a limited area, many of the issues raised are also issues in other parts of the state, particularly other rural counties. Important findings from these interviews included the fact that many women are unable to access prenatal care due to shortages of physicians, particularly specialists. A major concern in Florida over the past several years has been that of obstetricians/gynecologists ceasing obstetrics or moving out of the state due to the high cost of medical malpractice insurance. This issue hits especially hard in rural counties, where there are sometimes only one or two obstetricians serving a multi-county area. The Chipola study also identified an important issue related to enabling services in rural areas: lack of adequate education for parents, teens, and young people.

Linkages that Exist to Promote Provision of Services and Referrals: The network of local Healthy Start coalitions ensures appropriate linkages between agencies that provide services for pregnant women and at-risk children. Coalitions assess the community's ability to provide services such as nutritional assessment/counseling, psychosocial counseling, parenting education and support, childbirth education, breastfeeding education and support, and smoking cessation counseling. In some cases, Healthy Start coalitions are able to subcontract with established entities experienced in providing the needed services. If no appropriate established service provider exists, coalitions may obtain training for existing staff or hire staff to perform the services. In either case, the local coalitions ensure availability of services and provide appropriate client referrals to at-risk pregnant women and children. Healthy Start coalitions also maintain good working relationships with local Children's Medical Services personnel to help ensure children with special health care needs are also linked to appropriate needed services. Between 2000 and 2004, Florida has seen a dramatic increase in the number of smoking cessation services provided to pregnant women through the Healthy Start program. The number increased from 6,811 in 2000 to 14,281 in 2004. Another example is that of psychosocial services provided to at-risk pregnant women. The Healthy Start program reported 19,053 services provided in 2000, and 51,472 in 2004. Parenting education and support is another important need in Florida. Between 2000 and 2004, the number of parenting education and support services provided to pregnant women through Healthy Start increased from 7,869 in 2000 to 16,423 in 2004.

Existing Resources for Providing Community-Based Care, Specialty Care Through Pediatric Centers, Community-Based Specialty Clinics, and Multi-Disciplinary Centers: Florida continues to have challenges related to health care provider shortages. The following maps illustrate counties that are medically underserved and that have a shortage of health care professionals. In general, counties with large urban populations and/or university medical centers/teaching hospitals are more likely to have pediatric centers, community-based specialty clinics, and multidisciplinary care centers; however, even within most of Florida's largest cities, there are pockets of medically underserved individuals with little to no access to care.

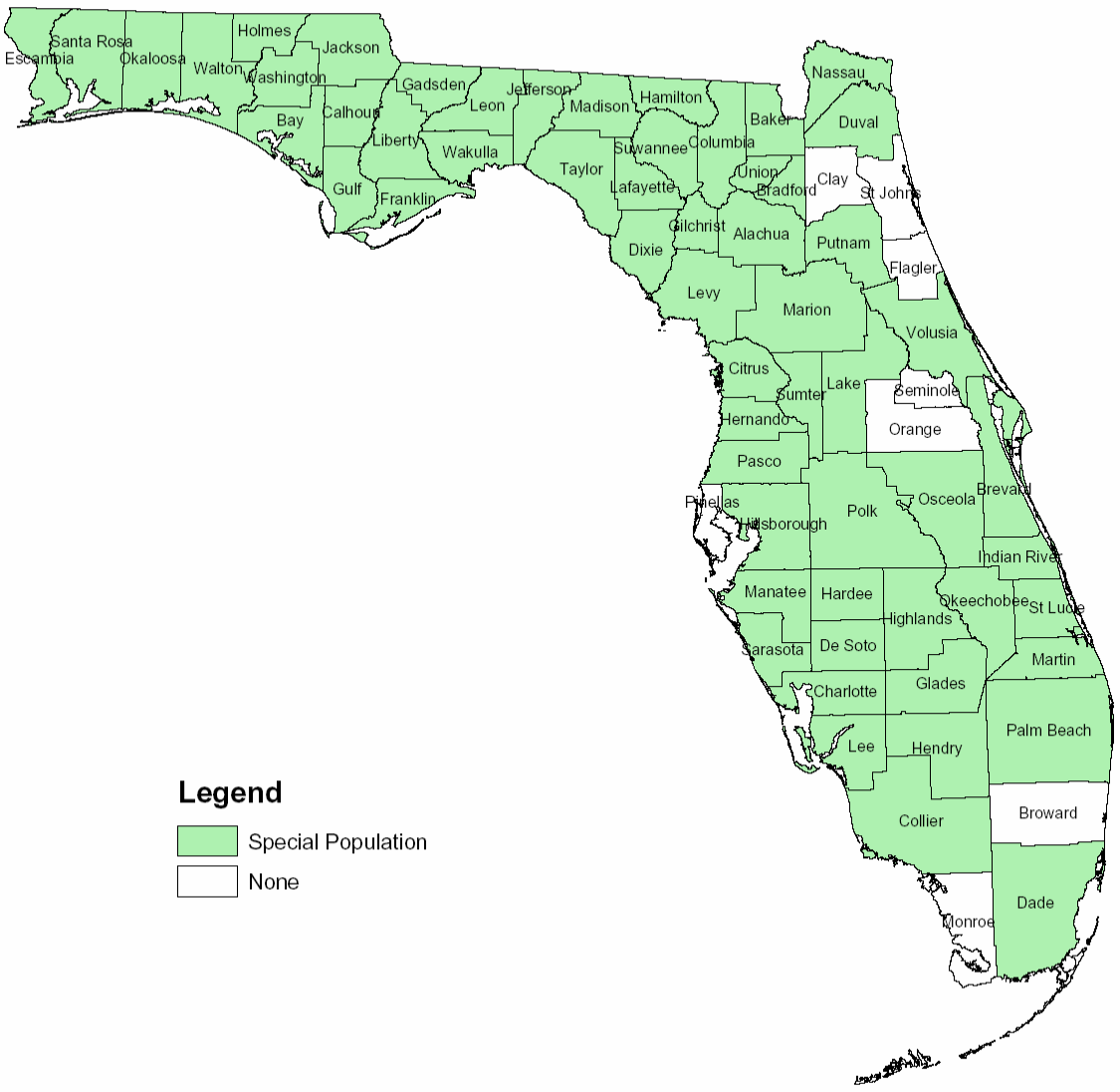
Health Professional Shortage Areas
Primary Care



June 2004

www.doh.state.fl.us/recruit

Health Professional Shortage Areas
Dental



June 2004

Health Professional Shortage Areas
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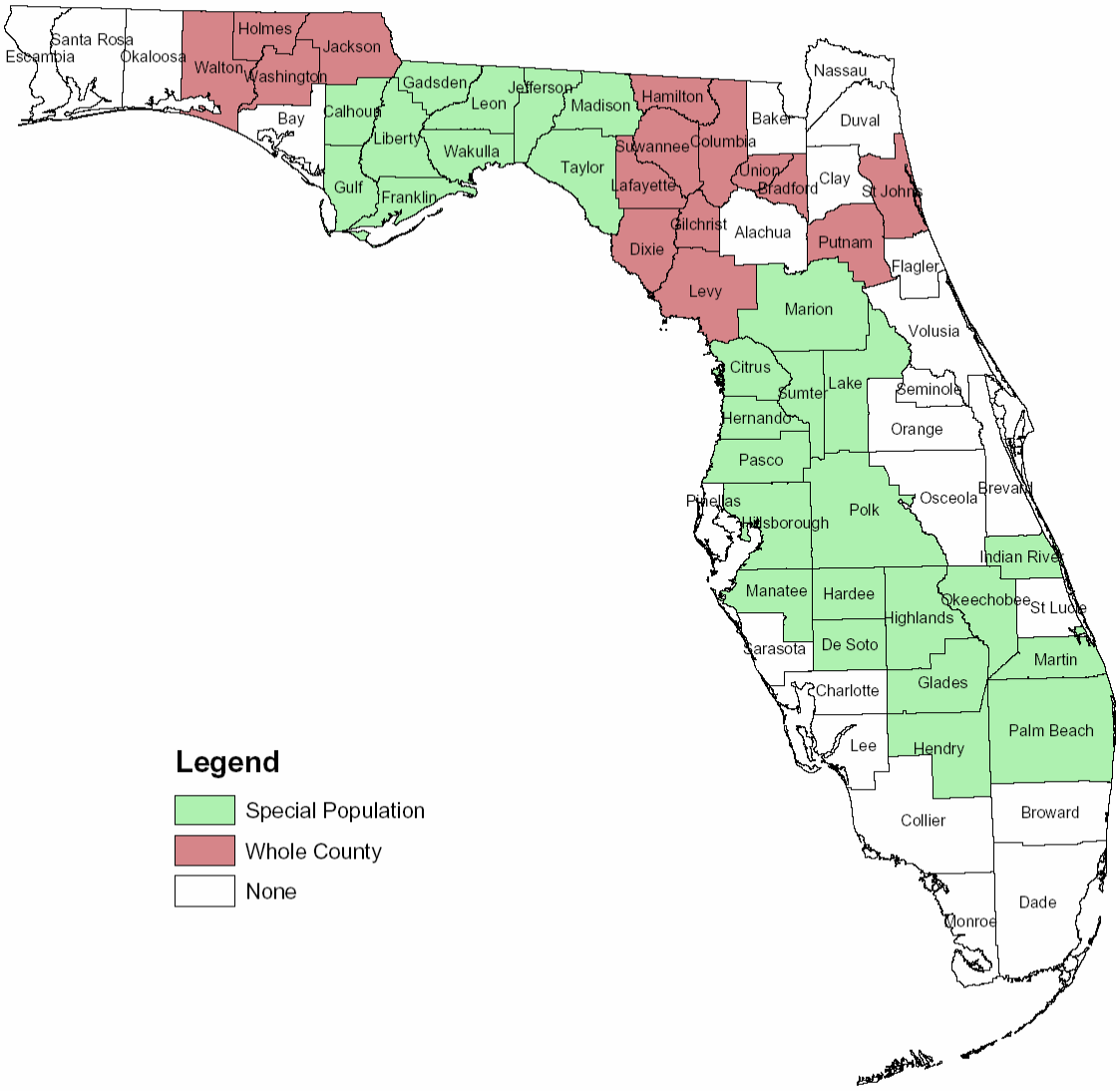
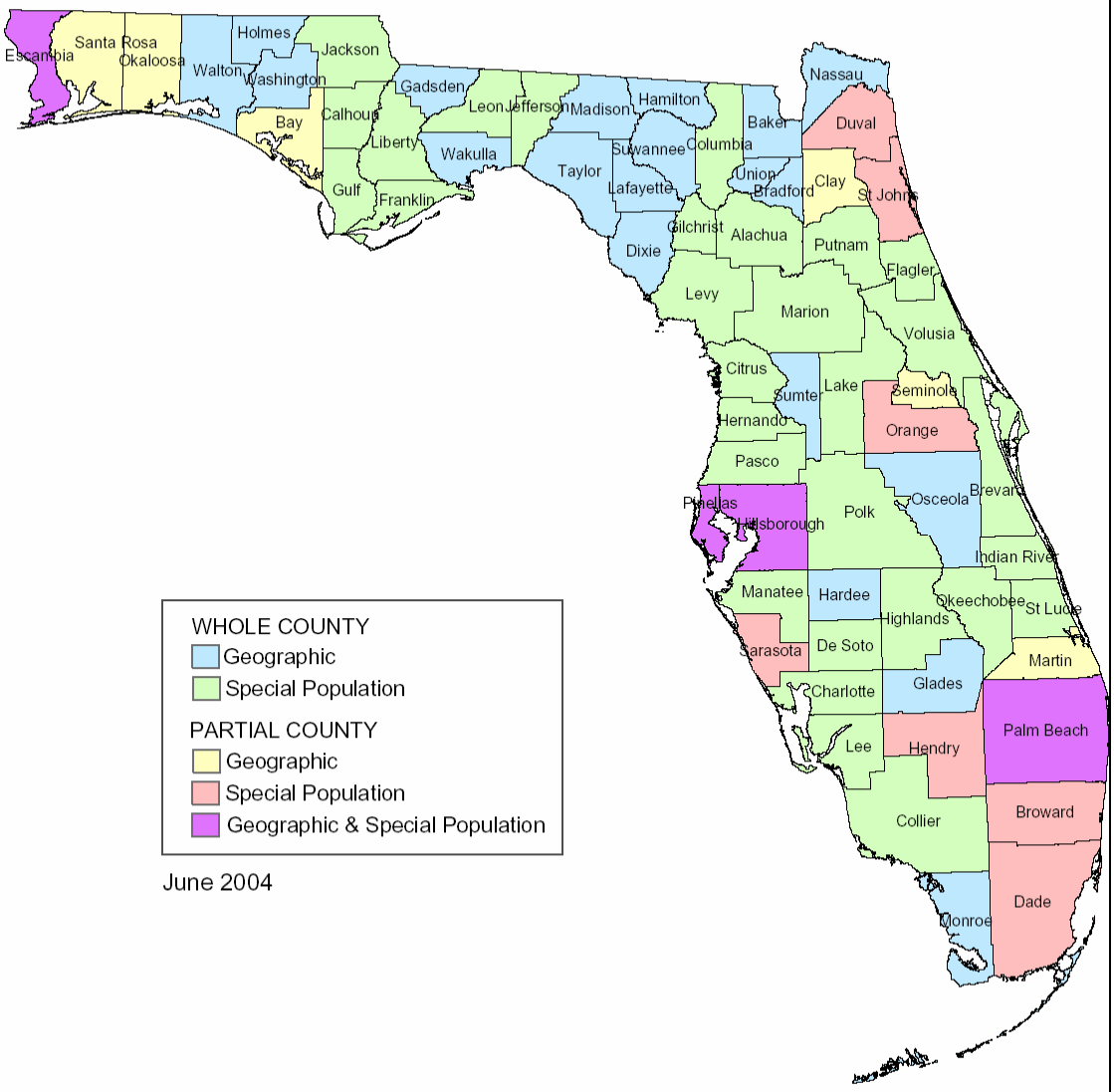


June 2004

Medically Underserved Areas
Medically Underserved Populations
MUA/MUP



June 2004

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Relationship of Title V with Others in the State Who Address Inadequate or Poorly Distributed Health Care Resources: The unique makeup of local Healthy Start coalitions ensures that the Florida Title V program maintains strong working relationships with others who address inadequate or poorly distributed health care resources. Healthy Start coalitions include members representing health care providers, hospitals, social service agencies, private businesses, and organizations such as March of Dimes and the United Way. The diverse make-up of these coalitions helps create coordinated systems of care that can meet the unique needs of local communities. In the event there is not a coalition, the local county health department assumes the responsibilities for the Healthy Start program. Currently, there are 31 coalitions covering 65 Florida counties.

During the 2003-04 fiscal year, Healthy Start coalitions reported leveraging almost $21.2 million in additional funds for the maternal and child health system, and another $2.6 million for in-kind services. Local coalitions work in partnership with local county health departments and the Florida Department of Health to develop programs and services that will work best in their community. Strategies that work in a large urban area may be very different than those that will be successful in a smaller rural county. Florida's rich cultural diversity creates unique challenges for providing health care services. Services must be delivered in a manner that is culturally appropriate and the delivery system must be able to accommodate many languages and dialects. Through allowing for a large degree of local input and local planning, plans to address inadequate or poorly distributed health care resources can be best tailored to meet local needs.

Population-Based Services

Healthy Start Screening: In addition to serving as a driving force for community-level, regional, and statewide assessment and planning for allocation of resources to serve the MCH population, Florida's Healthy Start program, through the statewide system of universal prenatal and infant screening, also serves as one of the most important population-based health initiatives; through prenatal and infant screening, particularly vulnerable pregnant women and infants are identified and their care coordinated to ensure they are linked with appropriate and available services in their area. The Healthy Start program is the common thread that links almost all direct health care services, enabling services, population-based services, and infrastructure-building activities related to maternal and child health in Florida.

Healthy Start is a statewide initiative designed to reduce infant mortality, reduce the number of low birth weight babies, and improve health and developmental outcomes. Healthy Start primarily identifies women and infants at high risk for poor outcomes, provides a professional assessment of their needs, identifies resources, and provides timely and important linkages, referrals, or services to reduce the risk of poor birth outcomes among pregnant women, infants, and children up to age three, as well as to reduce poor infant development. The Department of Health works in collaboration with the Florida Association of Healthy Start Coalitions, local county health departments, Children's Medical Services, and other key partners to ensure the development and implementation of public health interventions. Healthy Start services are provided in all 67 Florida counties through local coalitions that include health care providers, hospitals, consumers, social service agencies, private businesses, and charitable organizations such as the March of Dimes and United Way. The success of Florida's Healthy Start program demonstrates that Florida is well-equipped to provide population-based services for pregnant women, infants, children, and children with special health care

needs.

During calendar year 2003, 212,243 infants were born to women in Florida. The Healthy Start program screened 108,218 pregnant women and 149,644 infants, and identified 92,167 women and infants at risk for poor outcomes. The program provided 1,468,517 services to 98,104 pregnant women and 900,972 services to 67,307 infants, which includes families identified prior to 2003. This represents an increase of 4,512 in the number of women served, and an increase of 261,007 in the number of services provided to pregnant women, an increase of 2,144 in the number of infants served, and increase of 104,600 in the number of services provided to infants over the numbers served during fiscal year 2002. There were 37,922 at-risk families that Healthy Start providers were unable to contact.

One continual challenge for the Healthy Start program is to improve screening rates. Several coalitions held focus groups during 2004 to discuss the limitations of the prenatal screening procedures. Findings of these focus groups will be used to inform the development of strategies aimed at increasing the screening rate. Additionally, staff from the IMRH unit participates on the *Healthy Start Screening Strategy Workgroup*, which has worked to revise the prenatal and infant screening brochure used statewide to provide information to providers and citizens about the importance of Healthy Start screening.

Childhood Immunizations: As previously mentioned in the health status indicators section of this report, the immunization rate in Florida for 2-year-olds fell sharply in 2003 before rebounding in 2994. Probable causes for this drop included: immunization registry not fully implemented for access with private health care providers; partnership with WIC not fully implemented for all health care providers; and the residual impact of the 2001-2002 national shortage of diphtheria, acellular pertussis, and tetanus vaccine (DTAP). In response, the Secretary of the Department of Health called for an increased emphasis on raising the immunization rate through an initiative called “85 by 05.” County health departments were asked to develop a countywide plan for raising the immunization rate in their area. They were directed to reenergize their immunization programs, and to work with WIC, local medical societies, CMS, and others to develop then implement their plans.

Through this initiative, the Florida Department of Health seeks to further integrate the efforts of public health departments and private sector physicians to raise immunization rates for all children. The goals of the initiative are to continue to protect children from vaccine-preventable diseases, promote awareness of early childhood immunizations, to establish an Early Childhood Immunization Action Network, and to further develop broad-based support for early childhood immunizations. Additionally, plans to improve and expand data collection systems for childhood immunizations are underway. The statewide early childhood immunization initiative will continue until immunization rates reach and exceed the goal established by the Florida Secretary of Health.

The Florida Vaccines for Children Program (VFC) also helps ensure more 2-year-olds are properly immunized. The VFC is a public-private partnership that has improved the health of Florida's children by encouraging comprehensive children's health care in a medical home through facilitating timely and appropriate childhood immunizations. The program is federally financed, and is administered in Florida by the Department of Health Bureau of Immunization. The program, which began in 1994, distributes over

$60,000,000 worth of vaccines to private physicians, hospitals and other public and private health care providers annually throughout Florida. Private health care providers enrolled in the VFC Program can provide free vaccines to uninsured children and others who cannot get recommended vaccinations without financial assistance. This encourages children to remain in their medical home, ensuring continuity of care. Providers also receive technical assistance from the Department of Health to help improve their vaccination rates, such as record-keeping, vaccine handling, and reducing missed vaccination opportunities.

Additional infrastructure designed to increase immunization rates is provided by Florida SHOTS. SHOTS is a statewide centralized electronic immunization registry that helps parents and health care providers keep track of immunization records. Florida SHOTS helps ensure that the required immunization records for children entering child care facilities and schools are easy to locate. Additionally, Florida SHOTS helps interpret complex immunization schedules, while keeping track of immunization records. The application also generates official immunization records for registered patients, and will soon help manage vaccine inventories, and generate reminder recalls.

Pregnancy Associated Mortality Review and Fetal and Infant Mortality Review (FIMR): Florida continues to maintain a statewide pregnancy associated mortality review and several local FIMR projects. The Department of Health has provided support and guidance to community FIMR projects since 1993. Funding constraints have resulted in approximately half of Florida counties not being covered by a FIMR project.

Infrastructure-Building Services

State's Capacity Related to This Level of the Pyramid: Staff of the Florida DOH IMRH unit, as well as Children's Medical Services staff, recognize the importance of infrastructure-building in ensuring long-term success, and in helping to anticipate and meet the needs of the MCH and CSHCN populations. Efforts are made to maintain existing relationships and forge new ones with other DOH departments, other governmental agencies, private organizations, and volunteer organizations that might have an interest in or impact on the health of these populations.

How Local Delivery Systems Meet the Population's Health Needs: As previously discussed, local Healthy Start coalitions are responsible for assessing available resources, identifying needs, and allocating resources accordingly, in order to effectively meet needs and reduce duplication of services. The Children's Medical Services Network serves a similar role in meeting the needs of children with special health care needs. Children's Medical Services staff works closely with families to assist them with renewal requirements so they maintain their coverage. Governor Jeb Bush signed into law legislation that improves access to Florida KidCare by providing year round open enrollment. CMS monitors legislative developments closely and works with other Florida KidCare program partners to implement any new program or policy changes.

Behavioral health needs are met through the CMS Behavioral Health Network for CMS enrollees with Title XXI coverage. The CMSN ensures continuity of care between behavioral and physical health services. The Behavioral Health Network is available for children who have severe behavioral health needs, are between the ages of 5 and 19, and reside in families who are between 101 percent and 200 percent of the federal poverty level. Services are provided through the CMSN in conjunction with the

Department of Children and Families. For children who are Medicaid-eligible, Medicaid covers these services.

The CMSN has contracted with the Florida Institute for Family Involvement (FIFI) to provide resources and input on issues that include the provision of family-centered care and family satisfaction. Many of FIFI's responsibilities under this contract have been carried out by the Family Health Partners (FHPs) who subcontracted with FIFI and were assigned to CMS Area Offices. FHPs continue to work with families to better understand their issues and needs, resolve conflict, and assist in navigating the system of care. They work in partnership with CMS professionals to ensure a family-centered environment in all CMS Area Offices. The CMS contract with FIFI ended in June of 2005 and CMS is releasing a request for proposals to ensure these issues continue to be addressed.

The CMSN contracts with the Mailman Center for Child Development at the University of Miami for Family-Centered Intervention and Management. This contract includes training of health care professionals. An electronic survey of CMS staff to determine training interests and needs was conducted in the spring of 2004 and identified topics for care coordination training that will better assist CMS staff in staying up-to-date with medical and family issues. The presentations are then developed by the appropriate Mailman Center staff and provided as web-based training to all CMS staff.

The CMSN contracts with the University of Florida Institute for Child Health Policy (ICHP) for family and provider satisfaction surveys. The ICHP staff is currently conducting a telephonic survey of over 2,000 families with children enrolled in the CMSN. In last year's survey, families continued to express high regard for care coordination in the surveys and a review of data has shown that most CMS families were receiving the services they need in a family-centered environment. Results of the current satisfaction survey will be available by August 2005.

CMS is awaiting the release of the survey results from the 2005 Child and Adolescent Health Measurement Initiative. In the 2001 National Survey of Children with Special Health Care Needs, Florida's successfully achieved: Outcome #1: Families of CYSHCN will partner in decision-making and will be satisfied with the services they receive at 69.4 percent compared to 74.3 percent nationwide; Outcome #2: CYSHCN will receive coordinated, ongoing, comprehensive care within a medical home at 46.9 percent compared to 52.7 percent nationwide; Outcome #3: Insurance adequate for CYSHCN at 54.4 percent compared to 59.6 percent nationwide; and Outcome #5: Community-based service systems organized for easy use at 69.4 percent compared to 74.3 percent nationwide.

Beginning in 2005 CMS Area Offices will begin submitting quarterly data for the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs. CMS anticipates that analysis of the data will provide useful information in measuring the six outcomes among the 22 CMS Area Offices as well as against state and national data.

The Institute for Child Health Policy prepared its year six evaluation of the Florida KidCare Program, *the Florida KidCare Program Evaluation Report, January 2005*, which covers the period from July 1, 2003 through September 30, 2004. The ICHP conducted 2,772 interviews with families to assess the experiences of new enrollees, established

enrollees, and disenrollees. The interviews showed the program continued to grow with a total enrollment of 1,550,936 children as of June 30, 2004, a 3 percent increase over the preceding year, and once again reflected a very high satisfaction rate with the program and its services. CMSN serves 83 percent of children with special needs who are enrolled in KidCare, which indicates there are some children with mild to moderate special health care needs enrolled in the other KidCare program components. This points to the possibility that the KidCare Program may experience higher than expected health care costs and must be attentive to the quality of the provider network to ensure appropriate access to specialists.

The Florida KidCare Program Evaluation Report, January 2005 indicates that the percentage of respondents who had children with special health care needs enrolled in the CMSN had the following changes in unmet health care needs in FY 2003-2004 prior to and after KidCare enrollment:

Health Care Need	Unmet prior to KidCare enrollment in CMSN	Unmet after KidCare enrollment in CMSN
Preventive Care	9.8 percent	1.2 percent
Surgical Care or Medical Procedure	20.0 percent	9.6 percent
Specialty Physician Care	16.7 percent	4.4 percent
Prescription Medication	3.4 percent	0.4 percent
Dental	35.7 percent	15.2 percent

Data collection from each of the CMS 22 area offices for the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs began in January 2005. Over time, as these reports are analyzed, CMS will be able to better identify strengths and challenges of meeting the national performance measures. Recently implemented, the new measurement system is too new to be able to report resulting data. Using the new measurement system, CMS Area Offices will continue to gather data and compile reports that will identify children at risk for and with special health care needs, utilize quality of care measures, and track health expenditures and costs of services. The results will be included in future reports.

Coordination Efforts with Other Organizations and Groups: As mentioned throughout this report, the Infant, Maternal, and Reproductive Health unit engages in many collaborative activities aimed at improving maternal and child health. One example of such a collaboration is the Florida Perinatal Periods of Risk Practice Collaborative Project. The Florida Perinatal Periods of Risk Practice Collaborative was undertaken in 2002 to impact the Florida's maternal and child health system through engaging in three activities: (1) identifying specific populations of pregnant women and babies with the greatest opportunity for improvement in key Florida communities; (2) developing capacity and expertise within Florida's maternal and child health system to fully utilize the PPOR approach by expanding the number of professionals well versed in it's practical application; and (3) to provide data to assist key figures in Florida's maternal and child health system to develop consensus regarding priorities and services, to identify public policy implications of findings, to identify joint assets and develop strategies and to address identified needs at the state and local levels.

The purpose of Florida's PPOR Practice Collaborative was to implement a PPOR initiative in the seven largest counties in Florida, in an attempt to bring about key

changes in the maternal and child heath system. The membership of the Florida practice collaborative consisted of representatives from the seven counties in Florida with the highest number of births: Dade, Broward, Palm Beach, Duval, Orange, Hillsborough, and Pinellas counties. Prior experience indicates that improvements in the outcomes for these geographic areas impact the state's statistical data on health indicators such as infant mortality. Each community had representation from the local county health department and a Healthy Start coalition. In addition to these partners, the Department of Health played a key role. Representatives from the IMRH Data and Evaluation team assisted with training and supporting local communities.

The project was a replication of a National Practice Collaborative in which three of the Florida partners had participated. The national offices of the March of Dimes, CityMatCH, and the Centers for Disease Control sponsored the National Practice Collaborative. The State Chapter of the March of Dimes funded the Florida replication project. CityMatCH and the CDC provided technical assistance and support to the Florida project.

Approximately 25 participants met quarterly for instruction and planning over a one year period from March 2002 to April 2003. Findings from the data analysis revealed that the greatest opportunity for improvement in birth outcome would be achieved by a greater focus on the health status of women prior to conception.

As a result of these findings, DOH implemented a number of changes designed to impact the health status of women prior to and between pregnancies. These activities included the development of a pilot project and subsequent protocol for services described as interconceptional education and counseling. In this model, 10 areas of risk are identified. These are defined as poor nutrition (overweight or underweight, anemia, etc), lack of physical activity, smoking, lack of routine health care (including but not limited to family planning), substance use or abuse, chronic high blood pressure, mental health issues, and environmental risk factors (exposure to chemicals). Two assessment tools have been used to develop educational intervention. These tools are a women's health questionnaire and the *Tell us About Yourself* psychosocial screening form.

Another example of coordinated efforts between the Department of Health and other groups is the positive working relationship maintained between DOH and the Florida Area Health Education (AHEC) network. The AHEC network is comprised of AHEC Programs based at each of the five medical schools in Florida and 10 AHEC community-based centers. In fiscal year 2003-2004, the members of the AHEC network shared state funding totaling $12.2 million. These funds provided clinical rotations of health professional interns and residents through rural and medically underserved communities, in partnerships with community health centers, county health departments, migrant health centers, and other community based primary care facilities. Additionally, AHECs provided these same communities with health promotion and disease prevention programs, continuing education hours for licensed health professionals, health professional retention and recruitment initiatives, health careers programs for youth, and library and technical support services for community-based health professionals. In recent years, AHEC has been increasingly involved in cardiovascular, obesity, tobacco prevention and cessation, breastfeeding, and other health initiatives that have direct impact on maternal and child health. The AHEC Community Health Care Worker Breastfeeding Training project began in December 2003 with a four-day *Train the Trainer* workshop held in Ft. Lauderdale. At this training, selected community health

care workers spent four days learning the skills needed to train new community health workers in a curriculum developed by the La Leche League. Subsequently, more than 90 community health care workers were trained who, in-turn, conducted 140 community presentations on breastfeeding and cardiovascular health to over 800 people.

There are also strong collaborative efforts between Healthy Start, WIC, and local immunization programs. Pregnant women and children with nutritional needs are referred and linked to local WIC programs. While at WIC visits, children's immunization records are assessed and children needing immunizations are referred to county health department immunization clinics. This often takes place on the same day, especially at those health departments in which WIC and the immunization clinics are co-located.

Over the past several years, the importance of depression screening for pregnant women and new mothers has been stressed. The Department of Health put on a statewide conference which focused on depression in women of child bearing age. We have updated our DOH health history forms, technical assistance guidelines, and our psychosocial screening tool to include screening questions for depression. A number of health departments obtained grant funding to begin screening pregnant and postpartum women for depression and providing either in home or clinic-based treatment services. Depression information has been included in the newly developed interconceptional care curriculum and group pregnancy care curriculum.

A representative from the DOH Office of Injury Prevention participates on the Governor's Suicide Prevention Task Force. The department established an internal work group made up of headquarters staff from different programs as well as health department staff to examine the role of the department in suicide prevention. Training on suicide and depression was provided at the statewide Public Health Nursing Directors meeting held in April 2005. Training sessions were provided on the importance of depression screening, available screening tools, and models for integration of depression screening and intervention into primary care. Training was also provided on suicide and suicide prevention strategies.

In order to increase the number of children who are receiving developmental screening, the department is training health department and Healthy Start staff on the use of the *Ages and Stages Questionnaire*. Healthy Start coalitions are reaching out to pediatricians to encourage referrals of at-risk children. DOH staff has also been participating in meetings with Florida Medicaid to explore new funding strategies for enhanced pediatric care services to include developmental screening, psychosocial screening of parents, and expanded anticipatory guidance.

A member of the Infant, Maternal, and Reproductive Health Unit has been participating in an 11-month training program for infant mental health therapists through the FSU Harris Institute for Infant Mental Health Training. Information from this institute will be utilized to develop enhanced training for home visitors in the Healthy Start programs.

Another exciting partnership to improve the health of preconceptional and interconceptional women is the Florida Vitagrant project. The March of Dimes Florida Chapter was awarded a $2 million grant from the Florida Attorney General's Office as a result of a settlement with multiple vitamin manufacturers. In June 2004, as a result of this grant, the March of Dimes partnered with the Florida Department of Health, the Florida Folic Acid Coalition, and the Florida Birth Defects Registry to promote the use of

folic acid in women of reproductive age throughout Florida. To facilitate greater awareness and consumption of folic acid in women of child bearing age, up to 450,000 multivitamins containing the recommended daily allowance of folic acid (400 micrograms) will be distributed free to non-pregnant women.

Recognizing the need and opportunity to provide more comprehensive preconceptional and interconceptional health education, the project promotes preconceptional and interconceptional issues awareness through training and educational materials. The vitamins and materials are distributed through multiple sites including family planning clinics, WIC clinics, Healthy Start providers, Early Head Start and Head Start Providers, community health centers, faith-based organizations, and other community partners. Vitamin and materials distribution began in January 2005 and will continue for three years or until all of the vitamins have been distributed. Interim evaluation reports will be available each year, describing the project's implementation progress and progress towards meeting process measure goals. The final evaluation report will include quantitative data on the ability to influence the knowledge and behavior of women of childbearing age in consumption of folic acid through provision of free multivitamins. At least three sites are included in the data collection for the project evaluation.

Infrastructure-Building Through Development of Standards of Care and Guidelines for Care: One of the CAST-5 competencies relates to the ability to promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being. In general, Florida was rated as being "partially adequate" for this indicator. Key opportunities for improvement included:

- Need to participate in processes led by professional organizations and other state agencies to provide MCH expertise in the development of licensure and certification processes
- Provide leadership to develop and promulgate harmonious and complementary standards that promote excellence in quality care for women, infants, and children, in collaboration with professional organizations and other state agencies with regulatory capacity as appropriate
- Participation with AHCA in selection of HEDIS

Another CAST-5 competency related to the development of standards of care is the ability to support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems. Florida was rated "partially" to "substantially adequate" in performance of this competency. Key opportunities for improvement included:

- Need to monitor progress of specific national MCH research and disseminate results to private and public health providers and policy makers
- Need to serve as source for expert consultation to MCH research endeavors in the state

Efforts to Monitor Program Effectiveness, Evaluation of Care, and Continuous Quality Improvement for Each MCH Population Group: Progress toward improving maternal health, reduction of infant mortality, and low birth weight is monitored at both the state

and local levels. The Department of Health provides an annual infant mortality health problem analysis for each county. The health problem analysis is a snapshot in time of the county's maternal and child health status. This tool includes data trends for infant mortality, low birth weight, and their contributing factors. The analysis also provides programmatic service information and data for related indicators such as early entry into prenatal care rates for the area. The health problem analysis, when used with the local coalition's service delivery plan, allows a county to set community specific goals for service delivery and develop special projects as the data indicates.

One of the CAST-5 essential services we evaluated was the ability to assess and monitor maternal and child health status to identify and address problems. In general, Florida was rated as being "substantially adequate" for this indicator.

For the CAST-5 essential service concerning diagnosing and investigating health problems and health hazards affecting women, children, and youth, Florida was also generally rated to be "substantially adequate." Notable weaknesses identified include:

- There are only two people at DOH headquarters to monitor lead toxicity issues statewide
- State Child Abuse team has requested expansion based on annual report but the legislature has not approved expansion
- Fetal and Infant Mortality Review projects do not exist in all communities

Staff from IMRH routinely performs on-site monitoring visits of both Healthy Start coalitions and local county health departments to assess program effectiveness, quality of care, and local efforts at continuous quality improvement for each MCH population group. While on-site, IMRH staff performs such tasks as reviewing local MCH data trends with CHD and coalition staff, reviewing clinical records in order to examine quality of care, and reviewing local client satisfaction survey results. At the end of these visits, positive accomplishments are noted, and areas for improvement are agreed upon by IMRH staff and the local CHD or coalition staff whom they are visiting. Formal reports for these site visits are written and presented to both state and local parties with an interest in maternal and child health.

Healthy Start coalitions play an important role in quality improvement and quality assurance. Healthy Start coalitions routinely perform on-site monitoring visits of all Healthy Start service providers to assess quality of program services and staff training, and to obtain provider input into the program. Pre-monitoring activities involve a review of service data and contract reports. While on site, coalitions interview front line and supervisory staff, review personnel training, review Healthy Start participant service documentation records, and review local client satisfaction survey results. Written monitoring reports, outlining both accomplishments and challenges, are sent to each provider and to the Department of Health.

The department and the local Healthy Start coalitions both have a role in ensuring the quality of Healthy Start services. The department has incorporated many quality assurance activities into their contractual relationship with the coalitions. Program reports are analyzed by the coalition staff and submitted on a monthly schedule to the department. Healthy Start providers are required by contract to perform quality assurance reviews on a quarterly basis and submit the results to the coalitions. Many

Healthy Start coalitions participate in these quarterly reviews, in addition their scheduled monitoring of the provider.

Efforts to Monitor the Development of Community-Based Service Systems: Through close working relationships with both local Healthy Start coalitions and local county health departments, staff of Florida's IMRH unit is often involved during the inception of new community-based service systems. One example of this is the development of a group prenatal care pilot project; the goal of the project is to help increase access to prenatal care. A Group Prenatal Care workgroup was formed and is led by an IMRH registered nurse. Currently the group is working on development of a script for consent for clients participating in the project, development of a curriculum for the project, and development of a guidebook to be used by group prenatal providers. Attention to current standards set forth by groups such as the American College of Obstetricians and Gynecologists (ACOG), and requirements set forth by the Medicaid program, have been integral throughout the project's development.

C. Needs Assessment Summary

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

1. Improve preconceptional and interconceptional health and well-being.

2. Decrease racial disparities in maternal and child health outcomes.

3. Increase access to health care for the maternal and child health population, including children with special health care needs.

4. Decrease maternal, infant, and child morbidity.

5. Decrease maternal, infant, and child mortality.

6. Decrease risk factors associated with poor maternal and child health outcomes.

7. Decrease teen pregnancy.

8. Ensure consumer-friendly, culturally competent systems of care.

9. Increase statewide and local data and analysis capacity.

10. Increase awareness of public health preparedness issues unique to the maternal and child health population, including children with special health care needs.

While similar to the priorities from previous years, there are some important distinctions in the 2005 list of identified priority needs. While previous year's application had focused on the outcome measures of infant mortality and low birth weight, this assessment resulted instead in the selection of addressing risk factors associated with those outcomes. This also led to the addition of attention on preconceptional and interconceptional health which replaced a former issue related to maternal infections. Likewise, maternal health was included in the priorities focusing on mortality and

morbidity. The priorities also include a broader focus on racial disparities, where before the racial disparity issues were related only to infant mortality. This is in line with the Florida Department of Health's larger efforts to address racial disparities in all health outcomes. Another priority area was added to address access to care with the provision of consumer-friendly, culturally competent systems of care. Attention to this area should decrease barriers to care, and increase capacity to reduce racial disparities. Finally, the 2005 list of priorities includes increased awareness of public health preparedness for the maternal and child health population. Through our experience with Anthrax events and more recently with the 2004 hurricane season, it has become increasingly evident that in times of public threat, there are issues unique to the maternal and child health population that must be given special attention.

Selection of priority needs for this assessment included the consideration of quantitative and qualitative data. Although both have been considered in the past, there was substantially more input from key stakeholders, direct service providers, and especially consumers with the addition of the survey performed by the Florida State University. Additionally, a needs assessment advisory group was formed that consisted of key partners in maternal and child health as well as consumer representation. This advisory group made initial recommendations using a nominal group process. There was consensus among the group especially around the issues of preconceptional and interconceptional care, racial disparity, and access to care issues. After the advisory group provided recommendations, maternal and child health staff met for a final review of data, both quantitative and qualitative, and the recommendations from the advisory group. Staff members identified three additional areas of need for the list of priorities. This included the provision of consumer-friendly culturally competent care, the awareness of public health preparedness for the maternal and child health population, and the addition of reduction of teen pregnancy. Although the data shows a downward trend in teen pregnancy, the team felt that this is a state priority and was also identified in the survey data as a top priority for all three groups surveyed.

The formation of the needs assessment advisory group and the comprehensive survey provided new avenues for collaboration among key constituents and partners. The local county health departments were instrumental in ensuring the high number of consumer respondents for the survey, more than ever before. This has been a particular challenge in previous applications, and serves a unique strength for this one. University and agency partners were also key contributors to the needs assessment process, helping not only to identify priority areas, but assisting in the developing of criteria in the selection of the priority areas. Criteria included selecting areas that will most likely have impact on the health outcomes for the maternal and child health population, choosing areas that are amenable to local level interventions and areas that can have a synergistic effect on maternal and child health outcomes and systems of care. Although the group felt strongly that evidence-based decision making was desirable, the feedback of consumers was also heavily weighed in the final decision-making process.

Quantitative data quickly pointed the group to the areas of racial disparity and preconceptional and interconceptional care. The rise in chlamydia is an example of the data that supports the need for attention to women's health prior to and between pregnancies. The Perinatal Periods of Risk analysis that has now been conducted for five years of data in Florida also provides evidence for the need to focus on maternal health issues. The Title V agency has begun to prepare for this shift to a lifespan approach to women's health. Capacity is being developed through the work of the new

women's health grant to increase collaboration among providers of women's health services, and is also being expanded through the development of standards and guidelines for the provision of interconceptional care through the Florida Healthy Start program. The identification of these 10 priority areas also provides support for local communities as they identify additional funding sources for service provision to the maternal and child health population. Community members suggested that having these areas identified assists in their local planning and submission of grant applications.

D. Health Status Indicators

Provisional data for 2004 indicates a statistically insignificant increase in the percentage of births where the infant was delivered at a low birth weight, 8.5 percent in 2003. Since 1999, this rate has fluctuated between a low of 8 percent in 2000 and the final rate for 2003 at 8.5 percent. The percentage of singleton births that were low birth weight remained at the same rate as 2003, which was 6.8 percent. Since 1999, this rate has fluctuated slightly between a low of 6.5 percent for 2000 and 6.8 percent. Provisional data on very low birth weight deliveries indicates that percentage also remained the same between 2003 and 2004, at 1.6 percent. This indicator has remained steady, with 1.6 percent reported for every other year 1999 except 2000 when the rate dipped slightly to 1.5 percent. Very low birth weight among singleton deliveries has also remained fairly constant, at either 1.5 percent or 1.6 percent for each of the past five years.

The death rate per 100,000 due to unintentional injuries among children age 14 and younger fell steadily between 1999 and 2002, going from a rate of 12 per 100,000 in 1999 to 10.5 in 2002, before climbing to 11.3 per 100,000 in 2003. Provisional data indicates a rate of 9 per 100,000 for 2004, but the rate is likely to increase when the data becomes final. Fatal unintentional injuries among children 14 and younger due to motor vehicle crashes have been falling steadily, from a five-year high of 4.7 per 100,000 in 1999 to 3.6 per 100,000 (provisional) in 2004. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth 15 through 24 peaked at 31.8 per 100,000 in 2000, has been declining slightly every year since then, to the current provisional rate of 27.0 for 2004, which is also likely to rise as data becomes final. Data on nonfatal injuries among children 14 and younger were lowest in 1999 at 221.1 per 100,000, rising to a five-year high of 246.8 per 100,000 in 2002. Over the past five years, the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children 14 and younger was also lowest in 1999 at 34.2 per 100,000, with a peak of 37.4 in 2002. The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth 15 through 24 was 138.6 per 100,000 in 1999, with the 2002 rate of 159.6 per 100,000 being the highest rate over the past five years.

Over the past five years, the rate per 1,000 women age 15 through 19 with a reported case of chlamydia has varied between a low of 22.9 per 1,000 in 2000 and a high of 26 per 1,000 in 2002. Provisional data for 2004 indicate an improvement over 2003, with a provisional rate of 24.1 per 1,000 for 2004 compared to 25.5 per 1,000 in 2003. The rate per 1,000 women 20 through 44 with a reported case of chlamydia has risen steadily each of the last five years, from a low in 1999 of 5.3 per 1,000 to the current high (provisionally) of 7.1 per 1,000.

E. Outcome Measures

Interventions to address infant mortality affect the neonatal, postneonatal, and perinatal death rates. These include increasing access to care, improving awareness of infant mortality issues at the local level, targeting funding towards areas of greatest need, and increasing the level of services provided to those identified as most at-risk. We have implemented a simplified eligibility form for Medicaid, and established a program that facilitates enrollment with a Medicaid provider. We will also continue efforts to increase funding opportunities for projects designed to reduce racial disparity in birth outcomes.

Other efforts to improve upon these outcome measures include additional focus on preconceptional health, better access to care, and further study by the Fetal and Infant Mortality Review projects. We will continue efforts to reduce the incidence of SIDS and shaken baby syndrome.