Maternal and Child Health Services Title V Block Grant

Mississippi

FY 2025 Application/ FY 2023 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

July 15, 2024

Shirley Payne, PhD, MPH
Director, Division of State and Community Health (DSCH)
Maternal Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services (DHHS)
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Payne:

The Mississippi State Department of Health (MSDH) is pleased to submit the 2025 Application and 2023 Annual Report for the State Title V Maternal Child Health Block Grant. We are excited to report on the work completed over the past year and are grateful for the support provided by the Maternal Child Health Bureau through technical assistance calls and site visits to Mississippi. Over the past four years, the state has been breaking down silos and engaging with new community partners as we navigated some of our most challenging times together. Through these experiences and with your agency's support, we have been able to identify critical needs in our state and to adapt our infrastructure to respond to these needs.

We look forward to sharing the successes and challenges of the past year. We also will continue to stretch and grow as we implement our plans for the coming year to transform the health of women and infants, children, and youth with and without special healthcare needs in Mississippi by empowering them and their communities. Should you have any questions or comments, please contact me by phone at 601-576-7472 or by email at: Annalyn.Whitt@msdh.ms.gov.

Sincerely,

AnnaLyn Whitt

Dr. AnnaLyn Whitt, Title V Director
Mississippi State Department of Health

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Equal Opportunity in Employment/Services

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Introduction of the Mississippi Title V Program

As the leading public health agency in the state, the Mississippi State Department of Health (MSDH) provides the core public health functions and essential services for more than 2.9 million citizens in the state. MSDH's mission is to protect and advance the health, well-being, and safety of everyone in Mississippi. The Title V/Maternal and Child Health (MCH) Block Grant aligns with the MSDH mission to provide services and programs that promote and improve the health and well-being of Mississippi's mothers, children and youth with and without special health care needs, and their families.

MSDH's public health system includes policy guidance from the State Board of Health, the State Health Officer, and programmatic/administrative personnel distributed across the following divisions: Health Administration; Community Health and Clinical Services (including Health Services); Epidemiology and Communicable Diseases; Public Health Pharmacy; Public Health Laboratory; and EMS and Acute Care Systems. The MSDH provides an extensive list of services, such as communicable disease surveillance, comprehensive reproductive health, preventive health, health protection, immunizations, vital records, environmental health, nutrition support and supplemental food services, health equity, health communications, health policy and planning, public health laboratory, health facilities, licensure/certification, and social services.

The Health Services Division is responsible for the administration of programs under the Title V/MCH Block Grant which focus on improving the health and well-being of women, infants, children, and adolescents across the state of Mississippi. Health Services oversees the provision of services and programs spanning the life course: (a) Women's Health, including the Maternal & Infant Health Bureau, Healthy Moms/Healthy Babies (HM/HB), Healthy Start, Breast and Cervical Cancer Program (BCCP), and Family Planning/Comprehensive Reproductive Health; (b) Child and Adolescent Health, including Genetics/Newborn Screening (NBS), Early Hearing Detection and Intervention (EHDI), Early Periodic Screening, Diagnosis, and Treatment (EPSDT), Lead Poisoning Prevention and Healthy Homes (LPPHH), Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Adolescent Health, and Children and Youth with Special Health Care Needs (CYSHCN) programs; (c) Early Intervention (EI); (d) Oral Health; (e) the Women, Infants and Children's Nutrition Program (WIC); (f) MCH Engagement and Coordination; and (g) Financial Management and Operations.

The Health Services Division partners with the Office of Health Data and Research (OHDR) which assists the MCH Programs in data management, surveillance, data analysis, reporting, and program evaluation on MCH populations. The Health Services Division also partners with other Offices throughout the MSDH to support women, infants, children, and adolescents, such as the Office of Preventive Health (OPE), the Public Health Pharmacy, and the Office of Vital Records and Public Health Statistics.

Needs Assessment, Program Planning, and Performance Reporting

The MCH Block grant supports health within a life course framework across the MCH population domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, Children and Youth with Special Health Care Needs (CYSHCN), and Cross-cutting/Systems Building. Information gathered through the comprehensive needs assessment process was used by the MCH programs and stakeholders to identify priorities for specific MCH populations and those across all MCH populations. MCH programs, with national technical assistance and input from stakeholders, advisors, and other partners, identified evidence-based/-informed strategies and designed activities to improve outcomes for the identified priorities for MCH populations. Program personnel and epidemiologists identify key performance and outcome measures and track implementation of evidence-based/-informed strategies.

Needs Assessment: 2020 Five-Year Needs Assessment

In 2019-2020, MSDH conducted comprehensive needs assessment for the 2021-2025 cycle in partnership with the University of Alabama at Birmingham (UAB), School of Public Health's Department of Health Care Organization and Policy, Applied Evaluation and Assessment Collaborative (AEAC). Key components of the needs assessment process involved: (a) quantitative analysis of key indicators; (b) qualitative data collection and analysis via surveys, focus groups, and key informant interviews; (c) a structured process for choosing priorities based on compiled data; and (d) an assessment of current and potential programming capacity for each identified priority.

The AEAC collaborated with three Mississippi community organizations to assist with outreach to ensure broad stakeholder engagement in the needs assessment: the University of Southern Mississippi Institute for Disability Studies, Mississippi Community Education Center, and the Family Resource Center of North Mississippi. These organizations worked with the AEAC to raise awareness of surveys, recruit focus group participants, handle logistics, and provide locations to host focus groups.

After collecting initial information via surveys and focus groups, formal stakeholder meetings were held with MSDH staff, partner organizations, and the public to examine each MCH domain to assist with selecting priorities and determining the importance and feasibility of various efforts. During these open meetings, recommendations were made to continue, improve, and/or adapt strategies to improve outcomes for MCH populations based on the progress on performance measures made during the reporting period.

Needs Assessment: Ongoing Needs Assessment

Mississippi's Title V MCH program conducts ongoing needs assessment by engaging diverse stakeholders in monitoring the progress achieved on priorities through the review of quantitative, qualitative, and program capacity data. This ongoing monitoring process helps the MCH program identify effective and ineffective approaches. Based on stakeholder input, the MCH program updates planned objectives, strategies, and activities to increase program effectiveness to achieve desired health outcomes and to respond to changing health needs. This iterative process of needs assessment and plan refinement is vital to the success of the MCH program and population health.

Identified Priorities and Performance Measures

As a results of the Five-Year Needs Assessment process, the MCH Programs and stakeholders, including community organizations, providers, advocates, and families, identified critical priorities for each of the key MCH populations as well as additional Cross-cutting/Systems Building needs. These priority needs are listed below along with the associated national and state performance measures (NPM/SPM). Priority needs identified for more than one MCH population are indicated with an "*" symbol.

Women/Maternal Health

- **Reduce maternal morbidity and mortality** (*SPM 10: % of severe maternal morbidity events related to hypertension; SPM 16: Nulliparous, term singleton, vertex (NTSV) cesarean rate*)
- **Improve access to care*** (*NPM 1: % of women, ages 18-44, with a preventive medical visit in the past year*)
- **Improve oral health*** (*NPM 13.1: % of women who had a preventive dental visit during pregnancy*)

Perinatal and Infant Health

- **Reduce infant mortality** (*NPM 5: % of infants placed to sleep A. on their backs B. on a separate approved sleep surface C. without soft objects or loose bedding*)
- **Improve access to family-centered care*** (*SPM 17: % of women, ages 18-44, on Medicaid with a preventive medical visit in the past year*)
- **Increase breastfeeding, healthy nutrition, and healthy weight*** (*NPM 4: A. % of infants who are ever breastfed B.*

% of infants breastfed exclusively through 6 months; SPM 12: % of women who are enrolled in WIC and initiate breastfeeding)

Child Health

- **Increase access to timely, appropriate, and consistent health and developmental screenings** (*NPM 6: % of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year; SPM 3: % of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age; SPM 13: % of infants with a hearing loss who received confirmation of hearing status by 3 months of age; SPM 14: # of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit; SPM 15: % of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely*)
- **Improve access to family-centered care*** (*SPM 21: % of children with and without special healthcare needs who have a medical home*)
- **Increase breastfeeding, healthy nutrition, and healthy weight*** (*SPM 11: % of children, ages 2-5 years, who have a BMI at or above the 85th percentile*)
- **Improve oral health*** (*NPM 13.2: % of children, ages 1-17, who had a preventive dental visit in the past year*)

Adolescent Health

- **Improve access to care*** (*NPM 10: % of adolescents, ages 12-17, with a preventive medical visit in the past year*)
- **Increase breastfeeding, healthy nutrition, and healthy weight*** (*NPM 8.2: % of adolescents, ages 12-17 who are physically active at least 60 minutes per day*)

Children with Special Health Care Needs (CYSHCN)

- **Assure medical homes for CYSHCN** (*NPM 11: % of children with and without SHCN, ages 0-17, who have a medical home; SPM 18: % of children with and without SHCN who received services necessary to transition to adult health care*)

Cross-cutting/Systems Building

- **Ensure health equity by addressing implicit bias, discrimination, and racism*** (*SPM 20: # of MCH programs with a written plan to address health equity*)
- **Improve access to mental health services across MCH populations*** (*SPM 19: Adolescent suicide rate*)

Assuring Comprehensive, Coordinated, Family-Centered Services

The MCH Program assures comprehensive and coordinated services in several ways. MSDH core services such as WIC, family planning, care coordination services, community outreach and health promotion are offered in county health departments. Title V funded MCH staff work at multiple levels: Central Office, three public health regions, and throughout 86 local health departments (see *Attachment 1: Regional, County, and Program Maps*). This organizational structure ensures MCH/Title V and other state and federal funds are comprehensively administered to counties across the state and program fidelity is maintained via direct management or contract. To ensure multi-directional sharing of information and ideas, regular in person and virtual meetings occur. Similarly, to ensure comprehensive coordinated family-centered services, the MCH program works with families by providing education around the importance of receiving services in a patient-centered medical home and how to partner with providers in the decision-making process. MCH personnel serve as advocates for children and their families as they seek information, services, and resources to improve their quality of life.

Eliminate Health Inequities, Advance Just and Fair Conditions, and Center the Lived Experiences of Individuals, Communities, Families, and Caregivers

A great strength of the Mississippi's MCH/Title V Program lies in its partnerships with individuals, communities, families, and

caregivers. The Mississippi MCH/Title V Program has pursued partnerships of all types, including the intentional engagement of families and customers, to employ a collective impact framework. These partnerships are the foundation for implementing approaches to eliminate health inequities and advance just and fair conditions in Mississippi. Examples of MSDH's MCH partners and partnering practices are described below.

MCH Advisory Board

In 2021, an MCH Advisory Board was developed to provide vital feedback to improve MSDH programs and services and to expand opportunities for family/youth/consumer engagement and leadership within all MCH programs. The MCH Advisory Board consists of youth, family members, MCH professionals, and stakeholders and provides guidance by reviewing proposed program policies and materials, advising on strategies and activities to address needs at the local and state levels, identifying consumers' and service providers' concerns and gaps in services, and assisting in the dissemination of information on MCH services and activities.

Community Partners

Mississippi's MCH/Title V Program further diversifies its partnerships through grant-funded activities that align with state priorities, such as providing support and training for family leaders, creating guidance/training for delivering teen-friendly services, and creating program- and office-level diversity and equity plans. Funded entities include, but are not limited to:

- Federally Qualified Health Centers and Community and School Health Centers
- Parent Advocacy Centers, including *Families As Allies*, the Family Voices recipient, and *Mississippi Coalition for Citizens with Disabilities*, the IDEA Parent Training and Information Center
- Community organizations, including *Mom.ME.*, *Six Dimensions*, *MS Public Health Institute, Teen Health Mississippi, Institute for the Advancement of Minority Health*
- Mississippi Perinatal Quality Collaborative
- Professional associations, including the *Mississippi Public Health Association, MS Chapter of the American Academy of Pediatrics, Mississippi Speech and Hearing Association*, and *Mississippi Head Start Association*

State Agencies and Public Institutions

The Mississippi MCH/Title V Program collaborates with state agencies to improve outcomes for MCH populations, including the Mississippi Department of Human Services (DHS), Mississippi Division of Medicaid (DOM), Mississippi Department of Education (DOE), Mississippi Employment Security Commission (MESC), and Mississippi Community Development. Title V also partners with institutions of higher education and the state university medical center on care coordination and workforce development.

Program Evaluation, Accomplishments, and Ongoing Challenges

Together, epidemiologists and program staff examine data to evaluate programs. With the support of the Title V State Systems Development Initiative (SSDI) epidemiologists facilitate the tracking and visualization of all measures among the MCH programs to enable MCH personnel and stakeholders to view progress made among all priorities.

In 2022, a new MCH Block Grant leadership team was formed to guide planning, development, and implementation of the state action plan (SAP) with the goal of increasing collaboration and breaking down siloed practices and activities. This 2023 annual report is the first to fully reflect the transition from program-specific activities to addressing integrated objectives, strategies, and activities. The 2025 application will continue the implementation of broad objectives, strategies, and activities across multiple programs with a unified approach to improving health outcomes for women, children, and families. Both are organized according to priorities and have been collectively developed by MCH program personnel and epidemiologists from the OHDR.

Despite progress on critical health performance measures and outcomes, the Mississippi Title V/MCH Program continues to address the ongoing challenges associated with professional shortages, hospital closures, significant health disparities,

high poverty, aging infrastructure, and frequent natural disasters.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Title V and state funding provide critical resources to address Mississippi's MCH priority needs and ensure the health and well-being of the MCH population. As per federal requirements, a minimum of 30% of Title V funding supports services for children and youth with special health care needs (CYSHCN) and a minimum of 30% of funding supports preventive and primary care services for children. Administrative activities such as 5-year and ongoing needs assessment, professional development, skills training, and other MCH personnel are also supported by Title V funds. Mississippi's three public health regions are appropriated Block Grant funding to serve their MCH populations. This helps to align work with MCH priorities and health improvement plans and increase consistency of efforts across the state. Contract expectations include supporting care coordination and medical home approaches for CYSHCN and focusing a portion of funds on other MCH priorities such as infant health, perinatal and maternal health, and health equity across populations.

Aligning Title V funds within the Divisions of Health Services and Preventive Health and Health Equity allows for planning across programs and divisions to address population health priorities by leveraging both federal and state funds for all priority areas. Title V state and federal funds have been used to support data collection and dissemination, workforce training, and facilitation of multiple partnership meetings across the state. Assuring supportive infrastructure for families is essential in preventing adverse childhood experiences (ACEs) and intimate partner violence and decreasing tobacco use. Further, the Office of Health Services has an active role via WIC (food security), Early Intervention (IDEA funds and Medicaid reimbursement), and investment in the built environment such as workforce development and other infrastructure support.

Title V funds support state and local funds dedicated to MSDH health department infrastructure clinic staffing. These staff include clerical/administrative, social workers, nurses, and clinicians. Staff supported by state funding provide services to patients accessing programs supported or related to maternal child health, including perinatal case management, EPSDT, childhood immunizations, and family planning are also supported by Title V funds for gap filling services.

III.A.3. MCH Success Story

Major Investment in Promoting Mental Health

Throughout the 2022-2023 program year, all MCH programs in Health Services providing care coordination, service coordination, and/or case management for infants, toddlers, and their families, including Children and Youth with Special Health Care Needs, Early Intervention, Health Moms/Healthy Babies, Newborn Screening, Early Hearing Detection and Intervention, and Lead Poisoning Prevention and Healthy Homes, participated in three cohorts to earn a national infant mental health credential in partnership with the Alliance for the Advancement of Infant Mental Health and the Mississippi Association for Infant Mental Health. Participants were provided 10 four-hour sessions of IMH-informed trainings and 12 two- and a half-hour sessions of reflective supervision in small groups each month across a year. At the completion of the training, successful participants earned the national Infant Family Specialist credential.

As Mississippi was new to the Alliance, the MSDH partnered with the National Alliance for the Advancement of Infant Mental Health (AIMH) who arranged for out-of-state trainers and reflective supervisors and to support personnel through the certification process. This project also supported the newly formed Mississippi Association for Infant Mental Health, which is now able to launch the Endorsement (IMH-E®) credential for residents of Mississippi for the first time. To build capacity, MCH staff members, including Early Intervention Service Coordinator Coaches and experienced Social Workers, completed a train-the-trainer process to ensure MSDH will be able to provide ongoing training and reflective supervision for new MCH personnel who will be subsequently onboarded.

Response to Rolling Fork Impacted by Tornado

In March 2023, a high-end EF4 tornado with windspeeds estimated at 195 miles per hour struck the communities of Rolling Fork and Silver City, Mississippi, as part of a deadly outbreak of damaging storms and tornadoes across the South. As a result, 17 people were killed, at least 165 were injured, and most of the buildings in Rolling Fork were damaged or destroyed. Over 78% of Rolling Fork and 96% of Silver City sustained damage; at least 300 homes in Rolling Fork sustained damage. In April, approximately 1/3 of the town or 500 people remained displaced and 200 remained displaced in August. The Mississippi Emergency Management Agency (MEMA) in partnership with the Red Cross provided meals and lodging for up to six months due to the large numbers of families who were displaced.

The MSDH, in collaboration with the Mississippi Emergency Management Agency (MEMA), provided public health services and established a mobile unit to assist impacted families in accessing their health records. MCH personnel assisted with connecting families to emergency clothing, water, and food. Home visiting programs, including Healthy Moms/Healthy Babies and Early Intervention, ensured displaced families could continue home visiting services either virtually or in-person at their temporary housing location. Families of CYSHCN were also provided additional resources and connected to community-based support services to address their critical and urgent health needs, including access to specialty clinics and refills of medications.

III.B. Overview of the State

Demographics, Geography, Economy, and Urbanization

Mississippi encompasses nearly 47,000 square miles, making it the thirty-second largest state by total area in the nation. The state is geographically located in the southeastern portion of the United States and is named for the river that flows along its western border. Mississippi is bordered by Tennessee to the north; Alabama to the east; Louisiana and a narrow coast on the Gulf of Mexico to the south; and across the Mississippi River, by Louisiana and Arkansas to the west. Mississippi's physical features are lowland with the hilliest portion located in the northeast section of the state, where the foothills of the Appalachians cross the border, and Woodall Mountain rises to 806 feet. However, the mean elevation for the entire state is only 300 feet. From east central Mississippi heading south, the land contains large concentrations of piney woods, which give way to coastal plains towards the Gulf Coast.

Southwest Mississippi tends to be quite rural with significant timber stands. The Mississippi Delta, the northwest section of the state, is technically an alluvial plain, created over thousands of years by the deposition of silt over the area during repeated flooding of the Mississippi River. The Delta is exceedingly flat and contains some of the world's richest soil. Mississippi leads the nation in catfish production, and the Mississippi Delta is the birthplace of the Blues, which preceded the birth of Jazz, the only other original American art form.

The residents of Mississippi are dispersed throughout 82 counties and 298 incorporated municipalities. While three-fourths of the state’s citizens reside in one of these incorporated places, most of these cities and towns are small. As of July 2023, Jackson, the state’s capital and largest city, had a population of 143,709 and the next largest city is Gulfport, with a population estimate of 72,823.[1] The state is predominantly rural, where 65 (79.3%) of the 82 counties are considered rural areas. Mississippi has three standard metropolitan statistical areas (MSA): the Jackson Metropolitan Area (Hinds, Madison, and Rankin Counties); the Hattiesburg area (Forrest and Lamar Counties); and the Gulf Coast Region (Hancock, Harrison, and Jackson Counties). Desoto County, located in North Mississippi, is included in the Memphis, Tennessee MSA. All 82 counties in Mississippi are designated whole or in part as medically underserved areas, according to the Health Resources and Services Administration (HRSA).

Mississippi’s population is estimated to be 2,939,690.[1] In comparison to the United States, Mississippi is less racially and ethnically diverse; however, it has the highest percentage of Black/African Americans of the total population of any state in the nation. Mississippi has higher rates of poverty for all ages, children living in poverty, and uninsured individuals under 65 years of age. Additionally, Mississippi has a lower percentage of its population with a high school education or higher, but it also has a lower employment rate and a higher rate homeownership. The tables below depict comparison rates between Mississippi and the United States, based on the July 1, 2023 Census Bureau population estimates, for racial and ethnic demographics as well as some socioeconomic factors.

Race	MS (%)	US (%)
White	58.8	75.5
Black	37.8	13.6
Two or more races	1.5	3.0
Asian	1.2	6.3
American Indian and Alaska Native	0.6	1.3
Native Hawaiian and Other Pacific Islander	0.1	0.3

Ethnicity	MS (%)	US (%)
Hispanic	3.6	19.1
Non-Hispanic	96.4	80.9

Socioeconomic Factors	MS (%)	US (%)
High school graduate or higher[2]	86.2	89.1
Unemployment rate (July 2021)[3]	2.8	4
Homeownership rate	69.2	64.8
Children in poverty (<18 yrs)[4]	26	16
Persons in poverty (all ages)	19.1	11.5
Persons without health insurance (<65 yrs)	13.1	9.3

Health Status of Mississippi's MCH Population

According to America's Health Rankings, Mississippi ranked 49th in overall health in 2023. Historically, Mississippi has consistently ranked at the bottom for overall health. Similarly, there are several MCH population indicators that continue to have severe challenges, including infant mortality and food insecurity. However, Mississippi shows strength on a few MCH indicators that include a high enrollment level in early childhood education and a low percentage of housing with lead risk. Based on America's Women and Children report, a sub-report of America's Health Rankings, Mississippi ranked 48th overall in Women's Health and 50th overall in Children's Health.[5]

State's Strengths and Challenges

Access to comprehensive, quality health care services is important for the achievement of health equity and increasing the quality of a healthy life for everyone. Health care access impacts overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Mississippians receive health care from a variety of sources that provide a continuum of care. The health care delivery system in Mississippi includes services for long-term care, care for the aged, and those with intellectual disabilities; mental health care, including psychiatric, chemical dependency, and long-term residential treatment facilities; perinatal care; acute care, including various types of diagnostic and therapeutic services; ambulatory care, including outpatient services and freestanding ambulatory surgical centers; comprehensive medical rehabilitation; home health services; and end stage renal disease facilities. Mississippi has 31 critical access hospitals, 50 rural hospitals with 49 beds or less, 311 Federally Qualified Community Health Centers, and 235 Rural Health Clinics, representing an increase of 103 FQCH Centers and 49 Rural Health Clinics over the past year.[6]

Efforts are being made to support and expand Mississippi's MCH infrastructure and health care delivery system. Strengths include strong partnerships and collaboration with private sectors, other state agency and local departments; increasing access to quality health care for mothers and children, especially for people with low incomes and/or limited availability of care; health promotion efforts that seek to reduce maternal mortality, infant mortality, and teen pregnancy; and family-centered, community-based systems of coordinated care for children with special health care needs.

Despite the health benefits to infants and mothers, Mississippi shows below average rates of breastfeeding. The Center for Disease Control and Prevention's 2022 Breastfeeding Report Card reports that for infants born in 2019 in Mississippi, 69.4% started out receiving some breast milk (compared to 83.2% nationally), 35.7% were

breastfeeding at 6 months (compared to 55.8% nationally), 22.2% were breastfeeding at 12 months (compared to 35.9% nationally), 31.1% were exclusively breastfeeding through 3 months (compared to 45.3% nationally), 15.6% were exclusively breastfeeding through 6 months (compared to 24.9% nationally), and 21.2% of breastfed infants received formula before 2 days of age (compared to 19.2% nationally). In addition, the 2023 America's Health Rankings found the percentage of infants exclusively breastfed for six months decreased 14%, from 18.1% to 15.6% between 2017 and 2019.[7]

Even so, Mississippi has had success in this area. Every two years, the CDC invites all hospitals to participate in a survey on their hospital maternity care practices that support healthy nutrition for infants, resulting in a Maternity Practices in Infant Nutrition and Care (mPINC) score, ranging from 0 to 100, with higher scores indicating better maternity care practices and policies. Mississippi's mPINC score for 2022 is 82 (compared to 81 nationally). In addition, over 50% of live births occur at Baby-Friendly facilities (compared to 27% nationally).

According to 2023 America's Health Rankings, tobacco use during pregnancy decreased 13%, from 7.8% to 6.8% between 2020 and 2021[8]; of live births, teen births decreased 8% from 27.9% to 25.6% of births between 2020 and 2021[9]; meningococcal immunization among children ages 13-17 increased 37%, from 46.0% to 63.0%; Tdap immunization among children ages 13-17 increased 31%, from 70.8% to 92.4%; and physical inactivity among women ages 18-44 decreased 9% from 30.1% to 27.4% between 2019-2020 and 2020-2021.[10] These improvements show the progress of our state and Mississippi's desire to improve its health rankings.

Mississippi has also shown steady improvement in education rankings moving from 50th in 2013 to 35th in 2021 and 30th in 2024 according to the Kids Count National Report.[11] The state maintained its historic gains in 4th grade reading on the 2022 National Assessment of Educational Progress (NAEP), while nationally scores dropped in all four NAEP subjects and grades. Based on information from the Mississippi Department of Education (MDE) statewide results from the 2022 -2023 Mississippi Academic Assessment Program (MAAP) show student achievement exceeding pre-pandemic levels in English Language Arts (ELA) and science and nearly tying in mathematics. Overall, the percentage of students scoring proficient or advanced reached an all-time high of 46.7% in ELA, 59.4% in science, and 52.6% in mathematics.[12]

As such, Mississippi is a leader among the few states that have shown improvements on one or more NAEP assessments over the past decade. Specifically:

- Mississippi achieved significant gains in 4th grade reading and math since 2011.
- Along with Washington D.C., Mississippi is the only state or jurisdiction that improved over a 10-year period in two of the four core NAEP subjects.
- Mississippi is one of only two states with improved 4th grade math scores over a decade and one of only three states with gains in 4th grade reading.
- In 8th grade, Mississippi scores remained flat in reading and math over the past decade while the average scores nationally dropped in both subjects.

While Mississippi has more improvements to make, substantial progress has been made through the state's steady achievement in education.

Despite these strengths and efforts, significant challenges still exist. Mississippi is still ranked last among all states for overall health system according to the Commonwealth Fund. Mississippi ranks 47th for access and affordability, 47th for prevention and treatment, 37th for avoidable hospital use and costs, 35th for income disparity, and 50th for healthy lives in 2023.[13] Mississippians, including our children, are routinely ranked as the fattest in the country and we lead the nation in high blood pressure, diabetes, and adult inactivity. The Delta region, which is well known for its poverty and sparse population, is at even greater risk for health problems because of lack of accessibility and

availability of medical care. An estimated 60% of Delta residents live below the poverty level. In 2022, as part of the Behavioral Risk Factor Surveillance System (BRFSS), 14% of Mississippians surveyed said they were unable to see a doctor at some point in the prior twelve months because of cost.[14]

The state's challenges particularly impact the state's most vulnerable residents, including CYSHCN and their families, Medicaid recipients, the working poor, undocumented immigrants, and rural residents. Mississippi has a high percentage of CYSHCN, 22.9% compared to the national average of 20.0%, with 26% of these children living in poverty significantly higher than the national average of 16%.[15] Furthermore, Mississippi faces more severe health care provider shortages than most states. In addition to those challenges are Medicaid changes to MCOs and the decision not to expand Medicaid within the state of Mississippi leaving many Mississippians with inadequate financial resources for health care, exacerbated by the rising costs of health care. In the absence of any intervention, the burden of high health care costs will worsen, as health care spending per capita in Mississippi is projected to nearly double from 2010 rates.

Akin to challenges for CYSHCN and other vulnerable populations, progress in improving maternal health outcomes is stunted due to inadequate access to obstetric and post-partum care. According to a report released by the March of Dimes in November 2023, more than half of Mississippi counties (51.2% of counties) are considered maternity care deserts.[16] A maternity care desert is one in which there are no hospitals providing obstetric care, no OB-GYNs, and no certified nurse midwives. It is important to note that since the report was released, additional hospitals that had provided obstetric care have closed, further widening the gap between those in need of help and the locations they can access it.

Understanding the composition of the state will help provide a measure to what is occurring within the health care needs of the population. The U.S. Census Quick facts as of July 1, 2022, reported Mississippi's population as 2,939,690 with 51.4% female, 48.6% male. Compared to the nation, a substantially larger percent of the Mississippi population is Black (37.8% vs. 13.6%) and substantially small percentages of the state population are Latinix (3.6% vs. 19.1%) and white (58.8% vs. 75.5%).[17]

State Health Agency Roles, Responsibilities, and Priorities

Title V/MCH aligns with the MSDH mission by focusing its primary mission on programs that promote and improve the health and well-being of Mississippi's mothers, infants, adolescents, and children, including children with special needs, and their families. The identified MCH program priorities relate to the state's MCH population, with MSDH being committed to improving the health and well-being of the MCH population across the life-course.

Office and Program Organization and Descriptions

Within MSDH, Title V/MCH is administered by the Division of Health Services. Health Services oversees the provision of services and programs in offices spanning the life course: (a) Women's Health, including the Maternal and Infant Health Bureau, Healthy Moms/Healthy Babies (HM/HB), Healthy Start, Breast and Cervical Cancer Program (BCCP), and Family Planning/Comprehensive Reproductive Health; (b) Child and Adolescent Health, including Genetics/Newborn Screening and Birth Defects (NBS), Early Hearing Detection and Intervention (EHDI), Early Periodic Screening, Diagnosis, and Treatment (EPSDT), Lead Poisoning Prevention and Healthy Homes (LPPHH), Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Adolescent Health, and Children and Youth with Special Health Care Needs (CYSHCN) programs; (c) Early Intervention (EI); (d) Oral Health; (e) the Women, Infants and Children's Nutrition Program (WIC); (f) MCH Engagement and Coordination; and (g) Financial Management and Operations.

The Office of Women's Health oversees the following programs and bureaus:

The **Maternal and Infant Health Bureau (MIHB)** aligns programs to reduce maternal and infant morbidity and mortality by understanding the causes of deaths through surveillance, review, and abstraction of records for infants, children, and women (pregnancy-related). MIHB utilizes the information and recommendations gathered to support health systems, organizations, and communities to implement quality improvement initiatives and prevention strategies. Staff in the MIHB coordinate all administrative activities for the Maternal Mortality Review Committee (MMRC), Child Death Review Panel (CDRP), and the Fetal and Infant Mortality Review (FIMR) program, maintain the Alliance for Innovation on Maternal (AIM) Initiative whereby patient safety bundles are implemented in birthing hospitals throughout the state, and lead the Count the Kicks© and Cribs for Kids© programs.

Also housed within MIHB are the **Northeast Mississippi Healthy Start Initiative** and **Maternal Health Symposium Workgroups**. The Healthy Start Initiative aims to improve health outcomes before, during, and after pregnancy and reduce racial and ethnic disparities in rates of infant death and adverse perinatal outcomes in NE Mississippi. The program provides clinical and enabling services for women/men of childbearing ages, pregnant women, new fathers, infants, and toddlers up to age 18 months in six counties (e.g., screening and referrals, case management, care coordination, health and parenting education, and linkage to clinical care). The program also convened a Maternal Health Symposium composed of members of the medical and public health communities to advise and inform activities. The Maternal Health Symposium established workgroups to develop and implement action plans to address maternal health from five areas: (1) Preconception Health; (2) 4th Trimester/Post-Partum Care; (3) Maternal Patient Safety/IPV; (4) Maternal Mental Health/Substance Abuse; and (5) Social Determinants of Health.

The **Healthy Moms/Healthy Babies of Mississippi** (HM/HB) program is a maternal and infant health support program working with families and communities to help ensure all Mississippi moms and babies have safe birthing experiences and healthy infant development. HM/HB offers patient centered, integrative and evidence-based approaches to case management and care coordination services, to assist pregnant and postpartum women, infants up to 12 months, and their families who have identified health risks. The goal of the HM/HB Program is to decrease preterm birth rates, improve maternal health, decrease infant mortality, and support infant physical and mental development while addressing social determinants of health (SDOH) that may affect pregnancy outcomes and infant's development. HM/HB program partners with the MS Division of Medicaid, medical homes, and communities to provide care coordination and home visiting services. Patients and families receive culturally sensitive, compassionate, non-judgmental care and services including assessment, education, empowerment and support, linkages to other services, management of high-risk behavior and response to SDOH.

The **Mississippi Breast and Cervical Cancer Program (BCCP)** promotes early detection of breast and cervical cancer in high-risk women who are more likely to have advanced disease when symptoms appear, including those who are uninsured, medically underserved, minority, and age 40 and older. The program provides education and promotes access to free screenings for breast and cervical cancer provided in partnership with screening providers in all Mississippi counties. As of June 2023, BCCP has a broad network of approximately 144 contracted providers offering BCCP-supported services at over 313 sites throughout the state. These providers include federally qualified community health centers (FQCHC), health department clinics, private family physicians and other primary care providers, hospitals, ambulatory surgery centers, surgeons, radiologists, medical oncologists, and laboratories throughout the state. Using a fee-for-service reimbursement model and with federal (CDC) and matching funds, mammography screening is available through contracted providers to uninsured women between 50-64 years of age. Women under 49 years old and younger with positive breast

symptoms are eligible for diagnostic screenings. Asymptomatic women 40-49 years old may receive screening using special funding. Timely follow-up and support are provided for all women with clinical findings through their enrolling providers. Timely referral to Medicaid for women diagnosed with cancer is provided directly through the BCCP clinical staff to expedite coverage for treatment.

The MS-BCCP and Office of Preventive Health, Heart Disease and Stroke Prevention Program (HDSPP) MSDH operate the **MS WISEWOMAN** program to extend additional preventive health services to women enrolled in the MS-BCCP, including screenings for cardiovascular disease, stroke risk, and diabetes and referrals for healthy behavior supports. The MS WISEWOMAN Program focuses on geographic areas of the state having the highest burden of cardiovascular disease and stroke-related mortality in partnership with two FQHCs.

In partnership with Jackson State University (JSU), a historically black college or university (HBCU), funded by the National Institute of Health's Centers of Excellence in Maternal Health program, the MSDH has implemented the **Time4Mom (T4M)** program. This initiative reduces maternal morbidity and mortality in the Mississippi Delta region and enhances maternal health outcomes by facilitating postpartum home visits provided by nurses and community heath workers, linking women with local health resources, referrals for mental health and lactation support, and providing educational support on postpartum health.

The **Family Planning/Comprehensive Reproductive Health (FP/CRH)** program aims to reduce unintended pregnancies and improve pregnancy outcomes by assuring comprehensive, quality FP services are available to assist women, men, and couples in determining the number and spacing of their children. The FP/CRH provides voluntary, affordable services, including pregnancy testing and counseling, preconception health services, and screening and prevention through the Medicaid Family Planning Waiver (FPW) for persons ages 13-44, with family income at or below 194% of the Federal Poverty Level (FPL), who are not currently pregnant and who have not had a vasectomy, tubal ligation, or hysterectomy. Under the FPW, the FP/CRH provides physical exams, Pap tests, clinical breast exams, counseling on birth control methods, contraceptive supplies, testing for pregnancy and human immunodeficiency virus/sexually transmitted infection (HIV/STI), and pre-conception counseling to help plan future pregnancies. Clients who require services not provided at public health clinics, lack health insurance coverage, and minors who desire confidential services that do not require parental consent, are provided resources to community providers (i.e., Federally Qualified Health Center and Title X clinics) and assisted with making appointment as needed. [Note: As of March 2023, the MSDH is no longer the Title X recipient for the state.]

The **Office of Child and Adolescent Health** oversees the following programs and bureaus:

The **Genetic Services Bureau** houses the **Mississippi Newborn Screening**, **Chronic Congenital Heart Defects (CCHD)**, and **Early Hearing Detection and Intervention (EHDI)** programs and the **Birth Defects Registry**. The Genetic Services programs aim to reduce infant mortality and morbidity of Mississippi Newborns with birth conditions through early detection and treatment, follow-up screening and referrals, and education for professionals and families using a family-centered approach. State law requires all newborns to be screened in accordance with the National Recommended Uniform Screening Panel (RUSP), including 63 core and secondary conditions. The NBS programs partners with Revvity, the state lab, which receives bloodspot cards, analyzes the samples, and provides a portal to collect and report results to the MSDH. The NBS programs provide short-term follow-up for newborns identified through bloodspot and point of service, ensuring repeat screens are conducted when needed, families are referred to specialists for confirmatory testing, and families of children with identified conditions or risks are referred for long-term follow-up, care/service coordination, and early intervention. These programs partner with birthing hospitals, tertiary clinics, and pediatric facilities statewide

as well as internal MCH programs, including CYSHCN, Early Intervention, HM/HB, MIECHV, and MSHD social services. In addition, the EHDI program provides peer-to-peer family support and access to Deaf/Hard of Hearing role models for families of children with confirmed hearing loss.

The MSDH clinic nurses provide **Early Periodic Screening, Diagnosis, and Treatment (EPSDT)** services in Mississippi as a gap filling service in areas with limited primary care providers. Children are provided well-child screenings according to the Bright Futures Periodicity Schedule. All children whose screens indicate needs are referred to a general practitioner or specialty provider for diagnosis and/or treatment and to a local primary care provider or community health center for continuity of care (wellness and sick care) in a medical home, and long-term follow-up as needed and available. Children identified through EPSDT screening are also referred to internal MCH home-visiting or service/care coordination programs.

The **Mississippi Lead Poisoning Prevention and Health Homes Program (LPPHHP)** ensures Medicaid-enrolled children are screened for elevated blood lead levels through Early and Periodic Screening, Diagnosis, and Treatment (ESPDT). All laboratories and medical facilities throughout the state are required to report all blood lead levels (BLL) to MSDH; these data are analyzed to determine the status of lead poisoning and healthy homes issues in the state and to identify high-risk areas to target education, outreach, and policy interventions. The LPPHHP identifies lead and other environmental home health hazards and provides practical prevention measures for families of children up to 72 months of age with a confirmed venous blood lead level (BLL) greater than or equal to 3.5 micrograms per deciliter (µg/dL) through care coordination services, including telephone counseling, home visits, environmental assessments, education on lead poisoning, healthy homes, and safe sleep, , recommendations for decreasing hazards, nutritional counseling, and referrals for additional supports/services. The goal of the LPPHHP is to reduce the number of children exposed to lead and environmental hazards through public awareness and implementation of prevention activities, policy intervention, and risk reduction activities for children and their families in partnership with community organizations.

The **Maternal, Infant, and Early Childhood Home Visiting (MIECHV)** program is responsible for providing evidence-based home visiting with families with children prenatal to kindergarten in 16 high-risk counties for poor maternal and child health outcomes. The program uses the *Parents As Teachers* model, which includes weekly personal visits, monthly community educational/networking meetings, health and developmental screening, and referrals for additional services and resources as needed. The goal of MIECHV-MS is to ensure children are healthy, safe, and ready to learn by: (a) increasing parent knowledge of early childhood development, positive parenting practices, and early detection of health and developmental issues and connection to services; (b) improving parent, child, and family health and well-being; and (c) strengthening community capacity and connectedness.

The **Adolescent Health** program seeks to improve connection and promote accessibility to health systems by educating adolescents and their healthcare providers and ensure the implementation of teen-friendly services that foster trust and understanding. The program focuses on the elimination of health disparities and inequities that affect young people and advances leadership practices for MCH at the national, state and local levels for adolescence (ages 10-17) and young adulthood (ages 18-21).

The **Children and Youth with Special Healthcare Needs (CYSHCN)** program provides family-centered care coordination services for children and youth with special health care needs from birth to 21 years of age. CYSHCN have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and require health and related services of a type or amount beyond that required by children generally (not due to accident or injury). Care Coordination is provided through a statewide, comprehensive, coordinated, multi-

disciplinary, system of care by the health department system and primary care practices for CYSHCN, their families, and caregivers, including personal contacts, counseling, education, referrals for a medical home, and supporting the development and implementation of a shared plan of care with primary and specialty care providers.

The **Mississippi First Steps Early Intervention Program (MSFSEIP)** is the Individuals with Disabilities Act (IDEA) Part C program in Mississippi. The MSFSEIP is responsible for coordinating a statewide comprehensive interagency system of early intervention services for infants and toddlers under three years of age with a developmental delay or condition likely to lead to a delay and their families. The MSFSEIP coordinates with healthcare providers, early care and education providers, and families across the state to ensure infants and toddlers with identified disabilities and/or developmental delays are identified, evaluated, and receive timely, comprehensive, and family-centered services. The MSFSEIP state office provides training, guidance, and oversight to the nine local early intervention programs (LEIPs) organized under three regional offices. The MSFSEIP conducts public awareness campaigns and outreach for Child Find, including promotion of developmental screening/monitoring by families and healthcare and education providers. Each LEIP provides service coordination from intake through transition to school- and/or community-based services and makes referrals to 422 participating early intervention providers, including physical, occupational, speech, and behavioral therapists, nurses, special instructors, and audiologists, who educate and support families in understanding their children's special needs and helping them help their children grow, develop, and learn.

The **Office of WIC** oversees the administration of WIC Special Supplemental Nutrition Program and Breastfeeding Promotion and Support Program:

The **Special Supplemental Nutrition Program for Women, Infants and Children (WIC)** safeguards the health of low-income women, infants, and children up to age five who are at-risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care. Mississippi WIC participants include pregnant women, postpartum non-breastfeeding women up to 6 months, postpartum breastfeeding women up to 12 months, infants, and children up to age 5. WIC participants use an eWIC card to pick up approved food items at 296 authorized retail vendors across 78 counties, including 4 commissaries, 73 independent grocery stores, 22 local grocery chains, 75 mass merchandisers, 29 national grocery chains, 83 regional grocery chains, and 10 local pharmacies. In addition, the WIC Shipping and Receiving Unit orders and ships special medical formula and WIC-eligible nutritional supplements to clinics for participants who have access issues.

The **WIC Breastfeeding** program promotes and supports breastfeeding. Breastfeeding peer counselors provide basic breastfeeding education, assist with and teach prenatal and breastfeeding classes, issue breastfeeding devices to WIC participants, troubleshoot breastfeeding issues and concerns with WIC participants, promote breastfeeding awareness in the community, and partner with community organizations to improve breastfeeding outcomes.

The **Office of Oral Health (OOH)** works with all MCH programs and with healthcare and community partners to support assessment, policy and program development, and assurance in the prevention and control of oral diseases across the lifespan. Oral health screenings, dental sealants, and fluoride varnish applications are provided in collaboration with public health clinics, schools, and licensed medical and dental health providers. The **Fluoride** and **Mississippi Seals** programs support communities to adopt community water fluoridation and provides preventive dental services in schools throughout the state, respectively. The OOH also engages in workforce development by offering practicum and internship opportunities for students to experience public health dentistry and engage them in efforts to address statewide oral health disparities and capacity building. As funding allows, the OOH also provides

Dental Admission Test (DAT) preparation and assistance with applying to dental school. The OOH employs Regional Oral Health Consultants (ROHCs), state licensed dental hygienists, who assist with grass roots implementation of all programs and trainings. The ROHC improve the oral health of all MCH populations by assisting county health departments deliver age-appropriate oral health anticipatory guidance and preventive oral health services in each public health district. ROHCs and other team members promote information sharing between health professionals and community stakeholders and engage in community outreach (e.g., school oral health programs, health fairs) to educate the public about the importance of good oral health and to reduce the burden of oral disease. The goals for the OOH are to promote oral health, conduct oral health surveillance, prevent oral disease, and coordinate dental care across the lifespan.

The **MCH Engagement and Coordination Office** supports MSDH Health Service and MCH program personnel through training and capacity building. The Office provides professional development for existing (internal and external) MCH personnel on topics of public health, Title V/MCH, and leadership. Using results from a staff survey, professional development opportunities have been developed to meet the unique needs of individual staff, including self-paced modules, in-person or virtual offerings with continuing education credit, recorded webinars, leadership book clubs, and printed publications.

Since March 2023, the Office has led an integrated public health social work program to provide short-term follow-up and social service supports to multiple MCH/Health Service direct service programs, such as genetic trait counseling, lead education, and CYSCHN care coordination. This integrated approach is rooted in “no wrong door” philosophy and enables appropriate referrals to programs depending on individual situations and needs.

The **Office of Financial Management and Operations** oversees all MCH budget expenditures and supports programs in developing budgets and tracking expenditures. The office provides computer generated cumulative expenditures, transaction listings and spending/receipt plans in electronic format for all MCH programs.

The **Office of Health Data and Research (OHDR)** assists the MCH Programs in data management, surveillance, data analysis, reporting, and program evaluation on MCH populations. In 2024, this Office was moved under Health Services and personnel are being embedded in the programs to offer epidemiological, evaluation, and research support.

The Health Services Division also partners with other Offices throughout the MSDH to support women, infants, children, and adolescents, such as the **Office of Preventive Health (OPE)**, the **Public Health Pharmacy**, and the **Office of Vital Records and Public Health Statistics**.

State Systems of Care for Underserved and Vulnerable Populations

Mississippi has worked hard to build a system of care that engages the public through heightened organization and improved alignment of policies, practices, goals, financing, and accountability. The intent is to provide the services and support needed to meet the needs of underserved and vulnerable populations, including CYSHCN.

Mississippi’s system of care model involves collaboration across agencies, community-based organizations, FQHCs, and various other entities. This approach provides a functional framework for making use of resources to optimize care. Planning, implementation, and evaluation are deliberately designed to include relationships with other systems.

The systems of care in Mississippi include but are not limited to:

- Mental Health System
- Alcohol/Drug Treatment System
- Education System
- Child Protection System
- Juvenile Justice System
- Vocational Rehabilitation Systems
- Health System

Mississippi has 31 Critical Access Hospitals designated to preserve access to local primary and emergency health services. These hospitals are in rural counties with a high prevalence of populations that demonstrate higher rates of obesity, diabetes, preventable hospitalizations, cardiovascular deaths, and cancer deaths as compared to state and national benchmarks. Additionally, they are staffed with fewer physicians and have a higher proportion of patients who live in poverty and are enrolled in Medicaid.

Mississippi also has 116 hospitals of which there are ninety-five acute care, eight psychiatric, one rehabilitation, one OBGYN and 10 long-term acute care facilities.[18] Seven counties in our state do not have a hospital: Amite, Benton, Carroll, Humphreys, Issaquena, Itawamba, and Tunica. A shortage of emergency personnel, including medical technicians and equipment is resulting in increased wait times for responses to rural and medical emergencies.

Compared to 2021, we have four comprehensive behavioral health state programs, six intellectual developmental disability regional programs, two specialized programs for adolescents and 11 regional centers with county governing authorities.[19]

Increased health promotion and prevention efforts, workforce staffing models, telehealth technology inclusion, data bridges to link EMS and trauma care and reform to healthcare coverage and reimbursement are needed provisions to build a healthier Mississippi.

Mississippi's Health Professional Shortage Areas

Besides poverty, Mississippi's inadequate and uneven distribution of providers contributes to the overall poor health of its residents. High quality health care services depend not only on an adequate supply of fully qualified health care professionals, but also an appropriate distribution of these providers for adequate access.

Eighty counties are federally designated as either whole or partial-county Health Professional Shortage Areas (HPSAs) for primary care (based on either the low-income population or geography). Seventy-eight counties are designated as dental HPSAs, and all but six counties are designated as mental health HPSAs. All of Mississippi's 82 counties are designated as either whole or partial-county Medically Underserved Areas (MUAs).[20]

In the state of Mississippi there are a total 128 hospitals, with 58 designated government hospitals and 36 private hospitals. There are 42 birthing hospitals in Mississippi. The total number of beds available in Mississippi is 14,986, with 81 hospitals having Helipad facilities.

In 2023, Mississippi had a total of 779,857 Medicaid enrollees providing coverage to 24% of the state's population. The state's average length of hospital stay is on par with the national average hospital stay of 5 days. There is only one children's specialty hospital in the state, located on the campus of the University of Mississippi Medical Center.

The chart below compares the distribution of health professionals serving rural versus urban areas.

Distribution of Primary Care Physicians, Dentists, and Psychiatrists in MS[21]		
Health Professions	**% Serving Rural**	**% Serving Urban (MSAs)**
Primary Care Physicians	26.3% 511 physicians serve 60 rural counties *1 rural county has no primary care physicians*	73.7% 1432 physicians serve 21 urban counties *all urban counties have primary care physicians*
Dentists	30.1% 385 dentists serve 56 rural counties *5 rural counties have no dentists*	69.9% 894 dentists serve 21 urban counties *all urban counties have dentists*
Mental Health (Psychiatric Only)	34% 42 psychiatrists serve 59 rural counties *6 rural counties have no psychiatric mental health providers*	66% 83 psychiatrists serve 17 urban counties *all urban counties have psychiatric mental health providers*

While the percentage of Mississippi adults who report being uninsured has dropped since 2019, cost is still the greatest barrier to obtaining health insurance coverage. The price of basic health insurance coverage with reasonable cost-sharing far exceeds the amount people are willing to pay without substantial subsidies. For those Mississippians with low incomes, unaffordable private coverage and lack of access to premium assisted coverage through an employer, the Marketplace, Medicaid, or other source, leave some with no other alternative than to remain uninsured.

To increase access to care, CYSHCN monitors and works closely with patients identified as not having medical health coverage. The program maintains a partnership with the state's Navigator office. Parents referred are expected to keep their appointments and to submit their letter of eligibility to the program in the processing of their application for services as verification of efforts to obtain affordable healthcare insurance. Similarly, the BCCP Program assists patients by providing direct payments for breast and cervical cancer screening and diagnostic services and provides a direct link for expedited eligibility and Medicaid coverage when a BCCP participant has diagnosed with breast or cervical cancer. Other programs that assist patients to access coverage include the Family Planning/Comprehensive Reproductive Health Program which promotes application to and uptake of Medicaid Family Planning Waiver, and the HM/HB Program which follows women through their pregnancies and up to 60 days postpartum and infants up to 1 year old to assure they understand the Medicaid coverage rules and renewal requirements.

State Statutes and Other Regulations Impacting Title V/MCH

The following legislation impacting the Mississippi Title V/MCH Program was passed during the most recent legislative sessions:

Mississippi Access to Maternal Assistance (MAMA)

In the 2023 legislative session, SB2781 was passed mandating the Mississippi Attorney General's Office to partner with other state agencies, including the Mississippi State Department of Health, and private and faith-based partners, to create a one-stop-shop e-resource center for pregnant women and new mothers.

See the Women's Health Annual Report for more details about the implementation of this state resource for pregnant and birthing people.

Presumptive Eligibility for Pregnant Women

In the 2024 legislative session, "presumptive eligibility" legislation was passed and signed by Governor Tate Reeves to go into effect July 1, 2024. Once implemented, Medicaid will pay for a pregnant woman's outpatient medical care for up to 60 days while her application for the government-funded insurance program is being considered.

See the Women's Health Application for more details about planned activities related to the implementation of this change in insurance.

Transfer of the Office of the MS Physician Workforce

HB 1129 transfers the office of physician workforce development from four state universities to the purview of the MSDH. The office shall have the responsibilities of assessing current workforce; assess future physician needs in the state; and provide accredited training programs for the workforce.

Establish the MS K-12 and Postsecondary Mental Health Task Force

Senate bill 2727 establishes a mental health task force to look at current available mental health resources and determine where gaps exist. The task force will review and recommend to the legislature all available resources and needs to address gaps in service delivery and treatment. This task force is required to work with the state agency coordinating Part C of IDEA (MSDH) to deliver a report that provides possible solutions.

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[1] U.S. Census Bureau QuickFacts: Gulfport city, Mississippi; Jackson city, Mississippi; Mississippi; United States

[2] U.S. Census Bureau QuickFacts: Mississippi; United States

[3] BLS Data Viewer and Civilian unemployment rate (bls.gov)

[4] Latest available data from 2022 Child poverty statistics in the U.S. (aecf.org)

[5] State Rankings | 2023 Health Of Women And Children Report | AHR (americashealthrankings.org)

[6] https://data.hrsa.gov/tools/data-explorer?ds=13

[7] Explore Breastfed in Mississippi | AHR (americashealthrankings.org)

[8] Explore Smoking During Pregnancy in Mississippi | AHR (americashealthrankings.org)

[9] Explore Teen Births in Mississippi | AHR (americashealthrankings.org)

[10] Explore Physical Inactivity - Women in Mississippi | AHR (americashealthrankings.org)

[11] aecf-2024kidscountdatabook-2024.pdf

[12] Statewide assessment results show student achievement reaches all-time high | The Mississippi Department of Education (mdek12.org)

[13] U.S. Healthcare Rankings by State 2023 | Commonwealth Fund

[14] Cholesterol Awareness Analysis of 2021 Mississippi Behavioral Risk Factor Surveillance System (BRFSS) Data

[15] NSCH 2021 22: Children with special health care needs, Nationwide vs. Mississippi (childhealthdata.org) and Child poverty statistics in the U.S. (aecf.org)

[16] Where you live matters: Maternity care access in Mississippi | PeriStats | March of Dimes

[17] U.S. Census Bureau QuickFacts: Mississippi; United States

[18] HRSA & MS Rural Health Plan 2022

[19] FY22 Annual Report (ms.gov)

[20] https://www.ruralhealthinfo.org/data-explorer?id=208&state=MS

[21] HRSA.gov

III.C. Needs Assessment
FY 2025 Application/FY 2023 Annual Report Update

Needs Assessment Process

Mississippi's MCH population needs are continuously assessed by MCH programs through ongoing monitoring and surveillance to evaluate progress and trends, track implementation of work plans, and identify and address emerging issues. The MCH personnel meet monthly to discuss programmatic efforts, accomplishments, existing and emerging issues, and next steps of ongoing and upcoming projects. This ensures MCH programs can align their efforts and encourages collaboration across MCH programs to support Mississippi's MCH population needs.

MCH Population Health and Wellbeing

Based on results of ongoing monitoring over the past few years, MCH populations in Mississippi continue to experience significant challenges and poorer outcomes for health and wellbeing. Women in Mississippi have had significantly increased rates of severe maternal morbidity and continued high rates for preterm (<37 weeks) and early term (37, 38 weeks) deliveries. Once better controlled, Mississippi has experienced an epidemic of syphilis cases with an 80% increase among adults and a 10+ fold increase in congenital syphilis cases. Likewise, after years of progress, Mississippi is seeing increases in teen pregnancies. Mississippi continues to have high rates of low-birth-weight babies, increasing trends of children identified with Neonatal Abstinence Syndrome (NAS), and increased rates for infant mortality, including those related to Sudden Unexpected Infant Death (SUID). Likewise, the child and adolescent mortality rates and childhood obesity rates have also increased while the percentage of children in good or excellent health has decreased.

Due to strains on the state's health care system due to financial policies, provider shortages, high-need populations, and the stress of a multi-year pandemic, many hospitals and practices have closed or reduced services, increasing challenges for MCH populations to access care. Over the past few years, Mississippi has seen decreases in the number of children who have been unable to access care and the number of CYSHCN who can access care in a well-functioning system. Further, the percentage of children who have received vaccinations has also decreased, related to a lack of access as well as a lack of trust in health care institutions and guidance.

Mississippi Title V Program Capacity to Address Needs

The Title V Program has increased capacity to address the following identified needs.

Provider Shortages
Provider shortages impact the health system by lowering the quality of care provided and increasing the number of poor health outcomes. Although Mississippi experiences provider shortages in *every medical and health field*, the following highlights some particularly challenging shortages:

Newborn Screening and Diagnostic Providers: The United States, and Mississippi in particular, is facing a shortage of pediatric audiologists and lacks the genetic specialists to work with families of infants who are found to have conditions identified during newborn screening. This shortage will be difficult to address as training programs are costly, lengthy, and insufficient to address the need. Further, economic pressures often divert providers away from working with the most need populations; for example, lower reimbursements and higher time commitments for working with pediatric populations disincentivizes audiologists from working with pediatric populations and instead encourages them to focus on older, geriatric populations which are more lucrative.

The Leadership Education in Neurodevelopmental and Related Disabilities (LEND), University Center for Excellence in Developmental Disabilities (UCEDD) programs, and University of Mississippi Medical Center are critical partners for preparing personnel who can help identify and intervene with children with disability and conditions impacting their development. These programs provide advanced training for professionals to improve the health of infants, children, and adolescents with disabilities. MCH Programs have many opportunities to partner with these institutions to increase the capacity to respond to MCH population needs and decrease provider shortages.

Dental Health Providers: According to the HRSA Bureau of Health Workforce, 248 dentists are needed to eliminate the dental shortage designations. This shortage will be difficult to address and presents a strong rationale to expand the scope of practice of support dental staff, such as hygienists and other midlevel personnel, to address the unmet primary dental health needs in the short term. In addition, consideration should be given to expanding teledentistry. Longer-term solutions point towards expanding dental education to build a pipeline to increase dental providers.

Mississippi's Office of Oral Health developed a Mississippi State Oral Health Plan, 2016-2021. The Plan called for surveillance and assessment of oral health status, which was subsequently addressed by the development of the Mississippi Oral Health Surveillance Plan, 2018-2022. The data collection for the surveillance plan is currently underway, and the results will establish a baseline for oral diseases and resulting health outcomes in Mississippi. The surveillance activities include dental caries, periodontal disease, cancers of the oral cavity and pharynx and access to care issues occurring over one's lifespan. This information will assist in the placement of new dental providers and public education programs in the areas of the state with the greatest needs. Other benefits of the surveillance process will be an improvement in actionable oral health data for the state and local health providers, more accurate data to report to policy makers, and baseline data to evaluate success.

Mental Health Providers: The need for mental health providers across the state is dire; for example, the ratio of mental health providers to residents is greater than 1:200,000 in the Mississippi Delta. These shortages include not only psychiatrists (i.e., HRSA designation of mental health provider) but also psychologists, clinical social workers, and other mental health professionals. Employing a regionalized approach and counting psychologists and licensed clinical social workers would provide a better assessment of capacity. In partial response to the need for psychiatrists, the Mississippi State Hospital (MSH) added a Psychiatric Residency Program with the first residents having started in July 2021.

Access to Patient- and Family-Centered Care

Mississippians are significantly impacted by inequitable access to care. Most health care resources are concentrated in a few areas of the state. Given the dearth of resources in some areas of the state, barriers, such as transportation, impede the quality and effectiveness of care received. Even when providers are geographically close, residents may still lack the financial resources, insurance, or time to utilize services, resulting in inadequate care. Furthermore, as health is largely driven by behaviors and experiences outside of healthcare services, healthcare providers need to acknowledge the importance of the patient in achieving positive outcomes and view themselves as partners, rather than directors, of health. New strategies are needed to ensure all Mississippians have access to quality and equitable healthcare that is responsive and respectful of them.

The MCH/Title V Block Grant supports Mississippi's efforts to increase access to patient- and family-centered care. For example, the CYSHCN program partners with specialty clinics, federally qualified healthcare centers (FQHC), and private clinics within communities to provide easier access to care and coordination of services to establish mental and dental homes for under-served citizens. The ability to provide access support via tele-medicine has also improved conditions for those in under-resourced areas.

Health Disparities and Discrimination Based on Age, Race, Class, Gender, and Gender Identity

Health disparities threaten the health and quality of life of the overall population. According to the CDC, “A growing body of research shows that centuries of racism in this country has had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These conditions—often referred to as social determinants of health—are key drivers of health inequities within communities of color, placing those within these populations at greater risk for poor health outcomes.”

In partnership among the Office of Child and Adolescent Health and the CYSHCN and Adolescent Health programs and Teen Health Mississippi (THMS), a community-based organization dedicated to attaining equitable health outcomes for adolescents, THMS conducted multiple focus groups with adolescents and providers. Their findings identified the personal values of healthcare providers and their support staff negatively impact the experiences of youth, decrease their likelihood of access services, and contribute to poor health outcomes for youth. Further, participating youth reported experiences of intentional and implicit bias related to race, gender, sex, sexual orientation, age, socioeconomic status, education level, and geographic location that negatively impacted their access to services and contributed to poor health outcomes.

The impact of centuries of racism have led to significant inequities in health and wellbeing both directly and through negative impacts on social determinants of health. To improve the health of Mississippi communities overall and for a greater quality of life, the public health system must address generational injustices that contribute to these health inequities in our state and nation.

The need to promote health equity was evident from the needs assessment findings. Health equity will increase community capacity to shape outcomes and foster multi-sector collaboration, in turn creating the foundation for a healthy and vibrant community. Several MCH program have made efforts to address this need through designing and offering racial equity trainings, focusing on the structural and social dynamics working within healthcare institutions and communities that prevent optimal births for every woman, particularly Black and indigenous women of color, and create barriers to integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling. With training on racial equity, social determinants of health inequities, collective impact and advocacy, participants will begin to realize their role within the transformation of those systems.

The MSDH requires training on health equity for all its personnel and offers additional workshops for healthcare providers on related topics, such as implicit bias and social determinants of health. This training helps MCH personnel in the state, including those internal and external to MSDH, to understand experiences of bias and inequities in our everyday life, understand how biases can affect the level of care for MCH populations, and discuss how to manage biases and promote health equity. For example, training participants are provided strategies for adjusting automatic patterns of thinking and eliminating discriminatory behaviors and equipped with tools to maintain and promote inclusive and respectful work environments. Additional training on the principles of patient- and family-centered care further supports health equity by promoting respect for patients’ and families’ values, preferences, and expressed needs.

Child and Adolescent Health programs also partnered with a community-based organization to review their policies, procedures, and practices to develop plans and policies centering health equity within their programs. These programs collaboratively developed a comprehensive plan with strategies to promote health equity broadly across programs as well as some wrote individual diversity and inclusion plans, such as the Early Hearing and Detection

Intervention (EHDI) program. Supported by the Office of Health Equity, MCH programs have expanded language access by providing real-time interpreters and translation services to enable non-English speaking populations to access health services equitably.

The Office of Preventive Health and Health Equity was asked to lead the efforts in addressing the impact of COVID-19 on minority and vulnerable populations such as rural communities, African Americans, Hispanics/Latinx, Vietnamese, and immigrants through education on protective and social distancing measures, access to COVID-19 testing, access to vaccines, and access to resources. The Office of Health Equity has worked to increase access to the COVID-19 vaccine for the state's minority and vulnerable populations through the Community Vaccination Program and by addressing vaccine misinformation and hesitancy through health promotion campaigns via multiple media platforms. The Office of Health Equity serves as a link and liaison between community-based organizations and community health centers and the community to provide timely and effective response to needs and issues surrounding the COVID-19 pandemic and distribution of vaccinations in minority and vulnerable populations in the state. The Office recruits community health centers and community partners to work together to identify sites in communities that will improve access to the vaccine for minority and vulnerable populations. To date more than 380 vaccination events have taken place across the state, and more than 8,600 vaccines have been administered through the Community Vaccination Program.

Mental Health Services and Education on Mental Health Issues

According to the Mississippi Primary Care Needs Assessment that was conducted by the Office of Rural Health, "Mental and behavioral health (MBH) comprise a range of conditions, the majority of which are responsive to treatment, and many of which are exacerbated by poverty. Of the 3 million residents of Mississippi, 4.7% (close to 150,000) of adults are reported to have a serious mental health condition, such as schizophrenia, bi-polar disorder and/or major depression, which are difficult to manage and often require hospitalizations. Other less acute mental health conditions, such as mild depression and anxiety, post-traumatic stress, etc., are preventable and respond well to treatment" (p.18).

To begin to build capacity to address the mental health needs in our state in MCH populations, MCH program personnel have participated in annual mental health first aid training and supported all personnel who provide care coordination, service coordination, and/or case management to earn a national Infant Family Specialist credential from the Alliance for the Advancement of Infant Mental Health through year-long training and reflective supervision. Furthermore, MSDH partnered with the newly formed Mississippi Association for Infant Mental Health to ensure several MSDH/MCH personnel became certified as trainers to build the state's capacity both within MSDH and across Mississippi for future personnel to be able to access the training and reflective supervision required for certification/recertification.

MCH programs have also coordinated workshops and mental services for families and other partners. The Maternal and Infant Health Bureau program also facilitated a partnership with MOM.Me to address the mental health needs in the state through:

- Establishment of a Maternal Mental Health Network
- Conducting health education and outreach
- Providing training to community stakeholders to increase provider knowledge of maternal mental health disorders
- Linking mothers, fathers, and children to support services

Adjustment after the COVID-19 Pandemic

The COVID-19 pandemic laid bare the influence of poverty, race, and ethnicity on the vulnerability to disease and the resulting health disparities. Disproportionate death rates were noted among African Americans and Native

Americans. Mortality rates per 100,000 among Blacks in Mississippi was twice the rate of White Mississippians, and the mortality rate among Native American Mississippians was ten times higher than the rate of White Mississippians and the highest rate nationwide for indigenous residents.

As the COVID-19 pandemic began winding down in 2022, MSDH and other health systems stabilized and returned to routine operations. Even so, new challenges emerged in ensuring access to care due to the unwinding of Medicaid coverage for many who were able to maintain care throughout the pandemic. In June 2023, the Mississippi Division of Medicaid began its first round disenrollments. By February 2024, over 116,705 people had been disenrolled from Mississippi Medicaid.

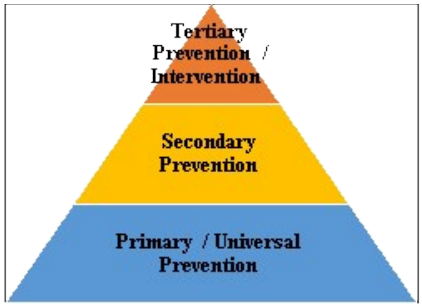
The MCH programs have partnered with the Division of Medicaid to assist with the dissemination of information about recertification of benefits. The MCH programs supported their enrolled families as well as engaged their extended community connections to ensure consistent messages were offered about changes with Medicaid benefits, the recertification process, and how to access services. Care Coordinators, Service Coordinators, Case Managers, and Health Services Social Workers not only provided education but also assisted families with contacting Medicaid, completing paperwork, and access information from the Division of Medicaid to mitigate any challenges and prevent service interruption.

Impact of the Title V Organizational Structure

Most of the MCH Programs are housed under the Division of Health Services, now under Community Health and Clinical Services. Within Health Services, there are several Offices and Programs, including the Office of Women's Health, which includes the Maternal and Infant Health Bureau, the Office of Child & Adolescent Health, which includes the Children and Youth with Special Healthcare Needs (CYSHCN) Program, Women Infant and Children (WIC), Office of Oral Health, and the Office of MCH Engagement and Collaboration. Addition Health Services personnel provide guidance and support for field-based clinical nurses who provide direct services, such as Early Periodic Screening, Diagnosis, and Treatment (EPSDT), and for program operations, finances, and grants development. Over the past few years, the organizational structure of the Title V Program has been impacted by expansion of programs and internal collaboration, agency and program reorganization, and staffing challenges.

The MCH Programs have continued to expand their ability to serve vulnerable populations through the establishment of new grant-funded programs, including the Maternal Infant and Early Childhood Home Visiting (MIECHV) under Child & Adolescent Health and the Wisewoman, Time4 Mom, and Healthy Start Programs under Women's Health. Existing MCH programs mainly offer universal health surveillance and referral services which address all or most children in the state or intensive tertiary prevention and/or intervention for children and adolescents with significant needs, such as Early Intervention for children with disabilities or developmental delays or CYSHCN services for those with special health care needs. The MSDH and Mississippi in general has fewer secondary prevention programs for selected populations of children and families to prevent rather than treat poor health and wellbeing. Under the Preventive Health Pyramid Model (*see graphic below*), these expanded programs provide Tier II: *Secondary Prevention* services, expanding the capacity of MSDH to reach beyond its existing Tier I: *Primary/Universal Prevention* and Tier III: *Tertiary Prevention and Intervention* programs.

Preventive Health Pyramid Model



Recognizing the power of prevention in improving the health and well-being of across the life course, Health Services and the MCH program has expanded its collaboration with the Office of Preventive Health and Health Equity to address the social determinants of health impacting the health of MCH populations and all Mississippians. Programs in Preventive Health and Health Equity assist MCH-related strategies around issues such as maternal and infant mortality, developmental screenings, well visits among adolescents, and cross-cutting issues such as mental health, health equity, and disparities. Mississippi's Title V MCH Program also continues to partner with numerous entities at the federal, state, and local level to expand its capacity and reach for its MCH population. (See the *Family Partnerships* and *Public and Private Partnerships* sections below for more detailed information.)

Over the past three years, MSDH has undergone reorganization of regions, divisions, office, programs, and personnel, increasingly so as the MSDH adjusted after the winding down after the COVID-19 pandemic. During this time, the Public Health Pharmacy was moved out of Health Services into its own Division, the Tobacco Program was moved under Preventive Health, and the Early Hearing Detection and Intervention Program was integrated with the Newborn Screening Program. In 2022, the MSDH established an Office of Workforce Development, leading the MCH Workforce Development Office under Health Services to be reorganized as the MCH Engagement and Coordination Office. In addition, Health Services established the Office of Financial Management and Operations for overseeing and supporting all programs budgeting and expending MCH funds. More recently, the state's three Health Regions were reorganized into four Health Regions, the Office of Health Data and Research was moved under Health Services to embed epidemiologist directly into the MCH programs, and the Early Intervention Program was moved out of Child & Adolescent Health. The MSDH is continuing to explore additional structural changes to improve alignment, coordination, and efficiency.

Over the past few years, the MSDH has experienced increased challenges with recruiting and retaining knowledgeable and skilled Title V staff. Over the past three years, the MSDH has experienced challenges seriously impact staffing and services, including the aging and exiting of the state's skilled public health professionals—with the COVID-19 pandemic further exacerbating critical personnel shortages. After the worst challenges of the pandemic, the MSDH was left with a 47% vacancy rate. Rebuilding and filling vacancies has been a very slow process. As a result, the majority of the Title V Block Grant leadership team is mostly comprised of personnel who have been in their roles for less than three years.

Since 2022, new key personnel have assumed MCH leadership due to personnel leaving the agency or retiring:

- In 2022, Thomas Dobbs, the State Health Officer who led the agency during the pandemic, announced he was leaving. In August 2022, Daniel Edney, MD, FACP, FASAM, became State Health Officer for the MSDH, after serving as the Deputy State Health Officer and Chief Medical Officer in 2021. Dr. Edney was in private practice in Vicksburg for more than 30 years and formerly served as president of the Mississippi State Medical Association and as a board member on the Mississippi State Board of Medical Licensure. He received his M.D. from the University of Mississippi School of Medicine with residency in the University of Virginia's internal medicine program. He holds board certifications in Internal Medicine and Addiction Medicine and is a Fellow of the American College of Physicians.
- In June 2024, Dr. Beryl Polk, the former Title V Director, retired after 24 years of service. In May 2024, Dr.

AnnaLyn Whitt joined the MSDH as the new Director of Health Services/Title V Director. Dr. Whitt has 25 years of experience in program and grant management, health, and social work. She oversees more than 300 employees, directly and indirectly, and across the state.

- In February 2024, Praise Tangbe left her role as the MCH Block Grant Coordinator. In June 2024, Stacy Callender, who previously served as the Director of Child & Adolescent Health and led the MCH Block Grant writing team for the past two years, officially assumed this title under her new role for Grants Development and Management to support all grant funded Health Services programs.
- In 2022, Ms. Krista Guynes, MSW, LCSW, became the Director of the Office of Women's Health, which includes the Breast and Cervical Cancer Program (BCCP), Healthy Moms/Healthy Babies (HM/HB) Program, Family Planning/Comprehensive Reproductive Health (FP/CRH) Program and the Maternal and Infant Health Bureau (MIHB). She previously led the BCCP and Perinatal High-Risk Management (PHRM) Programs.
- In 2022, Ms. Valecia Davis, MS, became the CYSHCN Director and interim Adolescent Health Director. She previously served in Early Intervention and Health Services Operations.
- In 2022, Dr. Jameshyia Ballard was appointed Director of WIC, when the previous WIC Director retired after more than 30 years of service. Dr. Ballard previously served as State Breastfeeding Coordinator and State Vendor Management Director with the WIC program.
- In 2021, Ms. Danielle Seale, MSW, LCSW, began the MCH Workforce Development Office, bringing more than a decade of public health experience. In 2022, the Office was renamed/refocused on MCH Engagement and Coordination. The Office was assigned a cadre of Health Services Social Workers to provide supplemental social services to Health Service programs.
- In 2022, Johnny Singleton began the Office of Financial Management and Operations from the MSDH F&A Office. The Office supports MCH programs in budgeting and tracking expenditures.
- In July 2024, Ashley Wolff was appointed Part C Coordinator for the Early Intervention Program, newly organized directly under Health Services.

Currently several key MCH leadership positions remain vacant, including:

- The Director for the Office of Child and Adolescent Health, which includes the Genetics/Newborn Screening, Birth Defects Registry, Early Hearing Detection and Intervention, Lead Prevention and Healthy Homes (LPPHH), Maternal Infant and Early Childhood Home Visiting (MIECHV), Adolescent Health, and Children and Youth with Special Healthcare Needs (CYSHCN) Programs;
- The State Dental Director which oversees the Oral Health Office.
- The Adolescent Health Director position, filled temporarily by the CYSHCN Director.

To recruit qualified personnel, MCH programs work closely with Human Resources and the Office of Workforce Development. Proactive strategies are used to recruit a diverse workforce, including publicizing vacant positions through targeted social media and working with colleges to provide internship opportunities to draw student talent. With the support of the Mississippi State Personnel Board, all positions have been reclassified with competitive salaries providing a livable wage.

Title V Workforce Capacity and Workforce Development

While MSDH has made some progress with recruitment, the MSDH also needs to improve retention. Previous workforce surveys found MSDH was viewed as bureaucratic, lacking innovation, and under resourced. Jobs should offer fulfilling, meaningful work, and provide mission-driven positions with the opportunity to make an impact on the community. To retain a qualified and competent public health workforce, which is essential to address existing and emerging public health issues, the MSDH and Health Services Division have instituted several efforts to build workforce capacity and commitment. To build MCH leadership capacity, some MCH Program directors have been

supported to participate in coaching and leadership training programs such as the certified public manager program through the Mississippi Personnel Board and the Advanced Applied Leadership Program through the Else School of Management at Millsaps College.

In 2021, the Office of Health Services also established a MCH Workforce Development (MCHWD) Office to assess, coordinate, and provide Health Service and Title V staff and interns with applicable knowledge about public health, MCH, and health services.

In 2023, MSDH received a CDC *Strengthening U.S. Public Health Infrastructure, Workforce and Data Systems* grant. This funding supported the establishment of the MSDH Workforce Office to address public health workforce needs, including recruiting, onboarding, and professional development with continuing education credit. With the agencywide Workforce Office, the MCHWD Office was refocused on MCH Engagement and Coordination (MCH ECO) to:

- Improve cross program communication;
- Enhance data collection and sharing;
- Promote staff development and professional benchmarks;
- Expand availability of quality infrastructure for operations; and
- Improve alignment of patient service delivery.

The MCH ECO participated with the Title V Learning Journey project from the National Workforce Development Office at University of North Carolina at Chapel Hill (2022-2023) to identify a departmental mission and vision statement, populations of focus, and values:

Mission: To strengthen the MCH Workforce capacity by assessing and improving (providing) exposure to evidence-based or -informed, culturally appropriate trainings and development opportunities for MSDH staff, health students, external partners to build a diverse and culturally sensitive workforce.

Vision: To work in partnership with the MSDH programs and community partners through promoting learning, recruitment, engagement, leadership, and retention for a diverse, knowledgeable, and competent current and future MCH workforce in the state of Mississippi.

Populations: MSDH and Health Service staff, Students in Mississippi Institutions of Higher Learning, Community partners

Values: Culture and Environment Change, Growing Staff with Joy, Communication, Leadership Cheerleading

Click on the links below to view the previous years' needs assessment narrative content:

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$9,228,087	$9,153,279	$9,278,900	$9,305,490
State Funds	$6,921,066	$119,623	$6,959,175	$366,106
Local Funds	$0	$549,527	$0	$660,083
Other Funds	$0	$3,171,965	$0	$5,520,459
Program Funds	$273,030	$3,079,950	$216,034	$432,470
SubTotal	$16,422,183	$16,074,344	$16,454,109	$16,284,608
Other Federal Funds	$4,300,000	$583,281	$4,625,000	$48,599,460
Total	$20,722,183	$16,657,625	$21,079,109	$64,884,068

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$9,272,183	$9,738,802	$9,305,490	
State Funds	$731,224	$0	$0	
Local Funds	$1,095,262	$1,821,870	$1,053,440	
Other Funds	$3,871,552	$5,328,005	$5,525,678	
Program Funds	$1,256,100	$154,227	$400,000	
SubTotal	$16,226,321	$17,042,904	$16,284,608	
Other Federal Funds	$113,758,690	$40,601,553	$106,139,568	
Total	$129,985,011	$57,644,457	$122,424,176	

	2025	
	Budgeted	Expended
Federal Allocation	$9,738,802	
State Funds	$0	
Local Funds	$1,028,134	
Other Funds	$6,130,968	
Program Funds	$145,000	
SubTotal	$17,042,904	
Other Federal Funds	$94,229,078	
Total	$111,271,982	

III.D.1. Expenditures

Fiscal Management

The Mississippi State Department of Health (MSDH) Division of Finance and Accounting (F&A) is responsible for all fiscal management at the agency including the Maternal and Child Health Block Grant (MCHBG). MSDH staff use the Mississippi State Government's Enterprise Resource Planning (ERP) solution and financial management system called MAGIC, operated by the Mississippi Department of Finance and Administration (DFA). This statewide accounting and procurement system of record encompasses Finance (e.g., accounting, budgeting, and grants management) and Logistics (e.g., procurement, fleet management, and inventory management).

The Title V/MCH federal funding, in conjunction with non-federal state monies and other federal funds, are obligated and expended to support Mississippi's priority needs and Title V requirements. Approximately 30% of Title V/MCH funding is allocated to support activities to address critical MCH priorities for each of the following populations: Children and Youth with Special Health Care Needs (CYSHCN), children and adolescents, and women and mothers. These funds support the MCH work of programs across the state and regions, such as reproductive health, perinatal care systems, infant and maternal mortality and morbidity reduction, infant safe sleep, breastfeeding initiatives, care coordination, lead poisoning prevention, oral health, and health equity initiatives, as well as health surveillance and data analyses to determine performance and guide improvement efforts.

The Maternal and Child Health Finance Director oversees all MCH budget expenditures. Computer generated cumulative expenditures, transaction listings and spending/receipt plans are available in electronic format for all MCH programs. This information can be accessed by both central and regional office staff. Contract agencies are also audited frequently, through document reviews, site visits, and program monitoring at contract agencies to ensure compliance with the contract's scope of services. The MSDH adheres to the policies and procedures developed by the DFA for financial management by state agencies, found on their website at: https://www.dfa.ms.gov/mississippi-department-finance-administration.

Total Expenditures

The budget for Mississippi's Title V/MCH Block Grant application was developed by MSDH Health Services in cooperation with the Office of Health Administration and F&A. The total program expenditures as follows for FY2023 was $17,042,904 of which $9,738,802 (57%) is Title V and $7,304,102 (43%) is match provided in-kind by the applicant. Sources of match funds are state and local funds, newborn screening fees, and Medicaid and other Third-Party earnings, as allowed by the MCH Bureau.

Pregnant Women and Infants

The goal of the Women's and Infants' Health programs is to support access to patient- and family-centered care to ensure healthy pregnancies and reduce maternal and infant mortality and morbidity to improve women's and children's health outcomes and quality of life. Many programs utilize a two-generation approach to provide health education, linkages to community healthcare providers and resources, and direct services as needed to fill service gaps across the state.

Total funds expended for programs serving pregnant and reproductive-age women and infants were as follows for FY2023: $2,961,417 for federal funds (30% of the total federal award) and $5,789,514 for non-federal funds (79% of total non-federal funds).

Child and Adolescent Health

The goal of the Child and Adolescent Health programs is to integrate services within and across agency boundaries for children and families to improve the availability and accessibility of services to improve health outcomes and quality of life for children and adolescents. Many programs utilize a two-generation approach to provide health education, provide health education, linkages to healthcare providers and community resources, and technical assistance and training opportunities for healthcare providers and community partners who serve children and adolescents.

Total funds expended for programs serving children and adolescents were as follows for FY2023: $2,950,323 for federal funds (30% of the total federal award), $695,819 for non-federal funds (10% of total non-federal funds).

Children with Special Health Care Needs

The goal of the Child and Youth with Special Health Care Needs (CYSHCN) program is to support a statewide system of care to improve the availability, accessibility, and coordination of services to improve health outcomes and quality of life for CYSHCN and their families. The CYSHCN program partners to share resources among the MSDH, University of Mississippi Medical Center (UMMC), Federally Qualified Health Centers (FQHC), public and private community health care providers and agencies, and other resources to provide health education, linkages to and coordination among healthcare providers and community supports, technical assistance and training opportunities for healthcare providers and community partners who serve CYSHCN, and system building efforts to identify barriers and gaps to assist with resolution.

Total funds expended for programs serving CYSHCN were as follows for FY2023: $2,941.716 for federal funds (30% of the total federal award), $818,769 for total non-federal funds (11% of total non-federal funds).

Administrative Costs

Administrative costs expended thus far are $885,346, which is 9% of the total federal grant award. This amount does not exceed the allowable 10% of the total Title V/MCH Block Grant as mandated in OBRA 1989.

Maintenance of Effort

The level of state funds provided for match for FY2023 is greater than the State's maintenance of effort level, i.e., the total amount of State funds expended for the maternal and child health program in FY1989.

Matching funds for the Title V/MCH Block Grant are identified by listing all direct program costs which have been paid from non-federal sources. These expenses include travel, medicine, medical services, clinical, and lab supplies. Funds used to match Medicaid or other grants are deducted.

The majority of matching funds are expended on salaries and fringe for agency personnel. The agency time study provides a report of the value of staff time paid from state or county funds. Time coded to Family Health, Family Planning, Maternity, Healthy Moms/Healthy Babies and other Maternal and Child Health efforts is used to match the pregnant women, mothers, and infants' category. Time coded to Child Health, Oral Health, and School Nurse is used to match the children and adolescent category. All salary and non-salary charges for the CYSHCN program are identified by the program budget.

III.D.2. Budget

Mississippi's Maternal and Child Health Block Grant financial management plan assures compliance with the Title V fiscal requirements. Mississippi state law requires all state agencies to submit a complete financial plan and base budget request for the ensuing fiscal year outlining proposed expenditures for the administration, operations, and maintenance of programs. Budget guidelines are prepared annually by the Department of Finance and Administration. The Department of Finance and Administration, in cooperation with all programs, is responsible for the preparation of the budget documents. The base budget request becomes law after it is approved by the General Assembly and signed by the Governor. A work program budget is then developed for each program.

The Title V MCH Block Grant budget for the FY25 Application allocates equal funds, equivalent to 30% of the total award, for MCH services for pregnant women and others, primary care for children and adolescents, and preventive and maintenance services for CYSHCN, with 10% for administration costs, include accounting and budgeting services and associated administrative support. Preventive and primary care services include policy and procedural oversight, local health department services, pharmacy and laboratory testing, newborn screening (dried blood spot, non-Title V funds; see Other Funds below), and varied family, maternal, and child health initiatives to bolster protective factors and mitigate risk factors. Other services provided include population-based maternal and child health systems coordination, e.g., cross-coordination of providers, specialists, school systems, government agencies, and community partners.

The program budget includes the mandated state match on a 4-to-3 ratio of federal to state funds and meets the maintenance of effort threshold. Sec. 505 (a)(4) of the Social Security Act requires states to maintain the level of funds provided solely by the state for MCH health programs (i.e., state match) at a level at least equal to the level provided by the state in fiscal year 1989.

The proposed FY24 budget complies with the state match as below:

- FY24 Anticipated Federal Allocation: $9,738,802
- FY24 Budgeted State Match: $7,304,102

The Mississippi State Department of Health Maternal and Child Health Program reviewed all federal investments relevant to the MCH state and national priorities, as reported in the state's MCH budget (as reported on line 11 of Form 2).

The program maximizes opportunities to leverage complementary state and federal MCH funding streams to meet Title V priority needs. Some examples of grants under the direction of the MCH Director and how they complement the work of MCH are as follows:

- **National Breast and Cervical Cancer Early Detection Program (NBCCEDP)** – These funds assist women to access screenings for breast and cervical cancer. The program works with healthcare providers across the state to expand access to care.

- **Preventing Maternal Deaths: Supporting Maternal Mortality Review Committee** – The MSDH uses the recommendations from data reports from this committee to implement prevention strategies and reduce the number of deaths among women in the state due to complications before, during, or soon after delivery of an infant.

- **State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)** – This

funding supports surveillance of children from birth to 72 months of age for elevated blood lead levels. The program makes appropriate referrals for follow-up by infant health programs, provides family education on prevention, and conducts environmental assessment at the residence or other place most frequently (e.g., childcare, playground, grandparents' home).

- **Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)** – This funding supports the identification and serving of infants and toddlers with disabilities from birth to 36 months of age and their families. The program coordinates with other state agencies to provide developmental evaluations, service coordination, and linkage to community based, family centered early intervention services according to an individualized family service plan as needed to improve developmental outcomes. In addition, the program empowers families to understand their rights, their child's disability, and how to help them grow and learn.

- **Universal Newborn Hearing Screening and Intervention** – This funding supports surveillance of children from birth to 36 months of age for hearing loss. The program works to ensure timely hearing screening, diagnosis, and early intervention.

- **Women, Infants, and Children (WIC)** – The WIC program coordinates with MCH and other health services programs to maximize the reach of women, infants, and children from birth to 5 years who receive services to reduce food insecurity. Due to its wide reach in Mississippi, the program serves as a main source of referrals to other health programs.

- **The Loving Support Peer Counseling Program (WIC: Breastfeeding)** – This funding expands the focus of the WIC program to support women on initiating and sustaining breast feeding, which support infant and child health.

- **Maternal, Infant and Early Childhood Home Visiting Grant Program (MIECHV)** – These funds support the delivery of evidence-base home visiting to pregnant women and children up to kindergarten who are at risk of poor maternal and child outcomes.

- **Mississippi WISEWOMAN Program** – These funds extend the services offered under MSDH's existing Mississippi Breast and Cervical Cancer Program to offer preventive health services, including heart disease and stroke risk screening and healthy behavior support interventions.
  - Eligible participants will be those already enrolled in MS-BCCP, ages 35-64 years old, and residing in the 5 counties targeted for initial implementation.
  - All 5 counties have a CVD death rate in Black/African American women that is higher than the state's average (478.9); all 5 priority counties have high blood pressure prevalence greater than the state's average of 43.6%.
  - The project will engage the support of health systems and community partners throughout the target counties and other areas of the state

- **Healthy Start Initiative-Eliminating Racial/Ethnic Disparities** – This fund is used to support the Healthy Start Initiative to improve health outcomes before, during, and after pregnancy and reduce the racial/ethnic differences in rates of infant death and adverse perinatal outcomes.

- **Alliance for Innovation on Maternal Health State Capacity Program (AIM)** – The AIM funds support best practices that make birth safer, improve the quality of maternal health care and outcomes, and save lives.

Maternal safety bundles address topics commonly associated with health complications or risks related to prenatal, labor and delivery, and postpartum care. The AIM Capacity program is a new funding initiative designed to support state capacity to implement AIM and expand the reach, depth, and quality of AIM throughout the state and nation

III.E. Five-Year State Action Plan

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

State: Mississippi

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

State Action Plan Table - Entry View

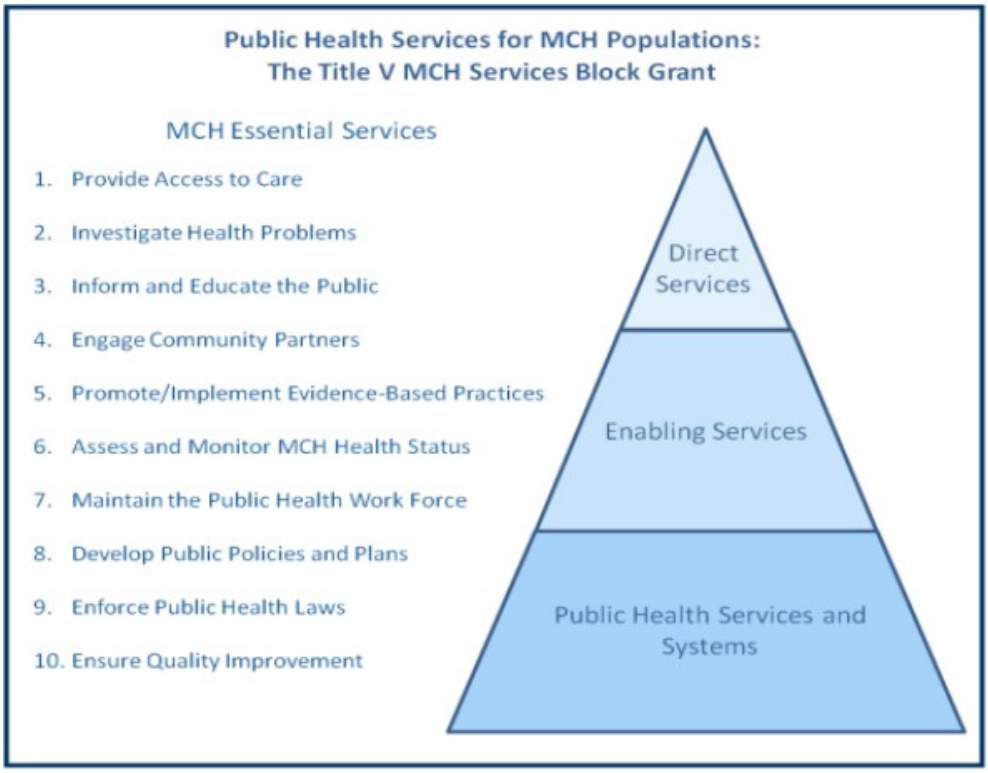
State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

Purpose and Commitment of the Title V Program

The MSDH Title V/MCH Program is responsible for leading and supporting efforts in local communities and across the state to improve the health and wellbeing of pregnant women, infants, children with and without special health care needs, adolescents, and others in the state. The MSDH Title V/MCH Program implements the 10 essential public health services through a combination of direct services, enabling services, and building infrastructure and capacity for public health services and systems.



Through coordinated efforts, the MSDH Title V/MCH Program strives to:

- Assure access to quality health care for mothers and children, especially for people with low incomes and/or limited availability of care;
- Assure access to comprehensive prenatal, delivery, and postnatal care for women, especially for women who are low-income and/or at-risk of poor health outcomes;
- Promote health to reduce infant mortality and the incidence of preventable diseases and to increase the number of children appropriately immunized against disease;
- Assure access to preventive and childcare services as well as rehabilitative services for children who need of specialized medical care and treatment;
- Promote family-centered, community-based systems of coordinated care for children with and without special healthcare needs;
- Assure access to preventive and childcare services as well as rehabilitative services for children who need of specialized medical care and treatment;
- Promote healthy behaviors in adolescents and successful transition to adult care;

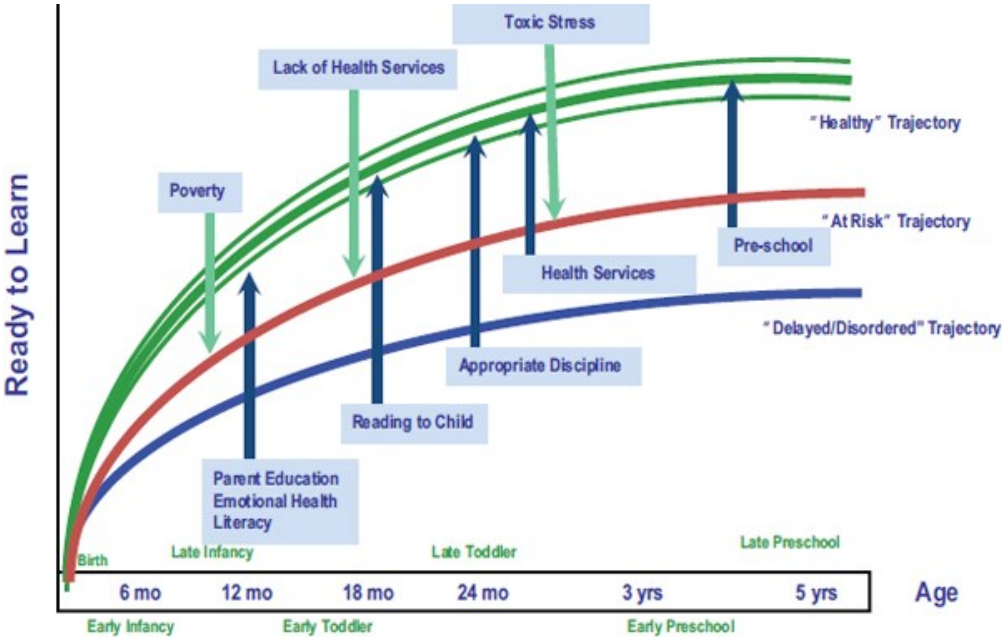
- Promote positive mental health and access to mental health care services to assure quality of life and wellbeing across MCH populations; and
- Promote health equity through addressing social determinants of health related to structural racism that are barriers to health attainment.

Conceptual Frameworks

The Mississippi Title V/MCH program is informed by the life course framework and the socioecological model of development. Both of these concepts inform the selection of strategies and approaches to meeting the needs of MCH populations.

Life Course Framework

Public Health uses the life course framework to conceptualize the factors that impact an individual's health across the lifespan and the underlying social, economic, and environmental factors that drive health inequalities. The life course framework (see figure below) illustrates the impact of various risk and protective factors on the readiness for learning of a child, represented by a growth curve, across the first five years of life. The trajectory of the growth curve of a child "at-risk" can be depressed into a "delayed/disordered" trajectory, due to the negative impacts of risk factors such as poverty, lack of health services, and toxic stress, or supported into a "healthy" trajectory, due to the positive impacts resiliency factors, such as parent education, emotional health, literacy and reading, appropriate discipline, health services, and preschool.



Using life course framework, MCH programs can determine strategies not only to reduce risk factors but also to increase resiliency factors, especially as all risk factors cannot be eliminated. Further the model encourages selecting interventions to occur as early as possible in the life course, when the gaps are small and more amenable to life course change. The longer the exposure to risk factors without the commensurate support of resiliency factors the greater the gap and the more intensive the effort will need to be to restore the individual to a health trajectory.

Socioecological Model

To maximize the efforts and impact of our MCH programs' work, the socioecological model is utilized to encourage

the systems change approach to address the root causes of MCH issues. The socioecological model (see figure below) conceptualizes each individual as being encased in multiple concentric rings moving from the innermost circle representing the individual (including their knowledge, attitudes, and beliefs), through larger and larger rings representing interpersonal relationships (such as providers, family, peers, and social networks), organizational relationships (such as state/local health departments, employer/work sites, health care systems/academic medical institutions, public and private health insurance plans, tribal urban health clinics, professional organizations, and community-based organizations), community relationships (such as coalitions, health disparity collaboratives, tribal health department, community/state/regional advocacy organizations, research institutions, and media), and policy (such as local/state/national legislatures, federal government agencies, and national advocacy/non-profit organizations). This model considers the complex interplay between the individual and the interpersonal relationships, organizations, communities, and policies/policymaking bodies that influence them. The model also illustrates how factors at one level can influence factors at another level and indicates intervention approaches must act across multiple levels to be successful.

Using approaches informed by the socioecological model, MCH programs can leverage family/community members as partners to address the needs and concerns of MCH populations. For example, if addressing maternal mortality, the socioecological framework further assesses barriers and intervention points in the individual mother and her family, to her workplace or school, her community and the policies that contribute to the overall health the mother and her family. After utilizing the socioecological framework, programs can apply this information to align their strategies.

MCHBG's Goals and Mission

To address national and state performance measures, the MSDH Title V/MCH Program strategically coordinates activities and efforts with partners and stakeholders to improve health outcomes for the state's MCH population. The MSDH maintains a wide range of partnerships with health professionals, Title V families, and non-traditional partners who help oversee and implement strategies to address the needs of MCH populations across the life course. These groups take leadership in the agency's State Health Assessment and Improvement Committee (SHAIC), the MCH Leadership Team, the MCH Advisory Board, and with other advisory capacities.

Partnership/Leadership in Accomplishing the MCHBG's Goals and Mission

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State Health Improvement Plan (SHIP)

Beginning in 2014, the MSDH undertook a State Health Assessment (SHA) to determine the greatest health needs in the state. Over 19,000 residents, community partners, and public health professionals provided input to the Mississippi State Health Assessment and Improvement Committee (SHAIC) who collaboratively developed the first State Health Improvement Plan (SHIP). After five years of implementation and monitoring progress toward the original four priorities, a second round of assessment was conducted in 2019-202 and an updated plan was developed in 2021-2022.

This new process identified cross-cutting issues that if addressed would help achieve the vision of "*All Mississippians living healthier, longer lives due to a thriving public health effort that is supported by active and committed citizens and organizations*."[1] Key findings included:

- *Assessments showed 72.9% of the population was either overweight or obese with 25.4% of children ages 10-17 being considered obese (2018).*
- *Obesity is a result of societal barriers, such as access to care and food insecurity.*
- *Obesity is a root cause of most chronic illnesses. Obesity co-occurs with other health problems, such as hypertension and diabetes. Rates of obesity, diabetes, and hypertension prevent communities from being considered healthy and diabetes (14.3%), obesity (12.9%), and high blood pressure (12.2%) were rated as the top three most important health problems in communities.*
- *Mortality rates for diabetes and hypertension were shown to be consistently higher for African Americans than Caucasians in Mississippi; therefore, it is important to focus on populations with the greatest inequities to address obesity in the state.*
- *Social determinants of health (SDOH) are the conditions and environments in which people are born, live, learn, work, play, worship, and age; SDOH contribute to health disparities and inequities.*
- *Participants indicated housing, food insecurity and access, education, and employment as some of the greatest challenges in their communities.*
- *Employment and poverty were consistently listed as barriers to health and well-being, with 11.8% identifying a lack of quality jobs as one of the top issues impacting health and wellbeing. This included unemployment, underemployment, the costs of education/job training, and a lack of well-paying jobs.*
- *Addressing poverty and employment including focusing on educational attainment and job training as well as focusing on SDOH related to structural racism which limits economic opportunity and health attainment among people of color and minorities.*

Based on these findings, the SHIP was updated to set six goals across two priorities:

Priority: Battling Obesity to Manage Chronic Disease

- **Goal 1: Decrease obesity rates through the reduction of food insecurities**
  - Strategic Objective: Decrease food insecurity by reducing the number of food deserts in Mississippi
  - Strategic Objective: Decrease the rate of diabetes in Mississippi in order to address obesity
  - Strategic Objective: Enhance community engagement by strengthening collaborations
- **Goal 2: Decrease obesity rates through the promotion of healthy lifestyles**
  - Strategic Objective: Increase community-based physical activity opportunities

Priority: Improving Social Determinants of Health

- **Goal 1: Increase access to preventive health services**
  - Strategic Objective: Increase utilization of preventive health services
  - Strategic Objective: Increase availability of preventive health services
- **Goal 2: Decrease preventive health barriers related to health literacy**
  - Strategic Objective: Develop a method for assessing personal health literacy
- **Goal 3: Decrease the proportion of individuals with disabilities who experience barriers to preventive health services**
  - Strategic Objective: Increase access to early intervention for developmental delays
- **Goal 4: Decrease the impact that implicit bias has on health**
  - Strategic Objective: Increase the number of health policies that specifically address implicit bias

For more information about the SHIP, link to the UProot Mississippi website at https://uprootms.org/.

Maternal and Child Health Leadership Team

The MCH Leadership Team consists of the core Title V leaders across the five domains. The Team serves as a guiding and decision-making body to assist with the development and implementation of evidence-informed strategies and activities. The MCH Leadership Team also aids in the identification of additional partnerships and resources at the state and local level and assists with the recruitment of members of the MCH Advisory Board to ensure representatives bring expertise and lived experiences to inform all MCH efforts.

Maternal and Child Health Advisory Board

The MCH Advisory Board is composed of 13 external partners, including, adult recipients of MCH services, family representatives of children with and without special health care needs, youth representatives with and without special health care needs, and community-based health professionals and advocates. The role of the MCH Advisory Board is to promote the health and well-being of women, infants, children, children with complex health care needs, and their families. The Board advises the MSDH on MCH/Title V priorities and initiatives. The Board identifies needs, concerns, and gaps in services for families, youth, and consumers as well as reviews the development, implementation, and adoption of programs, policies, and strategies to ensure they are accessible and equitable for MCH populations and promote health, quality of life, and wellbeing.

Other Advisory Boards

Families and consumers also serve in leadership roles to ensure their concerns are addressed and the services provided are family centered. For example, families serve in the CYSHCN program's CYSHCN's Care 2 team, Early Intervention's State Interagency Coordinating Council, and the EHDI program's Advisory Committee.

- The CYSHCN Care 2 team consists of care coordinators, community health workers, and CYSHCN caregivers/parents. The role of this team is to enhance care coordination within family-centered medical/dental homes for CYSHCN. More specifically, the CYSHCN Cares 2 initiative promotes team-based care, population-based services, transitioning to adult healthcare providers, and family engagement.
- The Early Intervention State Interagency Coordinating Council is comprised of 20% parents of children under 12 years of age with developmental delays or disabilities, 20% providers of early intervention services, and representatives of various state agencies and community organizations who provide guidance to the program on addressing the needs of children with developmental delays and disabilities.
- The EHDI Advisory Committee includes a diverse membership of adults who are deaf or hard of hearing (DHH), family members of children who are DHH, healthcare and early intervention providers, and community-based advocates.

[1] 2022 State Health Improvement Plan: https://uprootms.org/wp-content/uploads/2022/08/ship_doc_design2.pdf

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

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

Developing a diverse, knowledgeable, and motivated public health workforce to serve communities is essential to improving Mississippi's health and well-being. Due to retirements and reorganizations, the MSDH has undergone significant personnel changes requiring training for both new and existing personnel to ensure they perform effectively. MCH programs use multiple methods for workforce development, including peer coaching, virtual professional development, and credential programs.

In 2021, the MSDH Human Resources conducted agencywide Workforce Assessment which identified needs for improved training, education, and credentialing of personnel, environments promoting employee engagement and efficient service delivery, and increased diversity of the workforce to reflect the communities served. From the results, the average employee was 49 years old with 10.5 years of experience. Agency staff demographics were as follows:

Race/Ethnicity	Percentage
Black/African American	50.1%,
Caucasian	47%
Asian	0.94%
Hispanic	0.79%
American Indian/Alaska Native	0.15%
Other	0.25%

Gender	Percentage
female	83%
male	17%

During 2022, the MCH Engagement and Coordination Office (ECO), formerly called the MCH Workforce Development Office, assessed the current MCH staff (N=219) to determine their demographics and professional development (PD) needs.[1] The survey had a 55% response rate. Of the respondents, 64% were Black or African American. Additional demographics were as follows:

Employment Status	Percentage
Full-time employees	89%
Full-time contractors	7%
Part-time contractors	4%

Gender	Percentage
female	92%
male	7%
preferred not to answer	1%

Ages	Percentage
25-34	15.7%,
35-44	28.1%
45-55	35.5%
55-64	18.2%
65-70	2.5%

Education Level	Percentage
High school diploma/GED	2%
Associate/2-yr degree	12%
4-year college degree	46%
Master's degree	29%
PhD or higher	7%
preferred not to answer	4%

Desired training topics were: Team building, Leadership, Communication, Critical thinking, Customer service, Decision making, and Problem solving.

The MCH ECO provides a quarterly newsletter called "Connections: Partnering with You" to highlight current public health trends, leadership topics, MCH Program spotlight, national and state resources, a training calendar, public meeting dates, self-care topics, and other professional development opportunities. The current distribution list includes 422 MSDH staff members and external partners.

The Training Calendar offers two webinars weekly, one on MCH Leadership Competencies and the other on requested topics. Over 130 webinars have been provided since 2022, including:

- Best Practices in Public Health Communication to Promote Equity and Inclusion
- Coaching as a Culture
- Communications Crash Course: Social Media for Public Health Communications
- Critical Thinking: Enhancing Judgment and Decision Making
- Declaring Racism as a Public Health Crisis
- Engaging Fathers in Maternal & Infant Health Programs: Importance, Challenges, Strategies
- Managing Conflict in the Workplace
- Public Health & Leadership Introduction
- Put the Ethical Guidelines for the Use of SDOH into Practice

The Leadership for All Book Club was started as another professional development opportunity. Books covered included:

- Developing a Leader Within You 2.0 by John Maxwell (6 participants)
- A Leader's Guide to Unconscious Bias: How to reframe bias, cultivate connection, and create high performing teams, by Pamela Fuller & Mark Murphy with Anne Chow (14 participants)
- The Six Principles for Service Excellence by Theo Gilbert-Jamison (10 participants).

The MSDH Learning Management System (LMS) hosts 22 self-paced training modules for the self-paced learner, including:

- basic computer skills
- Cultural Humility for Case Managers
- Reflective Supervision
- Home Visiting Safety for Case Managers
- STD/STI and Pregnancy
- Impact of Substance Use on Pregnancy
- MSDH Introduction to Motivational Interviewing
- Health Service/Title V Programmatic Orientation

Thus far, 255 participants have completed different modules and 30 participants have completed the Health Services/Title V orientation.

Agency Support for Professional Development

The MSDH provides employees with professional development opportunities to build their capacity. Yearly, MSDH mandates training for all MSDH employees which includes annual HIPAA, Privacy Policy Training, and IT Security Policy training. Staff members are encouraged and supported to attend and/or present at national conferences, including CityMatCH Annual Conference, American Academy of Pediatrics and National Conference and Exhibition, AMCHP, American Society of Health System Pharmacist (ASHP) and Training, EHDI Annual Conference, and the Division for Early Childhood Annual Conference. In addition, staff members participate in programs such as CityLeaders, AMCHP Leadership Labs, and national boards such as Workforce and Leadership Development Committee AMCHP.

The MCH ECO partnered with the **MSDH Office of Preventive Health and Health Equity** for the 10th Annual

Empowering Communities for a Healthy Mississippi Conference to offer a workforce development track. Presentations included:

- Real Colors
- Six Thinking Hats
- Customer Service–it is not just for Walgreens
- Building Connections: Effective Strategies for Developing
- Wheel of Business Communication
- Navigating Challenging Conversations and Building the Workforce by Learning how to Engage People with Lived Experiences
- Adaptability & Flexibility Training to Encompass Resiliency

The **MSDH Quality Improvement (QI) Office** provides a QI process training to introduce the general benefits and reasoning behind quality improvement, provides the introduction of 11 analytical tools and hands-on group activities. During the reporting period, 122 staff participated in the QI Introduction Training and 91 participated in the QI Intermediate Training.

In partnership with the **Office of Health Equity**, the Office of Oral Health (OOH) conducted Cultural Competency Trainings with Jackson State University School of Public Health in January 2023 and September 2023 with 36 students. Two new OOH staff also received training to become cultural competency trainers on June 28-30, 2023, resulting in a total of six OOH team members who are licensed to provide cultural competence training to organizations.

Professional Development Opportunities through Partnerships

The MSDH partners with the **MS Board of Examiners for Social Work and Marriage & Family Therapists (MBOE)** as a Social Work Continuing Education (SW-CE) Designated Provider. The MCH ECO Director and nine MSDH Social Workers serve as an Internal Review Committee for continuing education (CE) to meet MBOE CE guidelines and support licensure renewal. During the project period, MSDH sponsored 9 training events for a total of 25 CE hours at no cost to the social workers. To further increase the capacity of staff, support was provided to social workers preparing for the licensure exam. Twelve Master Level Social Workers participated in a study group with books, sample test questions, flash cards, and summary material provided.

Title V partnered with the **Essie B. & William Earl Glenn Foundation** to support their yearly Adverse Childhood Experiences (ACEs) & Trauma Awareness Symposium. This event brings experts in the field of ACEs and trauma, who share innovative strategies for preventing and mitigating trauma, abuse, and support for vulnerable populations. The 2023 Symposium reached 113 attendees, 23% of whom work for the Mississippi Department of Child Protection Services charged with protecting children, supporting families, and encouraging lasting family connections. Topics included health inequities among under-resourced, vulnerable and marginalized communities, social determinants of health and correlation to ACEs and health issues, natural and man-made environmental issues such as the Flint Water Crisis and Katrina, and the impact of such environmental issues for maternal, fetal and child health outcomes. Evaluations were completed by 53% of symposium attendees who reported 97% stated they “got what they wanted/needed from the Symposium,” 75% stated they were “Very Satisfied” and 97% reported the Symposium sessions were “useful to their professional practice.”

To strengthen family planning services throughout the state, three Nurse Practitioners (NP) completed the Comprehensive Colposcopy Courses organized by the **American Society for Colposcopy and Cervical Pathology**. These NPs will continue with their practicum until they are signed off for independent practice.

The MCH ECO participated in the 2022 Exploratory Workforce Learning Journey with the **National MCH Workforce Development Center (WDC)** between January 2022 to March 2023. The Mississippi team participated in monthly skill building sessions, sharing tools and resources, and individual and group coaching sessions, and completed three projects. The Mississippi team (1) surveyed MCH staff to assess strengths and gaps in their knowledge and skills; (2) developed an orientation on Title V/MCH and public health for new employees and students; and (3) developed a multiyear strategic plan for workforce development activities aligned with the needs and strengths of the MCH public health staff. Surveys of Health Service/Title V on the 12 MCH competencies and other professional development topics identified interests in training on: communication, interdisciplinary/ interprofessional team building, and developing others through teaching, coaching, and mentoring. These results informed the selection of professional development opportunities for the monthly training calendar.

Pipeline from Institutes of Higher (IHLs) Learning

The MSDH works to develop a “pipeline from IHLs” to Public Health through internships. To support this effort, since October 2021, the MSDH has obtained 35 in-state and 15 out-of-state Memorandums of Understanding (MOU) with IHLs to host interns from Social Work and Public Health programs. During the project period, the MCH ECO hosted three virtual and one on-site interns. The first intern, from the University of Southern Mississippi, School of Social Work, assisted with enhancing the MCH focus of an existing course: *Evidence-Based Public Health: Course in Chronic Disease Prevention*. The second intern, a 10-week summer GSEP intern through the AMCHP Workforce Development and Capacity Building program, developed a programmatic internal review of strengths and gaps across the MCH Domains (i.e., Women’s/Maternal Health; Perinatal/Infant Health; Child Health; Adolescent Health; CYSCHN; and Cross-cutting/Systems Building) to identify priority areas, strategies, and activities per domain. The third intern, from Walden University’s, Bachelor of Social Work program, assisted with building capacity for the Lead and Healthy Homes program and development of study tools for public health social workers. The fourth intern, a DrPH student from Jackson State University, School of Public Health, developed a tool for comparing MSDH home visiting programs to each other and other national programs.

The **Office of Oral Health, Program Interns** continues to expose students (elementary, middle school, high school, college, and post baccalaureate) to the numerous careers in dentistry and to encourage them to pursue the dental field. During this grant cycle, we offered two intern positions to students seeking a career in dentistry. One participated in our DAT Reimbursement Scholarship Program and is now pursuing a master’s degree from University of Mississippi Medical Center, School of Graduate Studies in Health Sciences Biomedical Sciences program. She is simultaneously applying to dental school and is has been wait listed for one dental school. The other intern has been working in the private sector as a registered dental hygienist but is interested in public health dentistry. She received her Master of Public Health Degree from University of Southern Mississippi in December 2023. These interns participated in a variety of public health and professional training and completed projects on dental workforce efforts, program evaluation/assessment, program planning, and grant writing. Due to their successful performance, each intern was offered a contract position to continue with the OOH to assist with various projects as the OOH workforce is being rebuilt.

At least two past interns and DAT scholarship reimbursement participants applied to and received the National Health Service Corps scholarship and are dental scholars with the program. As such post dental school, they have committed to practice dentistry in underserved or underinsured communities that qualify with the appropriate health provider shortage designation scoring. Additionally, one of our dental school students was accepted into a Public Policy program at Meharry Medical College, School of Dentistry.

Professional Development Offered by MCH Programs

Office of Oral Health (OOH)

Pathways2Possibilities (P2P) is a hands-on, interactive career expo for 8th graders and youth, ages 16-24, in South Mississippi every November at the Coast Convention Center in Biloxi, Mississippi. This career expo has expanded to the MS Delta at the Washington County Convention Center and is held every February. Two OOH contract workers participated in the career fair and shared oral health education as well as allowed students to participate in the indirect vision challenge, and conduct student-led mock oral screenings. Student participation at the coastal event numbered 6,621, and in the Washington County event, 1,352.

Community Health Workers Training: District Community Health Workers (CHW) and Regional Oral Health Consultants (ROHC) are both located throughout the state. The following interactions were recorded for the period of December 2022-April 2023:

- Dec. 1, 2022: Shared World Aids Day with CHW Robert (Dylan) McCoy and Patricia Taylor was shared on their social media platforms.
- Jan. 17, 2023: Southern District Meeting with CHW Dylan McCoy and Health Educator Kim Viewig discussed upcoming events and how the CHWs can work with the Office of Oral Health. Based on this meeting, a CHW component was the Forrest General Hospital Oral Cancer Awareness Event.
- April 19, 2023: The Offices of Community Health Worker and Oral Health met to begin conversations on the roles of the ROHCs and CHWs and how to collaborate best to meet the needs of our constituents. This meeting allowed team members to connect based on their locations throughout the state and gather more insight and value for each other's roles.

The **University of Mississippi Medical Center Shaping Minds to Inspire Lead and Explore (S.M.I.L.E. U) Summer Program** serves as an outreach and recruitment tool for eligible 6-8th grade students from underrepresented groups by providing early exploration of careers in Dentistry. S.M.I.L.E. U brings awareness to the academic curriculum and noncognitive skills needed to increase chance of success for undergraduate acceptance and admittance into professional health programs. The goal of S.M.I.L.E. U is to create interest in pursuance of dentistry as a career choice by teaching the importance of oral health, different career options in the dental field, and the steps to successfully gain admittance into dental school as early as possible through targeted, age specific exploration. On June 8, 2023, the OOH provided hands on learning opportunities for the students on the process of water fluoridation, causes and effects of enamel erosion, and the amount of sugar in common beverages. The students also participated in the Life Course game to "offer a way of looking at health, not as disconnected stages unrelated to each other, but as an integrated continuum." This game shows how many facets contribute to health outcomes across the course of one's life. "It builds on the public health and social science literature which highlight the influence of each stage of life on the next and shows how social, economic, and physical environments interact to have a profound impact on individual and community health."

We remain committed to replenishing the dental workforce and showcasing the importance of oral health to overall health. Dr. Filzen participated in the Evidence-Based Public Health (EBPH): A Course in Chronic Disease Prevention training hosted by the Mississippi State Department of Health, August 7-10, 2023. This training was sponsored by the Center for the Study of Community Health, School of Public Health, University of Alabama at Birmingham.

The course was centered around the following modules:

1. Introduction and overview of EBPH
2. Assessing and engaging communities

3. Quantifying the issue
4. Developing a concise statement of the issue
5. Searching and summarizing the scientific literature
6. Developing and prioritizing intervention options
7. Developing an action plan and building a logic model
8. Understanding and using economic evaluation
9. Evaluating the program or policy
0. Communicating and disseminating evidence to policy makers

Healthy Moms/Healthy Babies Program of Mississippi (HM/HB)

Effective July 2022, the historic perinatal case management program was rejuvenated and rebranded as the HM/HB. This new family support program's mission is focused on partnering with families and communities to ensure all Mississippi moms and babies have a safe birthing experience and healthy infant development. The program aims to decrease preterm births, improve maternal health, decrease infant mortality, and support infant physical and mental development.

To support the transition from a 3-person case management model, i.e., Nurse, Social Worker, and Registered Dietician, to a nurse case manager with social workers and RDs serving as Extended Service Providers, the HM/HB provided training to build workforce capacity. HM/HB significantly increased its staffing of Nurses as Nurse Case Managers, growing from 3 to approximately 40 nurses. In partnership with MPHA and UMMC, HM/HB developed new standards of case management for the program and training modules to prepare new personnel. MSDH social workers were then transitioned to support multiple MCH programs, including Genetics/Newborn Screening, Lead, and CYSHCN.

Trainings for staff include:

- Social Work and Psychosocial Assessments (10/6/2022 approx. 60 MSDH staff attended virtually)
- Understanding Complications in Pregnancy (10/18/2022 approx. 60 MSDH staff attended virtually)
- SBIRT training regarding SUDs (11/10/22-11/17/22, 50 staff from HM/HB participated with other MSDH staff)
- Helping Families Cope with Grief (11/17/2022, 60 HM/HB staff attended virtually)
- MS Telehealth Baby and Me Tobacco Free Informational (11/30/2022, 40 HM/HB staff attended virtually)
- HM/HB Nurse Training on Referrals and Targeted Case Management (3/6 and 3/9/2023, 30 staff attended)
- Syphilis and pregnancy education and updates (March 2023, 40 HM/HB staff attended with other MSDH staff)
- Community Health Worker training (4/11/23, 25 staff HM/HB staff attended with other MSDH staff)
- EPIC Cadence Training for Nurse Case Managers (04/19/23, 30 participants attended)
- Postpartum Wellness Summit (5/4/23, 30 staff attended from HM/HB along with other professionals)
- Mandatory Reporting Infant and Child Abuse, Who Reports? Training (05/18/23, 30 MSDH social workers attended)
- Sickle Cell Disease: Promoting Family Cantered Support and Self-Management (6/14/23, 20 HM/HB staff attended)
- Oral Health Training (7/11/23 and 7/13/23, 50 HM/HB staff participated)

HM/HB also developed weekly/monthly staff meetings including Monthly Case Rounds, Midwife Monday, Nurse Team Lead Meetings/Updates. HM/HB has partnered with MSDH Quality Improvement dept where 6 HM/HB staff members meet periodically to discuss a logic model to improve program performance and participation. HM/HB were also able to provide nurse case managers with Nurse Home Visiting Kits to be able to provide quality care, education and monitoring of high-risk pregnant women and infants.

In August and September 2023, HMHB was able to onboard three phenomenal staff/consultants to the HM/HB leadership team:

- **Certified Nurse Midwife** – provides clinical consultation to HMHB staff, liaison between providers and HMHB, creates health education, leads Midwife Mondays – clinical updates and training to HMHB staff.
- **Pharmacy Consultant**- provides medication management education, referrals, advocacy, health education, to patients with diabetes, gestational diabetes, hypertension, pregnancy induced hypertension, preeclampsia. Provides consultation to HMHB staff. Introduced the need for HMHB patients to have access to prenatal vitamins in MSDH clinics.
- **Clinical Director** – provides clinical oversight and training to HMHB program, directly supervises Nurse Team Leads, nursing staff. Billing and reduction of errors has improved greatly since the Clinical Director was onboard.

Early Intervention

Throughout the project period, the Mississippi First Steps Early Intervention Program partnered with the University of Alabama's Evidence-Based Internation Early Intervention Office (EIEIO) to create a 13-module online course on the **Routines-Based Model (RBM)**, an evidenced-based family-centered model of early intervention service delivery. Fifteen Service Coordinator Coaches participated in the training course both to earn their RBM certification and to become trainers. Upon completion of the course, participants will be able to support additional staff in completing the RBM credential.

Each module contained presentations, readings, videos, reflection assignments, practice assignments, and a test. The 13-Modules are as follows:

1. Introduction to the Routines-Based Model
2. Ecomap
3. Routines-Based Interview (Structure)
4. Routines Based Interview (Engagement, Independence, and Social Relationships Details - Digging Deeper)
5. Goal Decision making and matrix
6. Informal RBI Goals to Participation-Based Goals - Family Goals
7. Primary or Comprehensive Service Provider
8. Routines-Based Home Visits (Structure)
9. Routines-Based Home Visit (Family Consultation)
10. Collaborative Consultation to Children's Classrooms/Collaborating
11. Collaborative Consultation to Children's Classrooms/Integrated Services
12. Engagement Classroom Model strategies
13. Data Collection

In addition, the Mississippi First Steps Early Intervention Program continued its partnership with the Mississippi State University to maintain the **Early Intervention Credential Program-Level I**. This credential is designed for entry-level professionals and those who have not earned a credential specific to the provision of early intervention services. All personnel engaged in the early intervention system are expected to earn the Level I credential, preferably prior to or during their first year in the early intervention system. During the project period, 17 personnel completed the EI Credential Program-Level I.

The Early Intervention Credential Program, Level I, contains six (6) curriculum modules:

Module 1: Introduction to Early Intervention

- Unit 1: Early Intervention Services and Practice
- Unit 2: Federal Guidelines that Govern Early Intervention Services

- Unit 3: The Impact of Atypical Development on the Child and Family
- Unit 4: Working with Special Education and Related Service Providers

Module 2: Family Centered Practice
- Unit 1: Introduction to Family Centered Care
- Unit 2: Collaboration and Teamwork with Families
- Unit 3: Supporting Families in Natural Environments
- Unit 4: Interventions During Daily Routines

Module 3: IDEA Law
- Unit 1: What is IDEA?
- Unit 2: Part C of IDEA
- Unit 3: Part B of IDEA
- Unit 4: IDEA Due Process

Module 4: Evidence-Based Intervention and Instruction
- Unit 1: Typical and Atypical Development
- Unit 2: Individualized Intervention and Instruction
- Unit 3: Assessment Practices
- Unit 4: Introduction to Tele-Intervention for Children and Families

Module 5: Coordination and Collaboration
- Unit 1: Effective Communication and Coaching
- Unit 2: Tele-Intervention and Coaching
- Unit 3: Partnering with Families for Effective Evaluation and Services
- Unit 4: Role of a Consultant

Module 6: Professionalism
- Unit 1: Using Data to Enhance Services for Children and Families
- Unit 2: Using DEC Code of Ethics, DEC Position Statements, and Recommended Practices
- Unit 3: Advocacy and Equity in Early Intervention
- Unit 4: Being a Reflective Professional

Each module is subdivided into four units and contains varied content, including slide presentations, videos, readings, reflective activities, and quizzes. In general, the modules are self-paced, involving asynchronous online instruction supported by experts within the Mississippi State University School of Human Sciences. The 6-module sequence requires participants to complete each module, with passing quiz scores, within a two-month period to be approved to move forward to the next module in the sequence.

[1] The goal is to send this survey out again summer 2024 for a comparison to the 2022 baseline data.

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

The MSDH understands family/consumer engagement is a core principle of the Maternal and Child Health Program. To ensure MSDH programs are family-centered in their policies and approaches, the MSDH developed and adopted a *Maternal and Child Health Engagement Manual* originally in 2020.[1] This manual provides a framework and set guidelines for the engagement of families served by MCH programs. The guidance was developed to align with the agency's mission "to protect and advance the health, well-being and safety of everyone in Mississippi", and encourages a health equity approach and use of strategic community partnerships to eliminate inequities. The goal is to ensure effective, well-integrated family/youth/consumer participation in the design, implementation, and evaluation of MCH programs.

The guidance was informed by several models of family engagement, including:

- Association of Maternal and Child Health Program's (AMCHP) Levels of Family Engagement[2]
- Joyce Epstein's Framework of Six Types of Involvement[3]
- Lucille Packard's Framework for Assessing Family Engagement in Systems Change[4]

Levels of Engagement

As a result the MSDH Title V/MCH Program adopted the following levels of engagement:

1. **Inform:** Provision of public health information to the general public and targeted populations is integral to the mission of the agency. Information is used to increase health literacy in a culturally and linguistically appropriate manner for the target audiences. Communication channels are diverse, using consistent messaging, evidence informed/evidenced-based practices, and promote linkages to resources. MCH programs use a variety of resources, including but not limited to: print media, digital media, publications (peer/non-peer reviewed), mass media, social media, curricula, public service announcements (PSAs), and webinars. A significant proportion of interactions with MCH populations occurs at this level which still has the potential for generating meaningful and positive public health impact.
2. **Consult:** Engagement at this level involves programs seeking more specific assistance regarding the acceptability, clarity, and appropriateness of program practices and materials. MCH programs have varying levels of outreach and service provision, but all have a process for obtaining feedback about the quality of the program and services offered, such as satisfaction surveys, parent interviews, focus groups, pre-testing of program materials, or community forums. MCH Program consult with families/youth/consumers to solicit feedback, such as the accessibility of services, clarity of message, courtesy/helpfulness/professionalism of personnel, timeliness of services, (general or program-specific) knowledge, and overall satisfaction.
3. **Involvement:** This level of engagement is exemplified by multiple strategies within MSDH MCH programs. Programs which provide home visitation and coordinating services assist clients/families with providing optimal environments for growth, cognitive and socio-emotional development, and positive health outcomes by enhancing parenting, lifestyle, and self-management skills. This supportive, asset-building role builds family capacity for mitigating risks, strengthening resiliency, and involvement in assessments and implementation of health interventions.
4. **Collaboration/Partnership:** This level of engagement mirrors the practices of community engagement and coalition building, including collaboration, accountability and transparency. At this level, families/youth/consumers serve on advisory councils and board and/or are engaged in teams with program personnel, serving in explicit roles as equal partners and indispensable contributors who provide a lens of lived experiences to interpret and guide the production of products and plans. To support collaboration/partnership, MCH Programs provide access to training to family members/consumers, i.e., *Serving On Boards*, to ensure they have the support for being equal partners and contributors.

5. **Shared Leadership:** At this level of engagement, stakeholders are in leadership positions and share decision-making responsibilities. Shared leadership is evident in MCH Programs who are guided by family/consumer leaders. For example, MCH Programs employ family members/youth/consumers to lead their family/youth engagement efforts and/or explicitly require the chair of their advisory councils and board to be chaired by families/youth/consumers. To support shared leadership, MCH Programs provide access to leadership training to family members/consumers to ensure they have the knowledge, skills, and confidence to serve in a leadership capacity.

Inclusion

Interactions should be characterized by inclusivity to ensure all MCH populations in the state have equal opportunities to participate at their desired level of engagement, regardless of their race, ethnicity, language, geography, income, educational, and health literacy levels. This requires engagement interactions to be authentic, compassionate, supportive, non-judgmental, professional and customer-focused. MCH professionals must demonstrate mutual respect, competence, and an appreciation of the considerable assets of MCH clients/families/consumers. All policies, partnerships, and practices must be developed and implemented with cultural sensitivity.

New Family Engagement Efforts During FY2023 and Since

Increased Social Media Presence

As part of FY23 and subsequent state action plan strategies, MCH Programs have increased their social media presence to provide outreach to people with lived experiences and to educate and strengthen family voices throughout their work. Programs such as Genetics, Healthy Moms/Healthy Babies, Oral Health, Early Hearing Detection and Intervention, and Breast and Cervical Cancer have used social media to disseminate information, especially during health observances. This engagement involves efforts to “inform/educate, communicating to the people you serve, and educating them about innovative efforts. People with lived experience are recipients of information and education. They are informed about programs and activities” through social media.[5]

Between October 2022 and September 2023, the MCH program collaborated with the MSDH Office of Communications to post on a variety of MCH topics on various social media accounts, including Facebook, Instagram, and Twitter/X. The Office of Communications tracked measures regarding each posting:

- **Facebook**: 104 messages on MCH topics, resulting in:
  - 569,835 impressions
  - 554,780 people reached
  - 1,302 link clicks

- **Instagram**: 81 messages on MCH topics, resulting in:
  - 62,617 impressions
  - 58,961 reaches
  - 188 shares
  - 741 likes

- **Twitter/X**: 32 messages on MCH topics, resulting in:
  - 57,907 impressions
  - 188 shares
  - 90 URL clicks

Examples of the postings include, but not limited to:

#FolicAcid is a B vitamin that helps prevent birth defects in your baby's brain and spine when mothers take it before and early in their pregnancy. You can get your necessary folic acid from a vitamin that contains folic acid, or by choosing foods fortified with folic acid, or by eating foods that naturally contain folates, such as leafy dark green vegetables and beans. Read more about this essential nutrient at HealthyMS.com/folic #HealthyBabies #HealthyMS #PowerToPrevent
COMING NEXT WEEK. The statewide Maternal Health Symposium addresses the serious issue of pregnancy-related deaths in Mississippi's mothers and infants. If you're a health professional, health planner, or have an interest in your community's health, register now to attend this free symposium in Jackson with maternal health experts. Be part of the change! Free registration: https://app.smartsheet.com/b/form/de8488c713b1405fb5b467ce8085e114 #HealthyMomsHealthyBabies #HealthyMS #ChangeCantWait
Each year, routine newborn screening identifies 60-75 Mississippi babies born with genetic disorders that can put their health at risk. This early detection means that steps can be taken immediately to ensure that newborns thrive in spite of obstacles. #HealthyBabies #HealthyMS https://t.co/DrQwBFjDEz
Mississippi had the highest rate of stillborn infants in the nation as of 2021, losing 355 unborn babies that year. Moms, track your baby's health during pregnancy with the free "Count the Kicks" app on your smartphone. Get it from your app store today. #ChangeCantWait #HealthyMS https://t.co/94QB1Mm1Uf
It's true: gum disease is linked to many chronic diseases, including diabetes, heart disease and stroke. Getting regular dental care and brushing daily keeps your smile bright and your body healthy! Learn more at HealthyMS.com/brush. #HealthyMouth #HealthyAging #HealthyMS
Join MSDH and the Museum of Natural Science for this family-friendly event on October 21! We'll have free health screenings and much more at this 5K walk/run to support #BreastCancer prevention. We look forward to seeing you there! Register for the free 5K at HealthyMS.com/walk
We're on a mission to give Mississippians a healthier future from the start. If you're an expecting mother with health challenges, or have a child with health needs that are hard to meet, we have free programs that can help. Check out our offerings — one may be right for you: HealthyMS.com/justformoms #HealthyMomsHealthyBabies #HealthyMS

Redesigned Peer Support Training for Parent Leaders

The EHDI-MS program revamped its Family Support Program which provides ongoing informational and emotional supports to parents of infants and toddlers who are diagnosed with confirmed hearing loss between birth and 36 months of age. The program employs parents of children who are Deaf/Hard of Hearing (DHH) to serve as Family Advisors and adults who are DHH to serve as DHH Role Models. In partnership with Families as Allies, the

Mississippi Family Voices recipient, training was developed to provide intensive, ongoing education and support for new and existing Family Advisors and DHH Role Models to provide peer counseling and nonbiased and nonjudgemental support. This training was implemented in the FY 2024 program year and is planned to be continue in the FY 2025 program year.

Advisory Committees

Maternal and Child Health Advisory Board

The Maternal and Child Health Advisory Board, which include family/consumer representatives, assists all MCH programs by:

- Reviewing the development, implementation, and adoption of programs, policies, and strategies to ensure integration across agencies and systems
- Advising on methods of integration at the local and state level
- Advising use of block grant funds to address needs in local communities based on state measures and supported by data
- Assisting in the development of information on MCH services and activities to ensure information is created in a culturally, literacy-level, and linguistic manner

Some MCH programs also have a program-specific advisory boards or committees based on federal or state requirements.

State Interagency Coordinating Council (SICC)

The Early Intervention Program has an advisory group, the State Interagency Coordinating Council (SICC) for Early Intervention, that provides guidance on all programmatic activities. The members of the SICC are composed of a minimum of 20% family members, including parents of children under six years of age. The Early Intervention Program continued to participate in intensive technical assistance from the national Early Childhood Personnel Center (ECPC), focused on the preparation personnel who work with young children with disabilities and their early childhood partners. The Early Intervention Program assembled a cross-state leadership team of nine people, including a parent representative, to participate in guiding the state effort.
The Early Intervention Program has supported this parent leader in ongoing participation on parent leadership initiatives at the state and national level.

EHDI-MS Advisory Committee

The EHDI-MS Program has an Advisory Committee of various screening, diagnostic, and intervention professionals as well as adults who are Deaf/Hard of Hearing (DHH) and family members of children who are DHH. Family members and adults who are DHH make up 20% of the Advisory Committee membership. This Advisory Committee has three workgroups, each with family representatives, who work on (a) systems building, (b) professional development and quality improvement, and (c) family engagement. The family engagement workgroup provides direction and feedback on the program's communication and diversity plans and helped establish the family support program. The EHDI-MS Advisory Committee also has members who work with other MCH programs on its family engagement board to expand efforts to promote higher levels of family engagement throughout our system.

Genetics Advisory Committee

The Genetics Advisory Committee (GAC) provides recommendations to the MSDH and Board of Health regarding rules, regulations, and procedures governing the operation of newborn screening and birth defects, including adoption of conditions to the Mississippi Newborn Screening Panel. The committee meets twice annually and is comprised of 13 volunteer members, including national experts, clinicians, consumers, parents, advocates, and

partner agency representatives. In 2022, HB 927 was passed requiring the Mississippi Newborn Screening Panel to include all Recommended Uniform Screening Panel (RUSP) conditions within three years of adoption, making a significant change to the role of the GAC. This change freed the GAC from spending most of its time focusing on *which* conditions to adopt and now allows them to provide more guidance and support to the NBS Program in the development and implementation of guidance and education for healthcare providers and families on the current and newly added conditions on the Mississippi Newborn Screening Panel, identifying and sharing testing and treatment options, providing guidance on public awareness and prevention efforts, and recommendations on newborn screening fees.

LPPHHP Advisory Board

The Lead Poisoning Prevention and Healthy Homes program (LPPHHP) established an advisory board in 2021 to advise the LPPHHP on the planning and implementation of lead screening, advocacy measures, policy recommendations and education/outreach. The board has also been responsible for advising and support the LPPHHP on legislative issues pertaining to lead and other environmental hazards affecting children, assisting with monitoring the progress of the LPPHHP in the implementation of the suggested activities, and to collaborate with the LPPHHP outreach efforts to educate the public about the effects lead poisoning has on young children and the requirements for screening, testing, follow-up, and reporting.

During the FY23 program year, the Lead Advisory Board met three times to address issues and concerns around lead poisoning. During these meetings the Risk Assessment and Healthy Homes Summary was revised to add additional questions regarding lead risk factors in hopes more children would be identified for testing for lead poisoning.

Community Water Fluoridation Advisory Board Committee

In 2021, the Offices of Oral Health and Environmental Health reconvened the Community Water Fluoridation Advisory Board Committee to identify strategies to improve acceptance of community water fluoridation in the state. The community water fluoridation program is housed under the Office of Environmental Health due to the regulatory compliance component; however, the Office of Oral Health closely collaborates with the Office of Environmental Health to share the benefits of community fluoridation in the prevention of oral disease. The Advisory Board promotes collaborative efforts with providers, public health organizations, and community stakeholders to increase the percentage of Mississippi residents who have access to community water fluoridation to 77% to meet the Healthy People 2030 goal. The Advisory Board and the American Fluoridation Society helped create a new community water plan for 2022-2025. The main goal for Mississippi's Fluoridation Plan is to improve oral health outcomes across all communities through access to optimally fluoridated drinking water. The plan has 5 goals, each with corresponding objectives:

- **Goal 1**: Mississippi has a network of stakeholders across the state who collaborate effectively to promote community water fluoridation
- **Goal 2**: Mississippians understand the benefits of community water fluoridation
- **Goal 3**: Community water fluoridation is available to future generations
- **Goal 4**: Communities in Mississippi have access to data they need to promote and protect community water fluoridation.
- **Goal 5**: The Mississippi Community Water Fluoridation Plan has an evaluation system to provide accountability and demonstrate plan progress

During the FY23 program year, the MS Community Water Fluoridation Advisory Board met quarterly on the following dates: (1) January 25, 2023; (2) April 19, 2023; and (3) August 16, 2023. Select members of the Mississippi Community Water Fluoridation Advisory Board also met intermittently to discuss best practices to achieve the goals

listed within the recently updated MS Community Water Fluoridation Plan, 2022-2025.

The final quarterly meeting was held December 20, 2023. Subsequent quarterly meetings will resume in January of 2024, where the focus for both new and existing members of the MS Community Water Fluoridation Advisory Board will be primarily on the MS Community Water Fluoridation Plan. Follow-up actions with constituents will ensure the implementation of more innovative ideas that will successfully propel the fluoridation initiative in Mississippi forward.

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[1] http://msdhweb/infocentre/manuals/m914.pdf
[2] https://amchp.org/wp-content/uploads/2021/11/Family-Engagement-Levels-of-Family-Engagement.pdf
[3] https://us.corwin.com/books/school-family-and-community-pa-242535 and https://www.oregon.gov/ode/educator-resources/Documents/6typesj.epstien.pdf
[4] https://lpfch.org/resource/a-framework-for-assessing-family-engagement-in-systems-change/
[5] source: https://mchwdc.unc.edu/wp-content/uploads/2022/10/Successful-Engagement-with-People-who-have-Lived-Experience-October-2022.pdf, page 24

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The Offices of Health Data, Operations, and Research are comprised of eight offices and approximately 150 personnel dedicated to health information management, epidemiology, technology, and data infrastructure for the Mississippi State Department of Health. Several of the offices provide support to Maternal and Child Health programs through indirect grant funding, such as the Offices of Data Governance, Information Technology Security, Health Information Technology Epic, Health Information Technology Support, Health Information Technology Operations, and Revenue Cycle. Others are funded in part by the Title V/MCH Block Grant, such as the Office of Health Data and Research and the Office of Vital Records and Public Health Statistics.

The Office of Health Data and Research provides non-communicable epidemiology and biostatistical support including surveillance, data analysis, reporting, and program evaluation. The office is currently without a director and Dorthy Young, PhD, MHSA, CCSA, CHP. CMPA, MSDH Chief Health Data, Operations and Research Officer, who supervises the position, is serving in this role. The epidemiological and biostatistical staff are directly supervised by a dual leadership team of Ellen Agho, DrPH, MPH, CHP, as the epidemiological lead and DeGarrette Tureaud, MPH, MBA, CPM, CHES, as the administrative lead. Presently, the dedicated MCH epidemiology workforce is composed of three full-time MCH epidemiologists, one full-time research data analyst, and one part-time research data analyst. In addition to these state staff, MSDH hosts a CSTE Applied Epidemiology Fellow.

The MSDH epidemiological workforce in the Office of Health Data and Research is located at the MSDH Central Office in Jackson, MS. OHDR is composed of professional staff who hold advanced degrees (MPH, MS, PhD, DrPH) in public health, epidemiology, and/or biostatistics. Many staff also hold advanced degrees in medical, allied health, or technical disciplines. All epidemiologists are required to have advanced degrees, work-related experience, and complete, at a minimum, HIPAA, information security, human subjects research, EPIC (for those using the EPIC health electronic records), emergency preparedness training, health equity, Civil Rights, and implicit bias training. MSDH also supports and encourages additional training and skills-building opportunities for analytic skills.

Recently, the Office of Vital Records and Public Health Statistics enhanced its partnership with the MSDH MCH program by providing direct epidemiological support outside of traditional roles of providing registration, amendment, issuance, and maintenance of certificates of birth, death, fetal deaths, induced terminations, marriages, and divorces. The Vital Records and Public Health Statistics epidemiology personnel are also responsible for BRFSS, PRAMS, and statistics of vital events in the state of Mississippi. The staff currently conducts the following MCH activities: Title V measure data analysis, CYSHCN data reporting, Maternal Mortality Review Committee data analysis and reporting, Infant Mortality Review Committee data analysis and reporting, and Healthy Moms/Healthy Babies vital records mortality review and birth data support.

The MCH epidemiologists and research biostatisticians participated in AMCHP, HRSA/MCHB and CSTE live in-person and virtual and archived training and peer learning opportunities. The team is also actively involved in the MSDH Grand Rounds and several presented projects and analyses during the grant year.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

MS SSDI is used continuously to support the work of the Title V/Maternal and Child Health (MCH) Block Grant reports and related analysis. The SSDI funding provides software, hardware, and professional development opportunities for analysts and staff in the Office of Health Data and Research (OHDR) to advance data capacity. MSDH continues to focus on modernization, data accessibility, and collaborative evidence-based approaches to enhance Mississippi's capacity to obtain and use critical maternal and child health data.

Goals and Activities

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to ensure data-driven programming.

The Office of Health Data and Research staff accesses, collects, analyzes, and uses reliable data from various internal MSDH offices and external state agencies, such as the Mississippi Division of Medicaid, the University of Mississippi Medical Center (UMMC), the Department of Education, and the Department of Human Services to develop indicators not directly available to MS SSDI Programs. Mississippi SSDI promotes data sharing within agency data systems and encourages enhancing current systems instead of building new ones. Likewise, SSDI supports the building of Mississippi MCH data capacity to support Title V program efforts and contributes to data-driven decision-making in public health and clinical programs. This includes needs assessment and Title V MCH Block Grant data support, identification of structural and process measures for the Title V program, and supporting MCH programs to develop State Performance Measures (SPMs) to address priority needs.

To meet this goal, the agency focused on the following activities:

1. Provide technology and data support to MCH programs
2. Provide data support for the Title V Block Grant application and reporting processes Develop/review structural/process measures
3. Support the implementation of a statewide Needs Assessment for the Title V Block Grant; Establish/review performance objectives for all measures
4. Provide coordinated data and technical support for timely and accurate Title V MCH Block Grant submission

Objectives and activities for the five-year term of this goal are to provide data and support to MCH programs across the agency, particularly the Title V Block Grant application and reporting processes and statewide needs assessment. Throughout the five-year term, SSDI will continually provide data and technical support for timely and accurate Title V MCH Block Grant submission. The MCH data capacity of the OHDR has dramatically benefitted from SSDI funding support. The ability to purchase needed software licensure and support epidemiologists and statisticians to conduct MCH data analysis is critical to the goals outlined in this application. In addition, with an emphasis on MCH data, the Office of Health Data and Research provides data analysis and reporting support to other Health Services offices, including the Offices of Women's Health, Child and Adolescent Health, and Oral Health. The epidemiologist and research biostatisticians also respond to data requests from other state agencies, the Mississippi Legislature, and the public.

Goal 2: Strengthen access to and linkage of key MCH datasets to inform MCH Block Grant programming and policy development and assure and strengthen information exchange and data interoperability.

Mississippi's analytic capacity has improved with the SSDI program funding throughout the previous grant cycles. However, some critical issues are still pending to complete the implementation of data linkages. Mississippi SSDI recognizes that data at the state and local levels are scattered among several agencies and departments, making it

difficult for community groups to compile and use data to guide decisions. MSDH's leadership also recognizes the need to evolve and the importance of having linked datasets that state and community stakeholders can use to increase collaboration and timely access to data. Utilizing related data systems increases state agencies, community stakeholders, and policymakers' capacity to design policies and fund interventions that affect health. Linked datasets provide early information to identify areas of vulnerability, monitor health disparities, and detect manifestations of adverse effects on health outcomes over time across domains of health or for a variety of subpopulations defined by geography, ethnicity, or other characteristics.

During the previous grant cycles, MSDH has focused on increasing the utilization of core data sets to create a robust data structure that supports State MCH efforts. The agency also renewed existing MOUs with the Division of Medicaid and expanded internal partnerships with the Office of Vital Records and Statistics for the linkage of birth records and program data such as lead poisoning prevention, newborn screening and maternal mortality data, and PRAMS to access essential data about women before, during and just after pregnancy. For the current grant cycle, Health Services will continue to focus on improving its collaboration with internal and external partners. The goals are to identify existing data gaps to meet the Minimum or Core Datasets (M/CDS), initiate all necessary MOUs to close data gaps and access the data elements necessary to meet the M/CDS and implement a new data linkage between birth and death records, and hospital discharge data or Medicaid eligibility data; and improve the availability and timeliness of linked MCH data reporting and the utilization.

In previous years, the SSDI epidemiologists supported efforts to obtain access and make available minimum or core datasets (M/CDS) through various sources. Many of these indicators will be utilized, as needed, for the Title V Needs Assessment and various reporting activities. To meet M/CDS, an assessment to evaluate Mississippi’s capacity for reporting on the M/C Indicators will be conducted. Much of the data is captured through the Office of Vital Statistics and the Mississippi Department of Medicaid, two stakeholders in the MCH programs. MOUs were also executed with managed care organizations that operated the Division of Medicaid programs. For the coming year, SSDI/MCH epidemiologists will continue to analyze both unlinked and linked datasets to support programmatic efforts. MSDH will maintain the data-sharing agreements with the Division of Medicaid and increase collaboration with internal and external partners to assess data gaps.

The SSDI/MCH epidemiologists have continued to analyze linked data to support programmatic efforts. In addition, the epidemiologists have worked with the Office of Vital Records and Statistics and the Division of Medicaid to ensure the timely linkage of birth certificates and Medicaid beneficiary data. The MSDH SSDI Program has maintained the data-sharing agreement with the Division of Medicaid and increased collaboration with internal and external partners to assess data gaps. The MS SSDI team has also maintained internal partnerships with the Office of Vital Records, Public Health Statistics, and PRAMS. MSDH MCH team and SSDI epidemiologists are authoring a plan to conduct a data needs assessment to create a statewide MCH data analysis plan that involves key data linkages, highlighting the need for integrated data at the state level. This plan would utilize existing agency strategic plans and individual program strategic plans for a comprehensive maternal and child health agenda that addresses state health improvement plans for long-term MCH data support. The plan will include considerations for MSDH Offices of Health Information Technology and Office of Data Governance to improve the data collection, storage, and dissemination for MCH surveillance and programs.

The epidemiologists in Health Data and Research are working with the MCH Office of Oral Health to update the Mississippi Dental Health Professional Shortage Areas (HPWA) map. The title V/SSDI team is developing a plan for additional data needs assessments to be conducted by the epidemiology staff in the Office of Health Data and Research and epidemiology staff serving MCH programs throughout the agency.

Goal 3: Enhance the development, integration, and tracking of health equity and social determinants of

health (SDoH) metrics to inform Title V programming.

The MSDH SSDI program recognizes the need to integrate and track the status of health equity data and the social determinants of health metrics to create and implement proper tools to plan and evaluate MCH programs effectively to inform Title V programming. Through these performance measurement efforts, Title V/SSDI epidemiologists can collect valuable contextual data that can help improve MCH service delivery and results. Therefore, the Title V MCH and SSDI team will track, monitor, and measure programs' activities and efficacy. MCH and SSDI will continue engaging with the MSDH multi-office initiative to develop a health equity data project that will guide the use of small numbers and best practices on data aggregation/disaggregation regarding race and ethnicity. For example, in Mississippi, there are difficulties in reporting data on some communities, i.e., Hispanics, Asians, and Native Americans, because of their small numbers and the utilization of outdated systems and definitions to collect race and ethnicity information. MSDH's Office of Vital Records and Public Health Statistics uses the NCHS standards.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Increasing Data Capacity Efforts

The Offices of Health Data, Operations, and Research conducted activities throughout several offices that support MCH data capacity enhancement activities. The Office of Data Governance provides legal oversight in the sharing and use of MSDH data within and outside the agency. In 2020 the office launched an online data request process for internal and external requesters to easily submit data requests. In 2021 MSDH Institutional Review Board (IRB) functions moved to the office to better coordinate the research and data capacity of the agency. This has enhanced the utilization of data and improved data capacity related to MSDH data.

The Office of Health Data and Research provides non-communicable epidemiology and biostatistical support including surveillance, data analysis, reporting, and program evaluation for MCH. Current MCH activities that improve data capacity are implemented in the following programs: Early Hearing Detection and Intervention, Newborn Screening, Childhood Lead, WIC, Healthy Moms/Healthy Babies, Child and Youth with Special Healthcare Needs, Oral Health, and Breast and Cervical Cancer Program. These efforts range from new interfaces between external and internal systems with the agency electronic health record, Epic, to referral process data analysis, to the creation of logic models, to evaluation activities.

The Office of Information Technology Security provides governance, information technology risk assessment, HIPAA, FERPA, HITECH compliance, and security response support for the MCH program. This is essential in supporting the expansion and modernization of MCH data capacity efforts. Similarly, the Office of Health Information Technology, Epic provides electronic health record (Epic) training and support, release of medical information, and clinical data reporting. Current MCH data capacity activities include: Children and Youth with Special Healthcare Needs transition to the platform, Early Hearing Detection and Intervention data extracts for child find and referral, Community Health Workers Initiatives user role and care coordination access, upgrading build for Healthy Moms / Healthy Babies, Genetics (Perkin Elmer interface and Critical Congenital Heart Disease) HL7 interface and establishment of longitudinal record for all babies born at a delivering hospital in Mississippi, MyChart implementation for patient questionnaire completion, referral build for the agency that will allow all programs to refer patients internally to each other to cover all services a patient may need and to capture referral and outcome data.

The Office of Health Information Technology, Programs provides project management, telehealth, interoperability, and purchasing support and services. Current MCH data capacity activities include Family Planning Telehealth implementation state-wide, Breast and Cervical Cancer Program efficiency project for data capture and integration with the Catalyst system, and patient self-check-in clinic functions for county health department clinical MCH services. The epidemiologists in the office are supporting MCH efforts through a project for REDCap utilization for WIC referrals and a statewide child and mother resource database. The Revenue Cycle Office is supporting the Early Intervention program's third-party payment capacity through the transition from manual programmatic billing to the use of an electronic clearing house.

The Office of Vital Records and Public Health Statistics provides registration, amendment, issuance, and maintenance of certificates of birth, death, fetal deaths, induced terminations, marriages, and divorces, and is responsible for BRFSS, PRAMS, and statistics of vital events in the state of Mississippi. Current MCH activities include Title V, CYSHCN, Maternal Mortality Review Committee, Infant Mortality Review Committee, and Healthy Moms/Healthy Babies vital records and surveillance.

CSTE Applied Epidemiology Fellow

During the two-year fellowship at MSDH, the Council of State and Territorial Epidemiologist (CSTE) Applied Epidemiology Fellow has had the opportunity to participate in activities that have broadened and enhanced their knowledge of technical data processes and how to navigate the application of data on the populations served. In the first year, the Maternal and Child Health (MCH) CSTE fellow assisted in the creation of logic models for Healthy Moms/Healthy Babies to be able to easily report monthly and quarterly data to Mississippi's Division of Medicaid, aided in evaluating the Lead Poisoning Prevention and Healthy Homes program by analyzing the data collected by providers and the program staff during counseling calls or home visits, and visited the O.B. Curtiss Water Treatment plant to better understand the importance of regular, timely maintenance to prevent a crisis during an already emergent situation. Additionally, the fellow has had the opportunity to work on an outbreak investigation, analyze data from an internal onboarding survey that was used to inform another region on the efficacy of their onboarding process, launch the LOCATe (Levels of Care Assessment Tool) project to assess the level of care neonatal and maternal units in Mississippi hospitals are currently operating at, and participate in several trainings to improve or acquire important skills needed to further their career in Public Health.

In the second year, the fellow worked with the Pregnancy Risk Assessment Management System (PRAMS) to identify significant trends between health, stress, and social determinants of health before/during the most recent pregnancy and the increase of cesarian deliveries in Mississippi. Also, the fellow aided in the modeling of a census-level Lead High-Risk Exposure map, shadowed a nurse at the Hinds County Tuberculosis clinic to complete a field investigation, assisted in the completion of grant proposals and created several Redcap surveys to help with project evaluations and intern placements. Some projects from the first year were continued into the second year such as monthly and quarterly reporting for Healthy Moms/Healthy Babies and reporting new cases/updating case logs for the outbreak investigation.

Along with the other projects mentioned, the fellow's major project was on the Perinatal Periods of Risk for Mississippi. This project initially identified the overall state, race, and geographical-specific fetal-infant mortality and excess mortality rates over several years to highlight high-risk groups and the disparities that can be found in each. The second phase of the project identified specific risks such as SIDS, congenital abnormalities, perinatal conditions, injury, etc. that are more prevalent in each community to better tailor prevention efforts by internal and external partners.

During the final months of the fellowship, the fellow has several oral presentations and posters that will be exhibited at conferences such as the 2024 CSTE Annual Conference and looks forward to submitting project manuscripts to scientific journals to be reviewed and published.

Key Challenges in The Use of MCH Data

There is a lack of complete data from some of the current data management systems, and the Data team is working with the programs to update the data management plans to ensure that complete and accurate data is captured.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

Disasters impact all Mississippians and are particularly difficult for our most vulnerable populations, including those who are challenged whether physically or mentally (vision impaired, cognitive disorders, mobility limited), limited or non-English speaking, geographically or culturally isolated, weakened elderly, pregnant women, and children. The state of Mississippi encompasses an area of 48,432 square miles with 82 counties. The coastline of Mississippi is a short 44 miles across three counties—Hancock, Harrison and Jackson. This area and adjacent inland counties are vulnerable to the threat of tropical depressions, hurricanes, and storm surge and much of the state is vulnerable to other extreme weather, water and climate-related emergencies. The most recent examples of emergency preparation and response are the COVID-19 pandemic, critical disruptions in water plant and water line operations in both the City of Jackson and the City of Vicksburg, massive flooding in the Delta as well as the Pearl River in and around the City of Jackson, severe cold and ice storms across the state, and regular tornados which have devastating impacts, such experienced by Rolling Fork. Mississippi's public health preparedness is an excellent model of public-private-volunteer cooperation.

In Mississippi, MSDH is the coordinating agency for ESF-8, the Public Health and Medical Services. MSDH shares this responsibility with the University of Mississippi Medical Center (UMMC). Mississippi has a written Emergency Operations Plan (EOP), which is reviewed every two years. The Public Health Emergency Preparedness Program and the Hospital Preparedness Program work with organizations and agencies that represent these vulnerable populations to ensure that they receive information necessary to prepare for their unique needs during a disaster or public health emergency in Mississippi. The MSDH At-Risk Workgroup meets twice a year to review state plans to ensure that the needs of all at-risk groups are considered and addressed.

The MSDH Office of Emergency Planning and Response (OEPR) is responsible for operating state and regional shelters for the medically fragile. MSDH has trained teams, which are MSDH employees, ready to respond in any event. A State Medical Needs Shelter (SMNS) is a shelter of last resort during emergency conditions for persons requiring limited medical and nursing oversight who cannot be accommodated in a general population shelter. A SMNS is designed to care for people with medical needs including: people with minor health or medical conditions that require professional observation, assessment and maintenance who cannot be served by the congregate shelter staff or that exceed the capability of the congregate shelter; people with chronic conditions who require assistance with activities of daily living or more skilled nursing care but do not require hospitalization; people who need medications or vital sign readings who are unable to receive such services without professional assistance; people with physical or cognitive disabilities including those that require the assistance of service animals; and people with other disabilities who cannot be sheltered at a general population shelter. While not specifically listing at-risk and medically vulnerable women, infants, and children, the SMNS sites can and do accommodate at-risk and medically vulnerable women, infants, and children and their families.

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

III.E.2.b.v.a. Public and Private Partnerships

The MSDH Title V/MCH Program partners with federal, state, and local entities to support the state's capacity to meet the needs of the MCH population. Partnerships focus on building a stronger public health system through expand outreach efforts, improve linkage to direct care services, and strengthened care coordination as well as infrastructure building service outside and within the agency. Some Title V/MCH Program partnerships are described below:

Alliance for the Innovation on Maternal Health (AIM) Capacity Award (HRSA)
The MIHB partners with the AIM/HRSA to support efforts/activities to identify, develop, and disseminating best practices to improve maternal healthcare quality and maternal and infant health outcomes as well as eliminate preventable maternal mortality and morbidity.

CHAMPS for Moms, University of MS Medical Center
HM/HB and UMMC have an informal partnership to make referrals for home visiting or the CHAMPS for Moms mental health professionals who address mothers' perinatal and postnatal mental health challenges.

Child Abuse Prevention, MS Dept of Child Protective Services
HMHB and MDCPS have a MOU to refer mothers and infants to HMHB who have tested positive for substance use during pregnancy or at delivery.

Delta Health Alliance
The MS WIC Program and the Delta Health Alliance formed a partnership during the BUILD Health Challenge for a breastfeeding project in the MS Delta. The project established a Baby Café' and the Delta Breastfeeding Coalition to serve the needs of families in the community.

Eliminate Maternal Mortality Initiative (ERASEMM), CDC
The MIHB partners with the CDC to convene Maternal Mortality Review Committee (MMRC) comprised of medical and public health representatives to review pregnancy-associated deaths (i.e., occur during or within a year of pregnancy) and to partner with additional organizations in the state to implement MMRC recommendations.

Families as Allies (Family Voices)
The EHDI-MS partners with FAA to provide training to EHDI Family Advisors on best practices for providing peer-support to other parents of children with special needs.

Healthy Birthday, Inc., Count The Kicks©
The MIHB partnered with Healthy Birthday, Inc. to implement the Count the Kicks campaign, an evidence-based stillbirth prevention program, in Mississippi. In collaboration with maternal health and non-clinical providers, expectant parents in the third trimester are educated on paying attention to their baby's movements, learning what are normal movement patterns for their baby, and the importance of promptly notifying providers if they detect any changes.

Institute for Advancing Minority Health
The WIC State Breastfeeding Coordinator is a member of the MCH Coalition for the IAMH and serves as a subject matter expert for breastfeeding initiatives addressing racial disparities. HM/HB and IAMH collaborate on community outreach for pregnant women and families. HM/HB is a part of the MCH Coalition implemented by IAMH.

Laurel Housing Authority 2023 Summer Feeding Program
The Office of Oral Health partnered with the Laurel Housing Authority to distribute education and supplies for 85 children and 31 adults who participated in their 2023 Summer Feeding Program.

Mississippi Breastfeeding Coalition
The MS WIC Program partnered with the MBC to develop breastfeeding initiatives to address racial disparities and access to equitable breastfeeding services. The MS MILC Leagues provide prenatal and post discharge breastfeeding support to new and expectant mothers. The WIC Program provides coaches to lead virtual and in person meetings. The WIC Program is also a collaborator in the annual MILC Breastfeeding Conference which provides evidence based training and continuing education opportunities to healthcare providers and lactation professionals.

Mississippi Public Health Institute
The MSPHI partnered with the WIC program to provide support for International Board-Certified Lactation Consultants (IBCLCs) mentorship and scholarship assistance for WIC peer counselors and registered dieticians to attain IBCLC certified. To date, 16 WIC peer counselors and registered dieticians have attained IBCLCs. WIC also collaborates with MSPHI in their REACH Project, that supports post discharge breastfeeding through the local MILC Leagues and a food bank to address food insecurity in the coastal MS communities. These programs share childhood obesity data to evaluate the impact and effectiveness of the program.

HM/HB collaborates with the MSPHI on SUID, referrals, and education.

Mississippi SIDS Alliance / Cribs for Kids
The MIHB partnered with Cribs for Kids® to promote safe sleeping environments by providing sleeping units to needy families. Cribettes are distributed to high-risk, low income families. Not only do they have safety features, but they also promote the ABCs of safe sleep with a printed message on the fabric: *Alone on my Back in a Crib*.

Mom.Me, Maternal Mental Health & Post-Partum Support for African American Women
The MIHB has a formal partnership with Mom.Me to assist pregnant and post-partum women of color in Central Mississippi. As pregnant and post-partum African American women are at higher risks for adverse health outcomes, Mom.Me expanded their outreach and promotion activities for early identification of these risks and linked these women to intermediate preventative health services after pregnancy.

HM/HB and Mom.Me have an informal partnership to make referrals to connect mothers to case management, mental health supports, and parenting education.

Mother's Milk Bank of Mississippi
WIC collaborates with the Mother's Milk Bank of Mississippi by encouraging moms to donate breast milk to promoting this life saving service for premature/neonatal intensive care babies. WIC peer counselors have assisted the Milk Bank of MS with finding milk depot locations within local communities that are more accessible for those who would like to donate their milk. WIC also provides promotion and support of the Milk Bank on our website and at community events and health fairs.

MS Public Health Association & UMMC School of Nursing
To support the transition to a nurse case management model, the HM/HB partnered with MPHA to develop standardized training for their new nursing staff. First a needs assessment was conducted. Then MPHA and UMMC faculty created standardized procedures for the HM/HB program aligned with evidence-based public health nursing practice, MS Medicaid requirements, and MSDH policy. Then they developed a 12-module training program

modeled after the Association of Women's Health, Obstetrics, and Neonatal Nursing which was implemented by HM/HB.

Rising Together, Operation Shoestring
The MIHB partnered with Operation Shoestring to address barriers to optimal maternal health outcomes for historically marginalized populations in Jackson, MS in the Georgetown, Midtown, Mid-City, and Virden Addition neighborhoods. This project focused on ensuring the communities receive adequate health and food-related resources.

Sims Foundation of Hope, Autumn Shower & Imagine You Conference
The MIHB partnered with the Sims Foundation of Hope on two health and wellness promotion events for middle and high school girls. The *Autumn Shower* provided health education, self-advocacy, breastfeeding, safe sleep, car seat safety, and maternal mental health resources. *Imagine You* promoted mental health and wellness, personal growth, and positive self-image/self-worth for middle and high school girls, including those who are homeless and/or are in the foster care system.

The Office of Oral Health partnered with the Sims Foundation to distribute education and supplies for 21 children, 28 support adults/spouses, and 91 pregnant mothers.

Six Dimensions, Improving Maternal Health Outcomes in Mississippi
The MIHB partnered with Six Dimensions to provide health equity training and outreach to healthcare providers and pregnancy journals to mothers to document their prenatal journey and details to families in cases where adverse events occur.

The CARE Project
The EHDI-MS partners with the CARE Project, a nonprofit organization dedicated to supporting families of children with hearing loss. CARE teaches professionals and students about the importance of family-centered care and emotional support. The CARE Project also supports families through shared experiences and networking.

W.K. Kellogg Foundation, Expansion of MSPQC and FIMR in Mississippi
The MIHB partnered with the W.K. Kellogg Foundation to implement activities aimed at decreasing maternal and infant mortality and increasing maternal and child wellbeing in Mississippi through building the capacity and quality of the statewide Fetal Infant Mortality Review (FIMR) and Mississippi Perinatal Quality Collaborative (MSPQC) through data-driven collaboration, convenings, and public awareness.

Wayne County Health Fair
The Office of Oral Health partnered with Wayne County to distribute education and supplies for 85 participants.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The MSDH Title V program has a longstanding, collaborative relationship with the Division of Medicaid (DOM) to ensure all MCH populations have access to the resources and services needed to maintain a healthy life. Mississippi's Medicaid program is one of the largest insurers in the state, serving one out of every four Mississippians through regular Medicaid, the Children's Health Insurance Program (CHIP), or Medicaid's coordinated care program, MSCAN. Over 24% of Mississippians identified as low-income (below the federal poverty level) are enrolled in Medicaid. Of the 779,857 Medicaid enrollees, 64.6% of enrollees were contracted through managed care organizations (MCO) and Primary Care Case Management (PCCM), with the remaining 35.4% of enrollees receiving services through the traditional fee-for-service (FFS) structure.

The MSDH and DOM have entered into Interagency Agreements (IAA) for the provision of nursing and social work FFS and targeted case management by MSDH nurses for infants at risk for poor health outcomes served through HM/HB (PHRM-ISS). The MSDH and DOM also have an IAA to provide targeted case management (i.e., service coordination) for infants and toddlers with disabilities and/or children with complex healthcare needs enrolled in the MSFSEIP. These children are also provided access to medical and developmental services through external therapists and related services professionals who have enrolled as providers in the state early intervention system. Women receive breast and cervical cancer services as well family planning services under Medicaid.

To transform the health care delivery system, the MSDH MCH programs have placed an emphasis on the need for more focus around health equity. Programs are in the process of collaborating with partners at the national and state level to incorporate health equity into the work of the maternal and child health programs and their partners to address social determinants of health. MSDH also collaborated with the DOM to advocate for an increase in reimbursements for ambulatory transportation. In a collaborative agreement with MSDH it will be possible reimbursements to be calculated at 100% of the Medicare rate, resulting in an estimated increase of $7.8 million per year at no additional cost to the state. The DOM has also offered Non-Emergency Medical Transportation for fee-for-service (FFS) Medicaid beneficiaries to receive free transportation to medical visits for rural Mississippians.

In the recent IAA, the Title V and XIX Medicaid Program collaborated to improve data sharing and usage which is a critical component of the payment and delivery system reform efforts. The IAA also includes information regarding the responsibilities of both MSDH and DOM in establishing, supporting, and promoting a collaborative effort to coordinate maternal and infant vital records data for analyses to inform efforts to address the high maternal and infant mortality and morbidity rates in Mississippi, including identifying and tracking populations with disproportionately higher risk (i.e., Black mothers and infants). In this data sharing and usage agreement, both parties will share and use appropriate, relevant data to improve the delivery of health care services and health outcomes for MCH and CYSHCN populations.

Other Title V MCH Programs have developed IAA for collaboration to improve data sharing and usage. The Lead Poisoning Prevention and Healthy Homes Program (LPPHHP) has an established MOU with the MS Division of Medicaid to share quarterly data on the number of children less than six years of age who are Medicaid-eligible and of those, how many received a blood lead test. This information allows the program to be able to match that data against the blood lead level data that is reported to the program from laboratories and providers to identify those children who missed a test or who had a test that was not reported to the program. This collaboration allows the program to target outreach to the areas of the state with the greatest need. The LPPHHP provides updates to Medicaid regarding lead screening and lead follow-up guidelines as well as lead recall information to share with providers through their direct communication channels (e.g., Medicaid Bulletin or Late Breaking News).

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

Title V/MCH Goals and Mission

The MSDH Title V/MCH Program supports Mississippi's health services and systems to meet the needs of our MCH populations, including pregnant women, mothers, infants, children, adolescents, and children and youth with special health care needs. MCH Services are delivered within a public health systems model addressing assurance, assessment, and policy development. All programs are data-driven and accountable for performance. Families are expected to be key partners across all levels of program development, implementation, and quality improvement. Key partnerships include patients or clients, families, representatives, and health professionals.

State Action Plan Development

This State Action Plan was developed based initially on the results of the 2019 Needs Assessment. In consultation with stakeholders, including community organizations, clinical providers, advocates, and families, the MSDH Title V/MCH Program identified priorities for each of the specific MCH populations and two large cross-cutting issues impacting all MCH populations.

Identified MCH Priorities

Note: Priority needs identified for more than one MCH population are indicated with an "" symbol.*

Women/Maternal Health:

- Reduce maternal morbidity and mortality
- Improve access to care*
- Improve oral health*

Perinatal and Infant Health:

- Reduce infant mortality
- Improve access to family-centered care*
- Increase breastfeeding, healthy nutrition, and healthy weight*

Child Health:

- Increase access to timely, appropriate, and consistent health and developmental screenings
- Improve access to family-centered care*
- Increase breastfeeding, healthy nutrition, and healthy weight*
- Improve oral health*

Adolescent Health:

- Improve access to care*
- Increase breastfeeding, healthy nutrition, and healthy weight*

Children with Special Health Care Needs (CYSHCN):

- Assure medical homes for CYSHCN

Cross-cutting/Systems Building:

- Ensure health equity by addressing implicit bias, discrimination, and racism
- Improve access to mental health services across MCH populations

Addressing the MCH Priorities

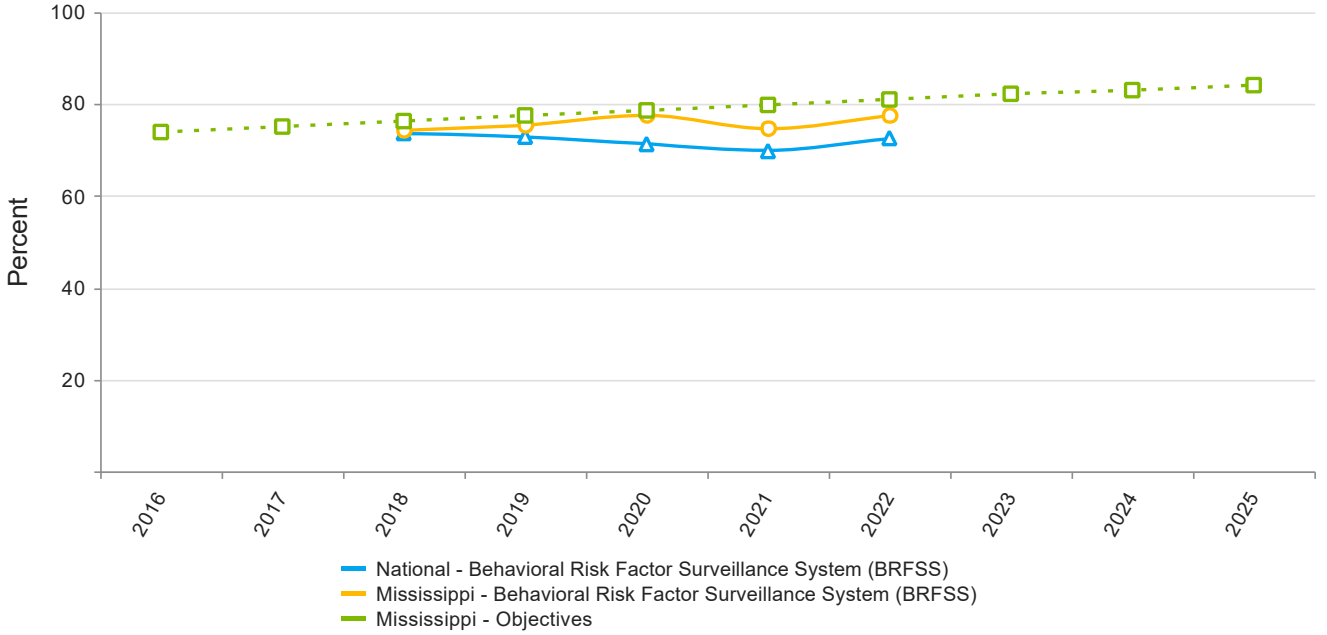
To address these priorities, the MSDH Title V/MCH Program worked with partners to identify key outcomes and performance measures and to select strategies and activities that leverage program capacity to move the needle on the performance measures and ultimately meet the priority needs for improved health outcomes for women, children, and families across the state. Over the past four years of implementation of annual State Action Plans, the MCH Program leaders, with feedback from families and consumers, input from their advisory councils and boards, and support from community partners, the programs have updated and refined their strategies and activities. Further, with the support of data personnel, they have also refined their objectives and evidence-informed strategy measures (ESMs).

Over the course of this refinement, this State Action Plan has transitioned, with new internal and external leadership, from a siloed set of strategies that were unique to each MCH Program to development and implementation of collaborative strategies and activities across MCH Programs to ensure collective impact. This 2023 annual report is the first to fully reflect the transition from program-specific activities to addressing integrated objectives, strategies, and activities. The 2025 application will continue the implementation of broad objectives, strategies, and activities across multiple programs with a unified approach to improving health outcomes for women, children, and families. Both are organized according to priorities and have been collectively developed by MCH program personnel and epidemiologists from the OHDR.

Women/Maternal Health

National Performance Measures

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		78.5	79.7	80.9	82.1
Annual Indicator	74.2	75.4	77.5	74.7	77.3
Numerator	389,320	390,297	403,215	379,846	389,062
Denominator	524,486	517,720	520,497	508,347	503,084
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	82.9	84.0

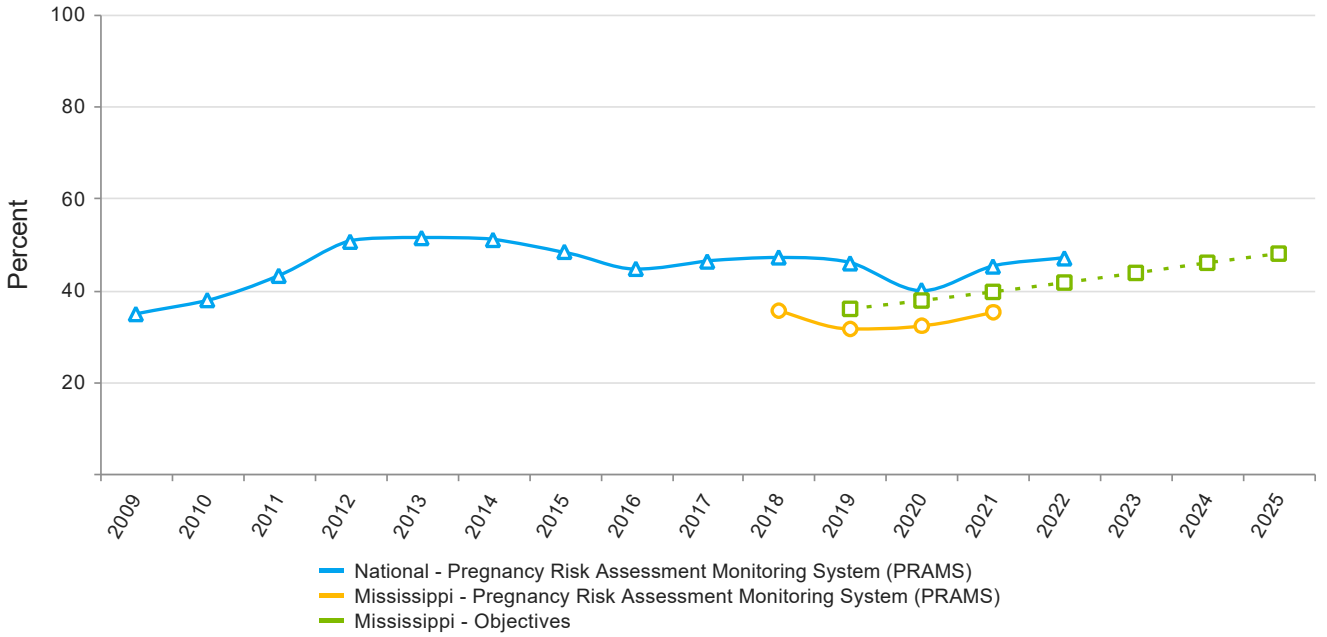
Evidence-Based or –Informed Strategy Measures

ESM WWV.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			100
Annual Indicator	641	56	113
Numerator			
Denominator			
Data Source	MS Quitline provider and Baby and Me Tobacco Free	MS Quitline provider and Baby and Me Tobacco Free	MS Quitline provider and Baby and Me Tobacco Free
Data Source Year	2022	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	125.0	150.0

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	35.9	37.7	39.6	41.6	43.7
Annual Indicator	35.4	31.6	32.1	35.3	35.3
Numerator	12,028	10,696	10,493	11,307	11,307
Denominator	33,953	33,881	32,729	31,993	31,993
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	35.9	37.7	39.6	41.6	43.7
Annual Indicator	35.4	31.6	32.1	35.3	
Numerator	12,028	10,696	10,493	11,307	
Denominator	33,953	33,881	32,729	31,993	
Data Source	MS PRAMS	MS PRAMS	MS PRAMS	MS PRAMS	
Data Source Year	2018	2019	2020	2021	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives		
	2024	2025
Annual Objective	45.9	47.9

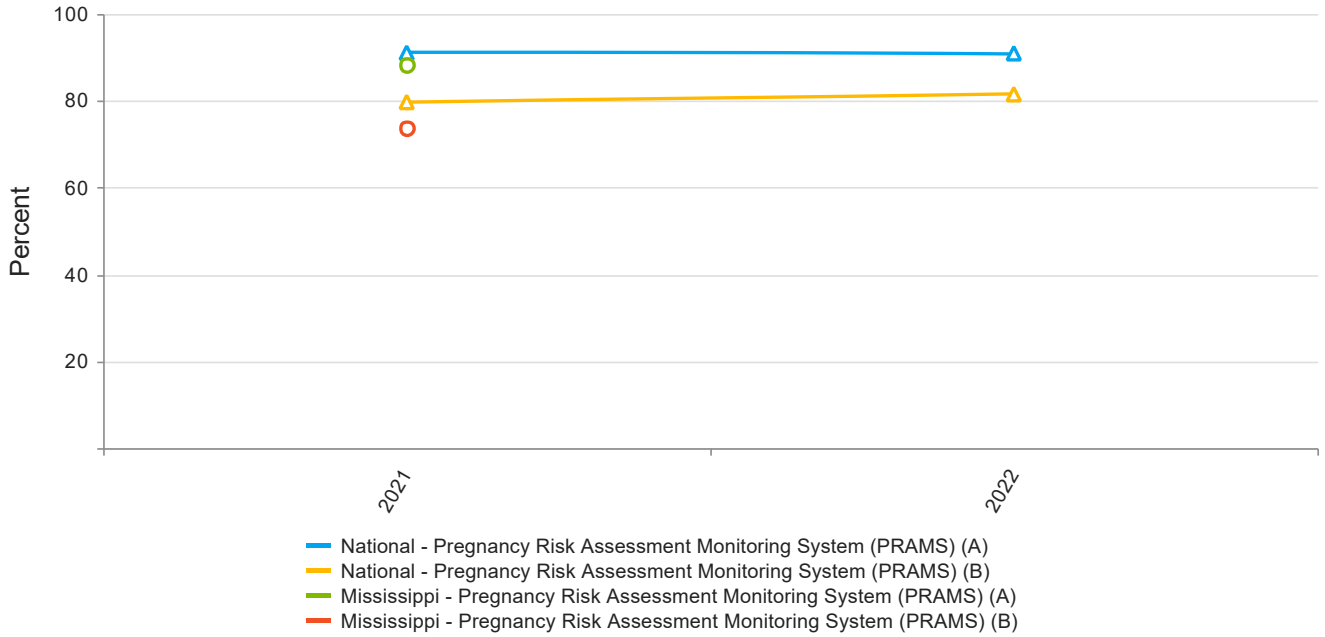
Evidence-Based or –Informed Strategy Measures

ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	600	650	700	750	800
Annual Indicator	409	347	0	1,000	1,000
Numerator					
Denominator					
Data Source	MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health - REDCAP	MSDH Office of Oral Health - REDCAP
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	850.0	1,000.0

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	88.1
Numerator	27,351
Denominator	31,060
Data Source	PRAMS
Data Source Year	2021

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	73.6
Numerator	20,009
Denominator	27,196
Data Source	PRAMS
Data Source Year	2021

Evidence-Based or –Informed Strategy Measures

None

State Performance Measures

SPM 10 - Percent of severe maternal morbidity events related to hypertension

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			2.2
Annual Indicator	3.5	3.4	3.9
Numerator	1,114	1,075	1,192
Denominator	32,010	31,331	30,637
Data Source	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	2.1	2.0

SPM 16 - Nulliparous, term singleton, vertex (NTSV) cesarean rate

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			28.5
Annual Indicator	31.7	30.5	30.3
Numerator	3,304	3,300	3,367
Denominator	10,439	10,830	11,096
Data Source	Mississippi Hospital Discharge Data	NTSV from Vital Records	NTSV from Vital Records
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	25.7	23.1

State Action Plan Table

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

Priority Need

Improve Access to Care

NPM

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Five-Year Objectives

By September 30, 2025, increase the number of family planning users within MSDH clinics by 5% (from 20,839 to 21,880).

By September 30, 2025, increase the number of Family Planning Waiver beneficiaries receiving family planning services within MSDH clinics by 5% (from 4,254 to 4,467).

By September 30, 2025, increase the number of women enrolled in the MS Breast and Cervical Cancer Program by 10% (from 3,548 to 3,903).

By September 30, 2025, 90% of enrolled women, actively participating in a home visiting/case management program will be screened for pregnancy intention and provided interconception care education and support to access services as needed

By September 30, 2025, increase the number of pregnant/postpartum women participating in a case management/home visiting program by 30% (from 923 to 1,200).

By September 30, 2025, increase the number of outside MSDH referrals for the case management/home visiting program by 20% (from 1,867 to 2,240).

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to women's health via media, social media, and other public-facing platforms.

Strategies

MCH-serving/supported programs will collaborate with internal and external partners to develop promotional strategies to increase family planning users

MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving women's/maternal health

Home visiting/case management programs will develop and improve relationships with internal and external partners to increase referrals to the program

MCH programs will collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of women's/maternal health issues

MCH-serving/supported programs will work with internal and external partners to provide information and linkages to services to promote tobacco cessation among pregnant parents

ESMs	Status
ESM WWV.1 - Number of community group and activities program attends and partners with	Inactive
ESM WWV.2 - Number of engaged users viewing social media messages delivered by MSDH social sites promoting women's preventive health services	Inactive
ESM WWV.3 - Number of social media message months promoting women's preventive health services	Inactive
ESM WWV.4 - Number of strategies or measures for racial equity related policy, practices and systems changes implemented at the program, division and department level.	Inactive
ESM WWV.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy	Active

NOMs
NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM
NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM
NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW
NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB
NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB
NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM
NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM
NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal
NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal
NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related
NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP
NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS
NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

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

Priority Need

Reduce Maternal Morbidity and Mortality

NPM

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Five-Year Objectives

By September 30, 2025, increase the number of postpartum women participating in a case management/home visiting program who attend a postpartum checkup within 12 weeks and receive recommended care components by 5%.

Strategies

MCH-serving/supported programs will work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward reducing maternal mortality based on MMRC recommendations

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

State Action Plan Table (Mississippi) - Women/Maternal Health - Entry 3

Priority Need

Improve Oral Health

NPM

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy

Five-Year Objectives

By September 30, 2025, increase the percentage of women who have a preventive dental visit in pregnancy by 10%

Strategies

Provide education to women on the safety and importance of proper oral health during pregnancy and postpartum

ESMs	Status
ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education	Active
ESM PDV-Pregnancy.2 - Number of WIC sites where oral health education is given to program participants by ROHCs	Inactive
ESM PDV-Pregnancy.3 - Number of pregnant women who saw the dentist post referral	Inactive

NOMs

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

State Action Plan Table (Mississippi) - Women/Maternal Health - Entry 4

Priority Need

Reduce Maternal Morbidity and Mortality

SPM

SPM 16 - Nulliparous, term singleton, vertex (NTSV) cesarean rate

Five-Year Objectives

By September 30, 2025, produce the annual Maternal Mortality Report inclusive of 2017-2021 maternal deaths to include recommendations for preventing maternal deaths

By September 30, 2025, increase the number of birthing hospitals and other health systems implementing one or more AIMS Safety Bundles by 10% (from 41 to 46).

By September 30, 2025, 10 pregnant women will have been referred to a home visiting/case management program to support syphilis treatment before delivery

By September 30, 2025, participate in at least 18 community outreach events to address maternal mortality disparities and promote Maternal Mortality Review Committee recommendations

Strategies

Provide administrative support and coordination with other MSDH Offices, health facilities, state agencies, et al. for the maternal mortality review case abstraction, exploration, and determination process for all maternal deaths through the Maternal Mortality Review Committee

Provide and/or partner with other stakeholders to offer educational opportunities and evidence-based trainings to birthing hospitals and other systems on strategies to reduce severe maternal mortality and morbidity

MCH-serving/supported programs will work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward reducing maternal mortality based on MMRC recommendations

Lead the promotion of health observances, and other outreach/engagement strategies to increase public awareness of maternal health issues

State Action Plan Table (Mississippi) - Women/Maternal Health - Entry 5

Priority Need

Reduce Maternal Morbidity and Mortality

SPM

SPM 10 - Percent of severe maternal morbidity events related to hypertension

Five-Year Objectives

By September 30, 2025, participate in at least 18 community outreach events to address maternal mortality disparities and promote Maternal Mortality Review Committee recommendations.

Strategies

MCH-serving/supported programs will work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward reducing maternal mortality based on MMRC recommendations

Lead the promotion of health observances, and other outreach/engagement strategies to increase public awareness of maternal health issues

Women/Maternal Health
Annual Report - FY2023

The following section outlines strategies and activities implemented between 10/1/2022-9/30/2023 to meet the objectives and show improvement on the measures related to women's and maternal health:

Activities in this domain were carried out by the following MSDH offices, bureaus, or programs during the reporting period:

- Breast and Cervical Cancer Program (BCCP)
- Family Planning/Comprehensive Reproductive Health (FP/CRH)
- Healthy Moms/Healthy Babies of Mississippi (HM/HB)
- Maternal and Infant Health Bureau (MIHB)
- Office of Oral Health (OOH)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

PRIORITY: Improve Access to Care

NPMs, NOMs, SPM, and ESMs:

- Well-Woman Visit/NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year
- SMM/NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations
- MM/NOM 3: Maternal mortality rate per 100,000 live births
- LBW/NOM 4: Percent of low birth weight deliveries (<2,500 grams)
- PTB/NOM 5: Percent of preterm births (<37 weeks)
- ETB/NOM 6: Percent of early term births (37, 38 weeks)
- PNM/NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths
- IM/NOM 9.1: Infant mortality rate per 1,000 live births
- IM-Neonatal/NOM 9.2: Neonatal mortality rate per 1,000 live births
- lM-Postneonatal/NOM 9.3: Post neonatal mortality rate per 1,000 live births
- lM-Preterm Related/NOM 9.4: Preterm-related mortality rate per 100,000 live births
- DP/NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy
- NAS/NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
- TB/NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
- PPD/NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
- WWV.5/ESM 1.5: Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy.

Objectives:

- By September 30, 2023, increase use of the family planning waiver by 5%
- By September 30, 2025, increase access and utilization of quality family planning services in 100% of MSDH county health departments
- By September 30, 2025, decrease the percent of women who report smoking during pregnancy by 1%
- By September 30, 2023, increase breast cancer screening rates by 10% among Hispanic, African American, American Indian, Asian, and other underserved, uninsured or underinsured women
- By September 30, 2023, increase cervical cancer screening rates by 10% among Hispanic, African American, American Indian, Asian, and other underserved, uninsured or underinsured women

New Strategy: *Engage the support of external providers to increase access to care for pregnant women and new mothers.*

Completed Activities:
During this project period, MCH programs engaged with multiple internal and external partners to increase access to care for pregnant women and new mothers. One of the partners with the Maternal and Infant Health Bureau (MIHB), Mom.me, conducted screenings for new mothers to assess their personal struggles with new motherhood, breastfeeding, mental health, domestic/interpersonal violence, and family/social support structures. Based on the results of the screenings, resources and referrals were given to new mothers who were impacted by any of the aforementioned issues. During the reporting period, Mom.Me supported 75 women through wellness events, provided 15 referrals to medical providers, and enrolled 19 women in support groups. In addition, there were 33 women who participated in the Centering Pregnancy program. These types of programs bring together several women who are either pregnant and/or recently delivered to offer healthcare related services (e.g. mental health, physical health, etc.).

MIHB also partnered with the Mississippi Chapter of the National Council on Alcoholism and Drug Dependence (NCADD). During the reporting period, NCADD screened 164 women who needed maternal and infant health resources. In addition, they hosted substance abuse and mental health workshops whereby 128 women attended. During the workshops, they distributed 28 pack n plays and 28 diapers/wipes bundles to low-income women who attended.

The Mississippi (MS) Breast and Cervical Cancer Program (BCCP) and the Office of Preventive Health, Heart Disease and Stroke Prevention Program (HDSPP) of the MSDH applied for and were awarded funding to offer the MS WISEWOMAN Program in 2023. The current funding cycle operates from September 30, 2023, through September 29, 2028. MSDH is accountable to the CDC for the appropriate use of these funds. The WISEWOMAN Program extends preventive health services to women already enrolled in the MS-BCCP, which include screenings and referrals for healthy behavior support services for cardiovascular disease, stroke risk, and diabetes. MSDH’s WISEWOMAN Program will be limited to only specific geographic areas of the state having the highest burden of cardiovascular disease and stroke-related mortality and stationed in already MS-BCCP contracted health systems, notably two FQHCs in the inaugural year. Plans to expand sites where WISEWOMAN will materialize is contingent upon funding, provider capacity, and data-driven decision making.

Under a partnership to seek funding which began in late 2022, MSDH was awarded a subgrant from Jackson State University (JSU) under the National Institute of Health's Centers of Excellence in Maternal Health program. This initiative targets reducing maternal morbidity and mortality in the Mississippi Delta region. The MSDH program, known as Time4Mom (T4M), has received a commitment for funding for the period August 1, 2023, to July 31, 2030, contingent upon funding from NIH. T4M focuses on enhancing maternal health outcomes by facilitating postpartum home visits provided by nurses and community heath workers, linking women with local health resources, referrals for mental health and lactation support, and providing educational support on postpartum health.

Though not funded until late in this reporting period, MSDH was awarded a 5-year grant from HRSA to develop an Enhanced Healthy Start program in Northeast Mississippi. This program aims to improve health outcomes before, during, and after pregnancy and reduce racial/ethnic differences in rates of infant death and adverse perinatal outcomes in NE Mississippi. The MSDH’s Healthy Start Program has two major focal areas: 1) providing direct and enabling services (e.g., screening and referrals, case management, care coordination,

health and parenting education, and linkage to clinical care) to enrolled HSE participants; and 2) developing/convening Community Consortia to advise and inform healthy start activities, as well as to develop and implement action plans to improve perinatal outcomes within Northeast Mississippi. The period of funding is for 5 years (September 2023 – September 2028).

Starting in June 2023, various programs throughout Health Services partnered with the Mississippi Attorney General's Office to carry out the legislative mandate under SB2781SG. This legislation charged the MS AGO to work with other state agencies, and private and faith-based partners, to create a one-stop-shop e-resource center for pregnant women and new mothers. Specifically, the legislation charged that the Mississippi Access to Maternal Assistance (MAMA) program website had to be active by October 1, 2023 and the MAMA mobile app by January 1, 2024. This partnership between MSDH and the MS AGO is overseen by the Office of Women's Health Director. To view the MAMA website, visit: www.ago.state.ms.us/mama"

Strategy: *Expand the use of One Key Question to promote pregnancy intent screening and targeted preconception and family planning counseling.*

Completed Activities:

This exact strategy was not implemented by the HM/HB program due to competing priorities and trainings for staff. However, as a standard of care, HM/HB staff discusses family planning through the Initial Comprehensive Assessment, closer to pregnant woman's delivery, at postpartum visit, and at enrolment of infant. Future trainings on family planning are forthcoming.

During the reporting period, nurses and clinicians who provide services to family planning (FP) clients, used the One Key Question ("Would you like to become pregnant in the next year?") to understand client's pregnancy intentions. This question is part of several included in the sexual history screening form in the Epic system used by the clinical staff to assess and document client's information. A total number of 28,072 clients responded to this question during this period. The responses were categorized as follows; 25,192 clients did not want to become pregnant; 1,605 clients wanted to become pregnant, 913 clients were okay either way and 362 clients were unsure.

Nurses and clinicians counselled and educated clients based on their responses to the one key question. Client who did not want to become pregnant received counselling and education on birth control method including information and guidance on various contraceptive options, and safe sexual practices including education on how to prevent sexual transmitted infectious (STIs), HIV, and maintain sexual health. Clients who wanted to become pregnant, were provided counselling and education on preconception health, including the importance of smoking cessation for maternal and fetal health, risks associated with alcohol and drug use during pregnancy and the importance of abstaining, daily intake of folic acid and prenatal vitamins to prevent birth defects, management of pre-existing medical conditions to ensure they are under control before conception, and guidance on maintaining a balanced diet and a healthy weight to support pregnancy. Clients who were okay either way or unsure received comprehensive counselling and education covering both preconception health and contraceptives methods to allow clients to make informed decisions based on their changing preferences or circumstances, and on safe sexual practices to prevent STI and maintain overall sexual health.

Since early 2023, the OWH Director has provided the ongoing logistical support and facilitation of the Family Planning Transition Workgroup. This Workgroup is comprised of individuals representing various departments of the agency, including FP/CRH Program, Field Services, Clinical Operations, Legal, Internal Audit, Pharmacy, Revenue Cycle, Finance and Accounting, Health Data and Research, Communications, Clinical Technology Intergration, MCH Block Grant Leadership, and Senior Leadership. The primary task of the Workgroup has been

to plan the transition of FP/CRH from being fully supported and funded by Title X to having no Title X funding and only relying on FP Waiver earnings and other revenue to sustain services. A major transition activity has been planning for a Special Rate Program, which would allow clients without insurance or who did not want to use their insurance to pay a reduced rate for FP services available through MSDH. The Special Rate Program is expected to launch in July 2024.

Strategy: *Empower low-income users to make informed decisions about family planning and preventive health services*.

Completed Activities:

The MSDH Family Planning Program continued to provide services to ensure access to affordable reproductive healthcare and a broad range of contraceptive supplies to women, men, adolescents, and teens throughout Mississippi. The program continued to provide Mississippi residents with access to information as a tool for making informed decisions that will produce a healthier lifestyle. MSDH website continued to promote and provide education on family planning services to the number of clients who visit the site. The program collaborated with office of Medicaid to produce FPW fact sheet, adding MSDH logo, translate in other languages (Spanish and Vietnamese) and put on MSDH Family Planning web page. In the period of 4/1/2022 – 3/31/2023 family planning main page viewed times 6,110 from 3,954 users and family planning waivers viewed times 1,777 from 1,340 users. Family Planning (FP) staff continued to work with other Health Services program coordinators who organize community outreaches and health fairs to educate and distribute education materials to clients. In the period of 10/1/2022 – 9/30/2023 office of family planning mailed a total of 35,100 FP educational materials/brochures (English, Spanish, and Vietnamese) to MSDH districts and local health departments to distribute to the communities for education.

The Title X Family Planning Program continued to provide family planning services to all Title X clients and work on improving the overall management of and administration of the Family Planning Program under the No Cost Extension (NCE) funds until March 31, 2023. Following the end of NCE, MSDH continued to explore opportunities to partner with Converge, the current Mississippi Title X grantee to provide services and support patients who need enhanced services offered under Title X. Clients without health coverage, social security and minors (under 18 years old) who cannot let their parents/guardian sign consent for minors to receive family planning services except for pregnancy testing and STI services were referred to Title X clinics. County health departments continued to educate clients about changes including cost for family planning services and navigating them to pay source including Family Planning Waiver (FPW), Breast and Cervical Cancer Program BCCP) etc. County health departments continued to educate and encourage client's men and women who do not have private plan or full benefit Medicaid coverage to apply for FPW to receive family planning and preventive health services through utilization of FPW.

In June 2022, MSDH started a project called "Operation Going Gold" which aimed at increasing access to and utilization of FPW among MSDH clients and continue to allow and promote the provision of family planning and some preventive health services to FPW clients state-wide. MSDH staff were trained to screen clients for FPW eligibility, educate clients on the benefits offered by FPW. Staff provided education, encouragement and one-on-one assistance to clients, men and women who do not have private plan or full benefit Medicaid coverage in completing FPW applications. Follow-up were made by sending reminders via calls, letters etc. to ensure patients are enrolled in the FPW and continue to utilize FPW to receive free family planning and preventive health services. In the period of 10/1/2022 – 9/30/2023, a total number of 6,902 FPW application were submitted to the division of Medicaid where 28% (1,936) of submitted applications were approved

During this reporting period, family planning services were provided to approximately 16,926 clients male and female. A total of 4,420 clients received FP services from county health departments under the Family Planning Waiver (FPW), representing an increase of 21% (771 clients) from the previous program year.

County health departments continued to provide family planning and preventive health services including provision of contraceptives, pregnancy testing, annual medical exams, pap smear, clinical breast exam, and STI/HIV testing and treatment. Specialized services were performed by Obstetrics and Gynecology Consultant Dr. Prater for 44 clients at county health departments in North Mississippi (Grenada) and South Mississippi (Hattiesburg), including cervical abnormality treatment including Loop Electrical Excision Procedures (LEEPs), colposcopies with and without cervical biopsy, and cryosurgery. In addition, Dr. Prater proctored Nurse Practitioners in colposcopy procedures and trained them on IUD insertion and removal.

The FP/CRH program further collaborated with MSDH Pharmacy to ensure that an efficient inventory of a broad range of contraceptive options was available to all MSDH clinic sites. Regular meeting occurred with pharmacy staff related to contraceptive use and spending.

MSDH continued to make efforts in expanding access to family planning services, particularly in areas that are more likely to experience health disparities through telehealth visits. The agency continued to collaborate with UMMC to increase telehealth services, and with MSDH Information Technology and Health Informatics to improve telehealth infrastructure and broadband. The agency's goal was to have all health department clinics utilize telehealth services by March 2024. The program collaborated with MSDH Pharmacy to ensure that an efficient inventory of a broad range of contraceptive options was available to all MSDH clinic sites. Regular meeting occurred with pharmacy staff related to contraceptive use and spending.

The FP/CRH program worked with consultants to review and update consent forms for colposcopies, Cryosurgery and LEEP, and procedures for following up on Pap Smear and Quick Start Algorithm as well as pap smear follow up guidance, quick start algorithm, FP trichomonas protocol, and a Telehealth Clinical pathway for MSDH.

The Family Planning central office and regional office MCH/FP coordinators continued to collaborate by holding thirty-minute weekly zoom meeting to discuss and review program challenges and policy/procedural updates regarding quality improvement and service provision. MSDH continued to provide staff training to ensure the provision of quality patient care. Three Nurse Practitioners (NP) completed Comprehensive Colposcopy Courses organized by American Society for Colposcopy and Cervical Pathology (ASCCP) during this period. Two nurse practitioners completed the courses online from January to March 2023, and one attended the in-person courses in Tampa Florida in March 2023. These NPs continue with their colposcopy practicum until signed off by the Women's Health OB Consultant for independent practice. Program staff continued to provide technical assistance to ensure clinic staff receive appropriate program updates. Orientation for new clinic staff was managed at the district/regional clinic level.

Other MCH programs serving families also provide information about family planning and preventive health services. For example, the HM/HB staff discusses family planning through the Initial Comprehensive Assessment, closer to pregnant woman's delivery, at postpartum visit, and at enrolment of infant.

To further support reproductive health services provided through the MSDH clinics, the MS-BCCP program initiated a Self-Breast Exam/Diagnostic Screening Push Card through the MSDH Office of Communications to be utilized as a teaching tool for women related to breast cancer screening and early detection. In September 2023, the Outreach Coordinator prepared a work request for a social media campaign to run through October

2023, which promoted breast cancer screening and early detection.

MS-BCCP Program Director/Program Compliance Monitor met virtually with (3) in attendance on August 2, 2023, with Magnolia Medical Foundation who support Latina/Hispanic women.

Lebanon Baptist Church District had six churches to participate in "PINK SUNDAY" the fourth Sunday in October 2022. Mt. Calvary had 30 people in attendance and the topic discussed was the importance of getting screened for breast cancer early and of the importance of screenings. Antioch had 70 people in attendance and the topic discussed was getting annual physicals, women, and men, for early detection of breast cancer. St. James had 25 people in attendance and the topic discussed was who's at risk for breast cancer and the resources available through MS-BCCP with the MSDH. Asia had 17 people in attendance and the topic discussed was the importance of early detection. Greater Nazareth had 30 people in attendance and the topic discussed was living as a breast cancer survival and the duties of a caretaker in the beginning and the outcome. The City of Tchula sponsored a Mayor's Health Council Fair and provided breast cancer screening information for 80 people in attendance.

The following activities were held for Breast Cancer Awareness Month, October 2022 and produced the following results:

- Collaborated with MSDH Communications Office on Facebook/Instagram/Twitter campaign specific to MS-BCCP content for Breast Cancer Awareness Month - Twitter: Reached 14,917 users and produced 11 website visits. Facebook/Instagram: Reached 110,373 users and produced 41 website visits.
- Pink Ribbon Honor/Memory Wall – 200+ ribbons were posted.
- Thursday All MSDH Men Wear Pink – 35 participants and the First Lady of Mississippi participated in a promotion and photo opportunity at MSDH.
- Pink Walk Around the Stadium – 100 participants.
- Screening & Early Detection Virtual Lunch & Learn – 41 participants.
- BCCP Breast Cancer Awareness Trivia - 556 quizzes completed by MSDH workforce.

With the support of the Office of Communications, a cervical cancer screening awareness social media campaign was carried out in January 2023. Promotional materials were provided to Boat People S.O.S. in February 2023 to support targeted outreach of Vietnamese American women in three Coastal Plains counties. In addition, the Outreach Coordinator and Nurse Consultants provided virtual training to Free Clinic/Primary Care Women's Clinic with four people in attendance and an in-person meeting with the Governance Council with 11 in attendance. These efforts presented the MS-BCCP to community leaders to assist in the identification of any women in need of services and to outline the screening/enrollment process. Further, a virtual meeting was held with El Pueblo with five in attendance to discuss language barriers/disparities being noted with some Hispanic women enrolling in MS-BCCP through other MS-BCCP providers that they were referred to. A UMMC *See, Test, and Treat* event was held March 23, 2023. At this event, three of the 13-women screened and referred to MS-BCCP for further testing were enrolled in MS-BCCP.

One-time "rapid patient navigation" MS-BCCP subgrants were awarded to two already contracted health systems to temporarily support workforce capacity. This CDC funding supported the health systems in hiring or redirecting staff temporarily to catch up on any backlog of MS-BCCP-patient related work (i.e., patient re-enrollment, patient recalls for annual appointments, patient reminders, patient navigation from screening to diagnostic resolution, submission of required reporting to MS-BCCP, etc.) to assure women who were already due or needing screening in FY2020, FY2021, or FY2022, but did not receive it, were navigated back to care by close of FY2023. Staff positions that were supported with this funding included clerical/administrative, nurses,

and clinicians who directly engaged in the practice of patient navigation related to MS-BCCP.

Delta Health Center was provided a subgrant and a list of 107 patients to outreach. Among them, 57 patients had obtained some type of insurance between their prior enrollment and the date of contact in CY2023, 27 patients were not able to be reached, 6 patients were determined to not need contact, 4 made appointments to re-enroll but did not show, and 8 were re-enrolled in BCCP by the close of FY2023. Family Health Care Clinic was also provided a subgrant and a list of 300 patients to outreach and did so via calls, letters, and text messaging. Among them, 132 patients were found to have completed a pap during the prior enrollment cycle, but the results had not been returned to BCCP. Those results were submitted to BCCP for entry and cycle closure, 64 patients were found to have had orders placed for screening mammograms during the prior cycle, but no appointments had been arranged. Patient navigators focused on returning those women to screening.

The need for a change in navigation processes was observed and a new procedure was established which required the screening mammogram appointment to be scheduled while the patient was in clinic on the day it was ordered. Delayed outreach to assist with appointment scheduling was shown to be successful only about 40% of the time. With the change to scheduling on the same day while the patient was in the clinic, appointment scheduling improved significantly, up to 98%, making it easier to navigate and track the patients. In addition, the number of mammogram referrals doubled. 44 women were re-enrolled in BCCP prior to the close of FY2023.

FHCC also conducted 15 outreach events where BCCP educational materials were distributed to 438 participants. The BCCP Champion as FHCC reported the following regarding quality improvement changes related to the project: “In identifying what occurred with the 300 patients with incomplete documentation, strengths and weaknesses in the process were identified. As changes were made in the process, reports were generated on a daily basis to show the staff during the morning huddles progress being made and corrections needed to be made. During the process, there were adjustments to the process. A strength was in the electronic health record that efficiently tracked orders and referrals. One of the weaknesses was standardizing the reason for the referrals. There were multiple ways routine mammogram was being described. An achievement was developing a method of identifying all of the mammograms and collating it to the mammogram orders. Tracking pap tests was simpler and easier because we performed the test on site. We could see that we needed to improve tracking of the referrals to the BCCP and tracking of the results from the referral to facility. We developed screen shot modules for making referrals and documenting the results while standardizing the verbiage.” From this project, of approx. 400 women were identified as “incomplete cycle” in a prior year during the height of the COVID-19 pandemic, most were successfully contacted by patient navigation support staff funded under the rapid navigation subgrants. Fifty-two (52) or 13% were re-enrolled in MS-BCCP to complete screening and navigation activities that had been derailed. Largely, this innovative project was a success. These two health systems were able to self-assess to determine what happened to the women, as well as what processes within their own structures needed improvement.

A review of Facebook social media posts during the reporting period showed that there were no posts exclusive to family planning. While some of the other MCH programs had some or frequent content posted to social media, there was a notable underutilization of the resources (i.e., Facebook, Twitter, Instagram) to promote messaging related to family planning decision making or services. It is important to note, however, that in a 5-month period (April 1, 2023, to August 30, 2023) there were nearly 1,500 visits to the Family Planning landing page of the MSDH website, generally ranking among the top 5 pages visited concerning women’s or child health issues. This suggests that there is a consumer-driven demand for information. A greater focus on utilizing the agency’s social media presence to promote family planning services will be prioritized for the next reporting period. Data for months prior to April 2023 was available; however, the methodology for calculations was different and meaningful comparisons between time periods could not be made.

Strategy: *Partner with the Office of Tobacco Control and other state and community agencies to promote awareness of risks of nicotine use in all forms (e.g., cigarettes, cigars, e-cigarettes, vaping) during pregnancy, and promote resources for quitting.*

Completed Activities:
HM/HB leadership made several attempts to connect with Federally Qualified Health Centers and the Tobacco Free Baby and Me National program, but the program was in transition at the time from providing in-person services to virtual services. Future trainings and collaboration with the MSDH Office of Tobacco Control concerning the Tobacco Free Baby and Me program are forthcoming. Training was provided after October 2023 and will be detailed in subsequent reports.

In the meantime, HM/HB staff continue to assess patients/caregivers' tobacco use using the Initial Comprehensive Assessment as well as a tobacco use screening tool in EPIC. All HM/HB patients/caregivers are asked 9 questions at initial enrolment regarding Tobacco/Nicotine. When a patient screens positive for use, add to POC, refer to the OTC Quitline and Baby and Me Program, Moving forward, the HM/HB will implement processes to collect data on the number of referrals made to the resources for future reporting.

County health departments continued to offer pregnancy testing services to family planning clients and document these services in Epic. As part of the client assessment, those tested for pregnancy were also inquired about their use of tobacco or other substances. All clients who received positive pregnancy test results, were given education and counselling on the risks of smoking during pregnancy including potential complications like preterm birth, low birth weight, and developmental issues for the baby. Additionally, clients were provided with resources, including the Tobacco Quitline number and educational materials such as brochures and pamphlets to aid in quitting smoking. A total of 2,294 clients received positive pregnancy test during this reporting period.

Strategy: *Implement worksite wellness programs aimed to increase breast and cervical cancer screening*.

Completed Activities:
Under CDC's most recent funding period for NBCCEDP grantees, BCCP programs are no longer required to implement worksite wellness activities effective 7/1/2022. Therefore, no worksite wellness programs or activities were implemented by BCCP. The focus instead was to engage community-based partners to support increased breast and cervical cancer screening uptake among high priority populations.

Strategy: *Engage the support of external providers to increase screening among high priority populations*.

Completed Activities:
During the reporting period, MS-BCCP partnered with nine subgrantees, six health systems and three community-based partners selected from a competitive RFP process to execute specific activities for recruitment, referral, enrollment, increasing screening, and providing patient navigation to address SDOH's of participants that reduce barriers to screening. These subgrantees included: Delta Health Center, El Pueblo, Family Health Care Clinic, Jackson Free Clinic, Jackson-Hinds Comprehensive Health Center, Mary Bird Perkins Cancer Center, North Sunflower Diagnostic Center, Southeast MS Rural health Initiative and Test Taking Solution.

Most of these subgrantees have completed their period of performance, which ran from January1, 2023 to December 31, 2023. Some, however, have had their project periods extended either 90 or 180 days to allow for

completion of their activities. Collectively, among the 7 subgrantees with the ability to enroll participants directly (Delta Health Center, Family Health Care Clinic, Jackson Free Clinic, Jackson-Hinds Comprehensive Health Center, Mary Bird Perkins Cancer Center, North Sunflower Diagnostic Center and Southeast MS Rural Health Initiative), 1,296 participants were enrolled from January 1, 2023, to December 31, 2023. Further, among program enrollees, twenty-seven (27) were referred to a non-subgrantee enrolling provider by a community-based subgrantee partner (i.e., El Pueblo, Test-Taking Solutions). All subgrantees were provided orientation, quarterly progress reviews, and tailored TA throughout their periods of performance to assure they were leveraging their subgrant funding according to the prime grant expectations. TA included budget and work plan preparation assistance, resolving barriers to progress, data tracking and reporting, and announcements of other funding opportunities as available.

A new RFP to invite proposals among already contracted providers and new community partners to increase screening and provide patient navigation is in process and expected to be posted publicly by January 31, 2024, with the performance period of July1, 2024 thru June 30, 2025. Under its expanded authority granted in the NOA, MS-BCCP will use unobligated funding from PY1 and PY2 to support these activities aimed at increasing participation among target groups and screening activities.

Preliminary data for MS-BCCP's Program Year (PY) 1 (June 30, 2022 to June 29, 2023) indicates:

- 3,503 participants enrolled, 96% of projected end date total (n=3,651)
- 3,696 participants served or 95% of projected end date total (n= 3,908)
- 1,777 Black/African American, non-Hispanic women enrolled, 97% of projected end date total (n= 1,837)
- 1,891 Black/African American, non-Hispanic women served, 95% of projected end date total (n=1,985)
- 637 Hispanic, all races women enrolled, 115% of projected end date total (n= 555)
- 664 Hispanic, all races women served, 126% of projected end date total (n= 526)
- 19 Asian, non-Hispanic women enrolled, 66% of projected end date total (n=29)
- 21 Asian, non-Hispanic women served, 75% of projected end date total (n= 28)

PRIORITY: <u>Reduce Maternal Morbidity and Mortality</u>

NPMs, NOMs, SPM, and ESMs:

- SPM 10: Percent of severe maternal morbidity events related to hypertension
- SPM 16: Nulliparous, term singleton, vertex (NTSV) cesarean rate

Objectives:

- By September 30, 2023, reduce the primary cesarean deliveries among low-risk mothers (NTSV) rate by 10% among participating hospitals
- By September 30, 2023, hold 4 multidisciplinary maternal mortality case review committee meetings.
- By September 30, 2023, review, synthesize, and disseminate recommendations for maternal mortality prevention
- By September 30, 2023, reduce the percent of severe maternal mortality events related to hypertension by 5%

Strategy: *Provide evidenced-based education, training, and/or technical assistance to internal and external partners to decrease risk factors for adverse outcomes, morbidity and mortality*

Completed Activities:

This strategy was written in mid-year 2022 and submitted under the MCH Block Grant State Action Plan as a strategy to be accomplished between October 1, 2022, to September 30, 2023. However, the oversight of the Mississippi Perinatal Quality Collaborative (MSPQC) transitioned to being housed and administered by the MS

Public Health Institute (MSPHI) in September 2022. Thus, many of the activities originally planned for the MSPQC when it was housed under MSDH could not be materialized or meaningfully tracked by MSDH. This change also coincided with an 80% turnover of key staff (4 of 5) in the Maternal Infant Health Bureau (MIHB). Without adequate staffing in the MIHB, this was not able to remain a priority during the reporting period. Since September 2022, MSPHI has received funding to support the MSPQC directly from the federal granting agency and does not have reporting obligations to MSDH. As staffing has stabilized in MIHB, by proximity and collaboration, MSDH is aware of and supports many of MSPQC's continued and new activities. MSDH was an active participant at the MSPQC Annual Meeting held in Flowood, MS on June 2, 2023. At this meeting, topics centered around patient engagement, C-section overuse and labor culture, partnerships, healthy equity, implementation of AIM Safety Bundles, and optimizing post-partum transitions. The Office of Health Data and Research (OHDR) initially interfaced with members of the MSPQC in May 2023 and further discussed hospital points of contact and implementation of the CDC Levels of Care Assessment Tool (LOCATe) at the Annual MSPQC Meeting. In June 2023, OHDR administered the LOCATe survey. The survey was live from June 2023 to September 2023. During this time, OHDR continued to reach out to birthing hospitals via emails, letters, and phone calls to improve the participation rate to 56.8%. After responses slowed, OHDR exported the deidentified data and sent to the CDC LOCATe team for analysis. CDC finished the analysis and sent over results by November 2023. OHDR plans to send letters to each hospital that participated to explain their individual results. MSDH partners closely with MSPHI on multiple initiatives including the implementation of the Alliance for the Innovation on Maternal Health (AIM) patient safety bundles. The AIM Capacity Building grant was awarded to MSDH in October 2023. The overall mission of AIM is to support best practices that make birth safer, improve the quality of maternal health care and outcomes, and save lives. Maternal safety bundles address topics commonly associated with health complications or risks related to prenatal, labor and delivery, and postpartum care. Ongoing AIM activities in Mississippi will include continuing to provide education and technical assistance to providers in relation to urgent maternal warning signs and bundle implementation. AIM grant is often a compliment to MSPQC funding, so deliberate and planned collaboration between MSPHI and MSDH is necessary to see all funding under both initiatives optimally used for non-duplicative work.

HMHB provided training on:

- March 2023 (2 trainings): procedures for receiving and processing high risk maternity and infant referrals and how to provide targeted case management services to those at risk of maternal and infant mortality and morbidity.
- March 2023: Perinatal/Congenital Syphilis and how to educate, treat and refer these patients.
- May 4, 2023: Postpartum Wellness Summit: Beyond the Baby Blues. This in-person educational opportunity was sponsored through the MS Department of Mental Health.

HM/HB onboarded two consultants to assist with education, training, and referrals.

- The HMHB Certified Nurse Midwife provides clinical consultation related to maternity and infant health to HMHB staff, she serves as a liaison between providers and HMHB, creates health education, leads Midwife Mondays – clinical updates and training to HMHB staff, such as family planning, gestational hypertension, maternal warning signs, maternal mental health, patient empowerment, and anticipating prenatal care visits.
- The HMHB Pharmacy Consultant provides medication management education, referrals, advocacy, health education, to patients with diabetes, gestational diabetes, hypertension, pregnancy induced hypertension, preeclampsia. Through a partnership with the MSDH MIHB, she also sends blood pressure cuffs to patients who need to self-monitor their hypertension in pregnancy and postpartum. Further, the HM/HB Pharmacy Consultant provides consultation to HMHB staff.

NOTE: *These consultants began working with the program in the final quarter of this reporting period, so a more thorough description of their work will be included in the next annual report.*

HM/HB program director and epidemiologists participated in CDC/Harvard Practicum in January 2023 and Summer 2023 which educated and provided assistance with program of developing an evaluation plan, smart goals, implementation of work plan and identifying outcomes.

Strategy: *Provide guidance and evidenced-based trainings to participating Mississippi Perinatal Quality Collaborative (MSPQC) birthing hospitals and community partners to reduce severe maternal morbidity*

Completed Activities:
The oversight of the Mississippi Perinatal Quality Collaborative (MSPQC) transitioned to being housed and administered by the MS Public Health Institute (MSPHI) in September 2022. Thus, many of the activities originally planned for the MSPQC when it was housed under MSDH could not be materialized or meaningfully tracked by MSDH. MSPHI receives its funding to support the MSPQC directly from the federal granting agency and does not have reporting obligations to MSDH. However, by proximity and collaboration, MSDH is aware of and supports many of MSPQC's continued activities. MSDH partners closely with MSPHI on multiple initiatives including the implementation of the Alliance for the Innovation on Maternal Health (AIM) patient safety bundles. The AIM Capacity Building grant was awarded to MSDH in October 2023. The overall mission of AIM is to support best practices that make birth safer, improve the quality of maternal health care and outcomes, and save lives. Maternal safety bundles address topics commonly associated with health complications or risks related to prenatal, labor and delivery, and postpartum care. Ongoing AIM activities in Mississippi will include continuing to provide education and technical assistance to providers in relation to urgent maternal warning signs and bundle implementation. Because this award's start date coincides with the closing of the MCH Block Grant's reporting period, detail on activities will be reported in the next iteration of this report.

Strategy: *Provide leadership and technical assistance in the state on Alliance for Innovation on Maternal Health (AIM) initiatives and Maternal Mortality Review activities*

Completed Activities:
The AIM Capacity Building grant was awarded to MSDH in October 2023. The overall mission of AIM is to support best practices that make birth safer, improve the quality of maternal health care and outcomes, and save lives. Maternal safety bundles address topics commonly associated with health complications or risks related to prenatal, labor and delivery, and postpartum care. Ongoing AIM activities in Mississippi will include continuing to provide education and technical assistance to providers in relation to urgent maternal warning signs and bundle implementation. Because this award's start date coincides with the closing of the MCH Block Grant's reporting period, detail on activities will be reported in the next iteration of this report.

The MIHB's Maternal Health Consultant, American College of Obstetricians and Gynecologists, and MIHB Director partnered to provide leadership and technical assistance to hospitals participating in the AIM initiative. The TA included (1) data reporting, (2) bundle implementation, and (3) overall support for implementation of related activities. During the reporting period, 1 training (August 1, 2023) was conducted to introduce hospitals to a new bundle (Postpartum Transition Discharge) that will be adopted in Mississippi. This activity is ongoing.

The Maternal Mortality Review Committee (MMRC) activities included an orientation and training (April 2023) to discuss updates regarding committee decision forms and processes. Of the 21 MMRC members, 16 attended the training. During the reporting period, the MMRC convened five (5) times to discuss 31 maternal deaths that occurred in 2020 (averaging 6 cases per meeting). A state-level report was developed and submitted to the Mississippi Legislature January 2023. The report is accessible online at:

https://msdh.ms.gov/page/resources/20200.pdf

Key findings from the MMRC report published January 2023 included the following:

- The maternal mortality ratio was 36.0 per 100,000 live births
- Black, non-Hispanic women had a maternal mortality rate 4 times higher than White, non-Hispanic women (65.1 versus 16.2) for the period.
- 57.5% of maternal deaths occurred during pregnancy or within the first 60 days after delivery, while 42.5% occurred more than 60 days but less than one year after delivery.
- Of the maternal deaths, 55% of women began prenatal care in the first trimester and an additional 20% began care in the second trimester.
- The majority of maternal deaths among Black, non-Hispanic mothers were due to cardiovascular conditions and cardiomyopathy while deaths among White, non-Hispanic mothers were distributed evenly among cardiovascular conditions, embolism, and cerebrovascular accidents.

Key recommendations from the MMRC membership included the following:

- Mississippi should make efforts to ensure insurance coverage before pregnancy and ensure patients receive options for ongoing insurance beyond the one-year postpartum period.
- The State of Mississippi should extend Medicaid coverage from 60 days postpartum to at least one year.
- A coordinated response system is needed from the point of the 911 call about the fastest method of transport, the closest capable location, and needed expertise to support local providers.
- Perinatal social services should be seamlessly integrated in with clinical care in order to facilitate complex medical and social care coordination, provide psychosocial support, and minimize multiple referrals and additional visits for patients to obtain psychosocial support. A perinatal social worker could be embedded within clinical practices and hospitals and facilitate care coordination as well as provide at home support.
- Expectant mothers should be educated on the warning signs for obstetric complications including postpartum depression and make a follow up plan with medical providers for where to go and what to do if a postpartum complication arises.

Concurrent to supporting routine administrative operations of the MMRC, the MIHB staff spent a significant portion of time in researching other state's policies and procedures for MMRC, Child Death Review Panels, and FIMRs. Over the course of a near 12-month period which began in July 2023, the MIHB developed 3 distinct policy manuals, 13 standard operating procedures for MIHB staff and committee members, and 31 appendix documents, including application forms, By-Laws, data dictionaries, confidentiality statements, consent forms, and interview guides. These documents are undergoing final draft approval before being memorialized in official agency policy. This was a critical activity for the succession of these committees under future MIHB leadership. Heretofore, there were no formalized, universal procedures that anchored operations.

Strategy: *Provide guidance and technical assistance to birthing hospitals on reducing nulliparous, term singleton, vertex (NTSV) caesarean rate*.

Completed Activities:

In September 2022, the oversight of the Mississippi Perinatal Quality Collaborative (MSPQC) transitioned from under MSDH to being housed and administered by the MS Public Health Institute (MSPHI). Thus, many of the activities originally planned for the MSPQC when it was housed under MSDH could not be meaningfully tracked by MSDH, including strategies to reducing C-Section births carried out under the MSPQC.

Further, the MSPHI receives its funding to support the MSPQC directly from the federal granting agency and does

not have reporting obligations to MSDH. Thus, MSDH is unable to report on this strategy as it did not provide any specific work or effort towards it. However, in future reporting periods, the MSDH will ensure strategies are assigned, align with current stakeholder capacity, able to be carried out under the MIHB, and align closely with the work carried out by MSPHI/MSPQC relative to reducing C-Section births.

Strategy: *Provide one-on-one technical assistance, knowledge sharing, and case review support to I-Support pilot hospitals.*

Completed Activities:
In September 2022, the oversight of the Mississippi Perinatal Quality Collaborative (MSPQC) transitioned from under MSDH to being housed and administered by the MS Public Health Institute (MSPHI). Thus, many of the activities originally planned for the MSPQC when it was housed under MSDH could not be meaningfully tracked by MSDH, including strategies to increasing vaginal births carried out under the MSPQC.

Further, the MSPHI receives its funding to support the MSPQC directly from the federal granting agency and does not have reporting obligations to MSDH. Thus, MSDH is unable to report on this strategy as it did not provide any specific work or effort towards it. However, in future reporting periods, the MSDH will ensure strategies are assigned, align with current stakeholder capacity, able to be carried out under the MIHB, and align closely with the work carried out by MSPHI/MSPQC relative to increasing vaginal births.

PRIORITY: <u>Improve Oral Health</u>

NPMs, NOMs, SPM, and ESMs:
- Preventive Dental Visit/NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
- TDC/NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
- SOC/NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- CHS/NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
- PDV-Pregnancy.1/ESM 13.1.1 - Number of pregnant and postpartum women who received oral health education

Objective:
- By September 30, 2023, increase the percentage of women who have a preventive dental visit in pregnancy by 5%

Strategy: *Provide education to women on the safety and importance of proper oral health during pregnancy and postpartum*.

Completed Activities:
HM/HB developed a Comprehensive Assessment in June 2023 to be completed by the HM/HB Nurse Case Managers when enrolling a maternity or infant patient. The purpose of the initial enrollment and comprehensive assessment interview is to gather immediate information about the patient and family to identify urgent needs and barriers which may impact their short- and long-term health outcomes. The comprehensive assessment of the individual's needs informs of any medical, educational, social, nutritional and or other services that are needed including the components of the Social Determinants of Health (SDOH).

Under the guidance of the Office of Oral Health (OOH), the comprehensive assessment also includes a section titled "Dental History" that includes 5 questions to determine if oral health education and/or referral to the MSDH

OOH is to be made. All HM/HB patients/caregivers are asked these questions at time of enrollment. There is also an Oral Health Screening in EPIC that is recommended to be provided if the nurse case manager or extended service provider has identified any dental needs.

In July 2023, HM/HB collaborated with the OOH to provide a training which focused on educating and referring pregnant women and families for oral health assistance. All HM/HB staff, including approximately 60 nurses, nutritionists, and social workers participated in the training to review:

- Procedures for educating pregnant women on the importance of oral health care and the risks of not following up with a dental provider while pregnant.
- Procedures for educating caregivers on the importance of good oral health care in infants, as well as caregivers taking care of their own dental needs.
- Explanation of when, why, and how to refer an HM/HB patient and/or family member to the Office of Oral Health Regional Oral Health Consultants (ROHCs) to provide brief oral health education and/or refer to a dental provider closer to patient's county of residence.

In addition, the HMHB staff were given oral health education and toothbrush kits to distribute to their patients.

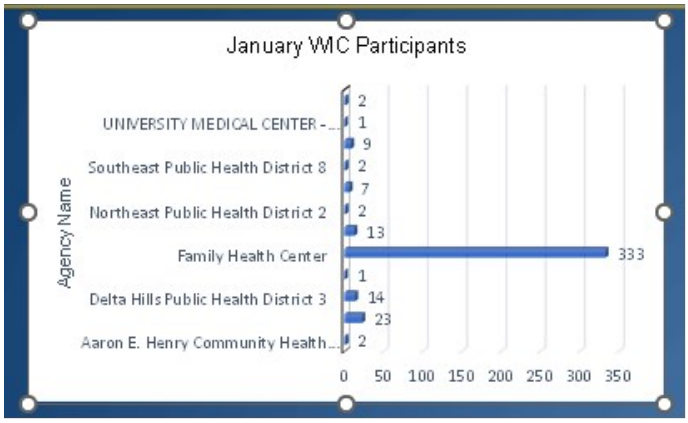
During the 1st quarter after the training (October-December 2023), 15 patients were assessed as being in the urgency category I for pain and referred to the ROHCs for follow up. Further, over 500 hygiene and educational products were disseminated to HM/HB staff who then provided education and tools to families.

According to the National Institutes of Health (NIH), neglecting oral and dental health during pregnancy does not only cause problems such as tooth decay and tooth loss, but may also lead to problems such as premature birth, low birth weight infant, and pre-eclampsia. However, in Mississippi, once a pregnant mother has aged out of comprehensive dental coverage (age 20), she may only receive limited exams and extractions through the Division of Medicaid. Oral health assessment and education efforts are intended to document the gap between need and services for urgent dental care.

Oral care in pregnancy - PMC (nih.gov)
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6883753/#:~:text=It%20should%20also%20be%20kept,infant%2C

Three Regional Oral Health Consultants (ROHC) provided 38 trainings to mothers participating in WIC programs in 21 counties: Forrest, Hancock, Hinds, Jasper, Jefferson Davis, Jones, Lauderdale, Leake, Lincoln, Neshoba, Newton, Rankin, Scott, Simpson, Smith, Washington, and Wayne Counties. A total of 1,671 women received oral health education and toothbrush kits which consist of a toothbrush, floss, and toothpaste from these in-person trainings. Additional oral health kits were donated to children and other adults attending the mother's WIC appointments; however, these donations were not included in the calculations above

This is the first full reporting year in collaboration with the WIC department on oral health education and distribution of hygiene kits (toothbrush, toothpaste, and floss). These data are captured in the WIC SPIRIT management information system allowing the OOH to receive monthly reports and referrals from the WIC Program (see example of graph below). Based on these reports, between January and September 2023, 3,585 mothers received oral health education and oral health hygiene aids.


January WIC Participants
Agency Name
UNIVERSITY MEDICAL CENTER -...
Southeast Public Health District 8
Northeast Public Health District 2
Family Health Center
Delta Hills Public Health District 3
Aaron E. Henry Community Health...
2
1
9
2
7
2
13
333
1
14
23
2
0
50
100
150
200
250
300
350

Women/Maternal Health
Application Year - FY2025

The following section outlines strategies and activities to be implemented between 10/1/2024-9/30/2025 to meet the objectives and show improvement on the measures related to women's and maternal health:

PRIORITY: Improve Oral Health

NPMs, NOMs, SPMs, and ESMs:
- PDV-Pregnancy/NPM 13.1: Percent of women who had a preventive dental visit during pregnancy
- TDC/NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
- SOC/NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- CHS/NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
- PDV-Pregnancy.1/ESM 13.1.1: Number of pregnant and postpartum women who received oral health education

Objective:
- By September 30, 2025, increase the percentage of women who have a preventive dental visit in pregnancy by 10%

Strategy: *Provide education to women on the safety and importance of proper oral health during pregnancy and postpartum*.

Activities:
- Implement oral health promotion and messaging through the WIC Shopper app
- Coordinate efforts with WIC and home visiting/case management programs to improve access and utilization of dental services for program participants

PRIORITY: Improve Access to Care

NPMs, NOMs, SPMs, and ESMs:
- WWV/NPM 1: Percent of women, ages 18-44, with a preventive medical visit in the past year
- SMM/NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations
- MM/NOM 3: Maternal mortality rate per 100,000 live births
- LBW/NOM 4: Percent of low birth weight deliveries (<2,500 grams)
- PTB/NOM 5: Percent of preterm births (<37 weeks)
- ETB/NOM 6: Percent of early term births (37, 38 weeks)
- PNM/NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths
- IM/NOM 9.1: Infant mortality rate per 1,000 live births
- IM-Neonatal/NOM 9.2: Neonatal mortality rate per 1,000 live births
- IM-Postneonatal/NOM 9.3: Post neonatal mortality rate per 1,000 live births
- IM-Preterm Related/NOM 9.4: Preterm-related mortality rate per 100,000 live births
- DP/NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy
- NAS/NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

- TB/NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
- PPD/NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
- WWV.5/ESM 1.5: Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy

Objectives:

- By September 30, 2025, increase the number of family planning users within MSDH clinics by 5% (from 20,839 to 21,880).
- By September 30, 2025, increase the number of Family Planning Waiver beneficiaries receiving family planning services within MSDH clinics by 5% (from 4,254 to 4,467).
- By September 30, 2025, increase the number of women enrolled in the MS Breast and Cervical Cancer Program by 10% (from 3,548 to 3,903).
- By September 30, 2025, 90% of enrolled women, actively participating in a home visiting/case management program will be screened for pregnancy intention and provided interconception care education and support to access services as needed.
- By September 30, 2025, increase the number of pregnant/postpartum women participating in a case management/home visiting program by 30% (from 923 to 1,200).
- By September 30, 2025, increase the number of outside MSDH referrals for a case management/home visiting program by 20% (from 1,867 to 2,240).
- By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to women's health via media, social media, and other public-facing platforms.

Strategy: *MCH-serving/supported programs will collaborate with internal and external partners to develop promotional strategies to increase family planning users*.

Activities:

- Collaborate with other MSDH departments to train all MSDH clerical and clinical staff who support family planning users on the "Going Gold" project to increase the number of Family Planning Waiver beneficiaries accessing services.
- Optimize telehealth visits to provide family planning visits to MSDH patients.
- Collaborate with other health systems on referrals for patients needing family planning services.

Strategy: *MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving women's/maternal health*.

Activities:

- Extend existing or select by competitive RFP, subgrantees, including health systems or community-based partners, to execute specific activities for recruitment, referral, enrollment, direct services, and participant navigation to address SDOHs of MCH program participants that improve women's/maternal health.
- Engage with other MCH-serving programs to share lessons learned to advance program knowledge. Activities may include hosting or participating in local/regional meetings calls, participating in peer-to-peer calls, presentations delivered by webinar, mentoring other programs, technical assistance, etc.
- Develop and maintain local resource/referral directories with internal and external partners to collaborate on improving health for new and pregnant parents enrolled in home visiting programs.

Strategy: *Home visiting/case management programs will develop and improve relationships with internal and*

external partners to increase referrals to the program.

Activities:

- Identify 3-4 potential healthcare settings, community-based, faith-based, social, volunteer service organizations, homeless/domestic violence shelters, residential programs, treatment programs, housing complexes, etc. to outreach per quarter and request opportunities to share information with “gatekeepers” of (i.e., community health workers, patient navigators, care coordinators, case managers, faith leaders, non-profit social service workers, helpers, etc.) or to the target population.
- Optimize MSDH electronic health record (Epic) and other platforms to create referral management processes and templates for use by external and internal referral sources to home visiting/case management programs.

Strategy: *MCH programs will collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of women’s/maternal health issues*.

Activities:

- Collaborate with the Office of Communications to promote CDC/HRSA/other approved messaging related to women’s health issues etc. Prepare social media post schedules and templates for observance months/days.
- Maximize available funding and in-kind support to develop or enhance direct health education approaches for consumers of MCH-serving programs focused on improving women’s health issues (i.e., breast and cervical cancer screening, well-woman/preventive health visits)

Strategy: *MCH-serving/supported programs will work with internal and external partners to provide information and linkages to services to promote tobacco cessation among pregnant parents*.

Activities:

- Update intake and ongoing assessments across all MCH programs serving new and pregnant parents to inquire about tobacco use and interest in tobacco cessation assistance.
- Develop and maintain local resource/referral directories with internal and external partners to collaborate on promoting tobacco cessation among new and pregnant parents enrolled in home visiting programs.

PRIORITY: <u>Reduce Maternal Morbidity and Mortality</u>

NPMs, NOMs, SPMs, and ESMs:

- PPV: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components
- SPM 10: Percent of severe maternal mortality events related to hypertension
- SPM 16: Nulliparous, term singleton, vertex (NTSV) cesarean rate

Objectives:

- By September 30, 2025, produce the annual Maternal Mortality Report inclusive of 2017-2021 maternal deaths to include recommendations for preventing maternal deaths.
- By September 30th, 2025, increase the number of birthing hospitals and other health systems implementing one or more AIMS Safety Bundles by 10% (from 41 to 46).
- By September 30, 2025, 10 pregnant women will have been referred to a home visiting/case management program to support syphilis treatment before delivery.
- By September 30, 2025, participate in at least 18 community outreach events to address maternal mortality

disparities and promote Maternal Mortality Review Committee recommendations.
- By September 30, 2025, increase the number of postpartum women participating in a case management/home visiting program who attend a postpartum checkup within 12 weeks and receive recommended care components by 5%.

Strategy: *Provide administrative support and coordination with other MSDH Offices, health facilities, state agencies, et al. for the maternal mortality review case abstraction, exploration, and determination process for all maternal deaths through the Maternal Mortality Review Committee*.

Activities:
- Engage with other Maternal Mortality Review Committees to share lessons learned to advance program knowledge, including hosting or participating in local/regional meetings or peer-to-peer calls, presentations delivered by webinar, mentoring other programs, technical assistance, etc.
- Implement findings from a focus group project including impressions, perceptions, and experiences of women who have given birth in Mississippi to make recommendations, plan additional strategies, and distribute MCH resources/programming to impact maternal health outcomes.
- Continue and expand maternal hypertension and gestational diabetes supports, to include education on urgent maternal and postpartum warning signs, for participants of MSDH home visiting/case management programs.
- Streamline the referral process for pregnant women with positive syphilis findings to home visiting/case management programs.

Strategy: *Provide and/or partner with other stakeholders to offer educational opportunities and evidence-based trainings to birthing hospitals and other systems on strategies to reduce severe maternal mortality and morbidity*.

Activities:
- Support the uptake/maintenance/continued implementation of AIMS Safety Bundles (i.e., severe maternal hypertension, obstetric hemorrhage, and reduction of primary caesarean births) in birthing hospitals and other health systems.
- Support the launch/uptake of new AIMS Safety Bundles (i.e., postpartum discharge transitions, perinatal mental health) in birthing hospitals and other health systems.
- Host the Annual Mississippi Maternal Health Conference to support future strategic planning on maternal health issues and mortality/morbidity prevention approaches

Strategy: *MCH-serving/supported programs will work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward reducing maternal mortality based on MMRC recommendations*.

Activity:
- Extend existing or select by competitive RFP, subgrantees, including health systems or community-based partners, to execute specific activities for providing health promotion, health education, and health equity-focused activities that improve maternal health (prenatal, perinatal, postpartum, and/or interconception)
- Update intake and ongoing assessments across all MCH programs serving new and pregnant parents to track postpartum checkups.
- Develop and distribute educational materials on the need for prenatal and postpartum care and eligibility for public insurance under the presumptive eligibility change and extended postpartum period.

Strategy: *Lead the promotion of health observances, and other outreach/engagement strategies to increase public awareness of maternal health issues.*

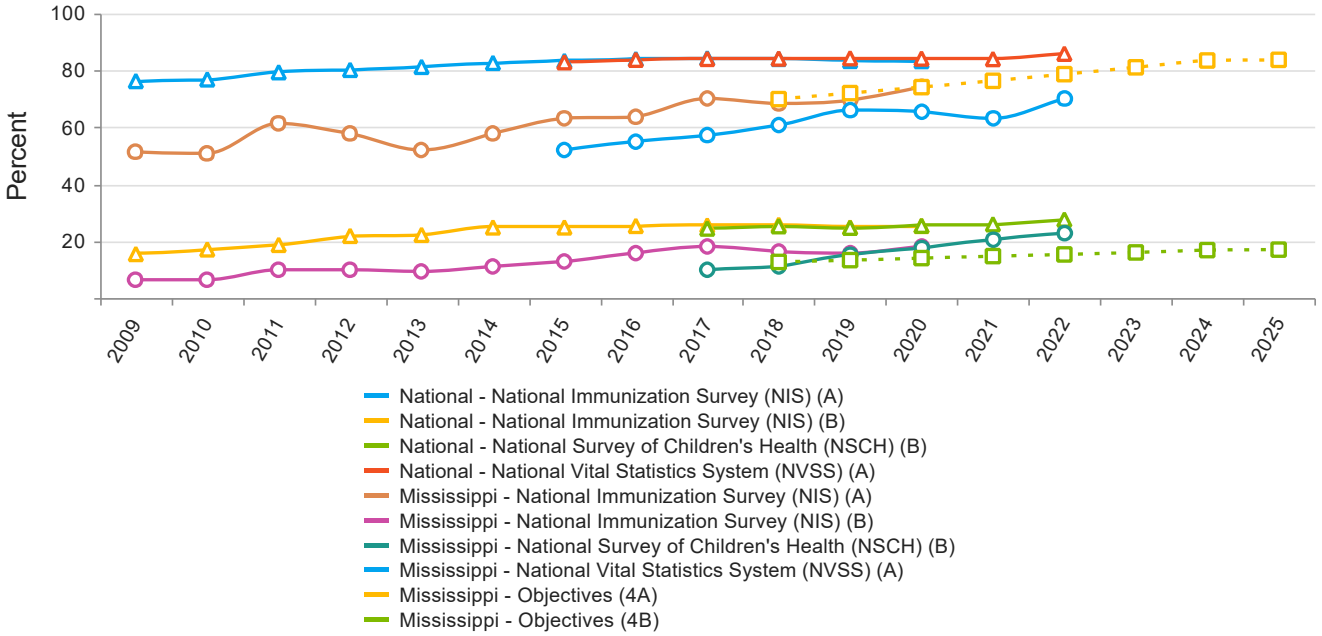
Activities:

- Collaborate with the Office of Communications to promote CDC/HRSA/other approved messaging related to maternal health issues (prenatal, perinatal, postpartum, and/or interconception) etc. Prepare social media post schedules and templates for observance months/days.
- Maximize available funding and in-kind support to develop or enhance direct health education approaches for consumers of MCH-serving programs focused on improving maternal health issues.

Perinatal/Infant Health

National Performance Measures

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



NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	71.9	74	76.2	78.5	80.9
Annual Indicator	63.4	70.0	68.0	69.4	74.2
Numerator	22,722	22,777	21,999	23,474	24,340
Denominator	35,813	32,539	32,351	33,806	32,793
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	80.9
Annual Indicator	69.8
Numerator	23,756
Denominator	34,054
Data Source	NVSS
Data Source Year	2022

Annual Objectives		
	2024	**2025**
Annual Objective	83.3	83.5

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	13.4	14.1	14.8	15.4	16.1
Annual Indicator	16.0	18.1	16.4	15.6	18.3
Numerator	5,507	5,651	5,200	5,053	5,746
Denominator	34,464	31,217	31,729	32,343	31,338
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2023
Annual Objective	16.1
Annual Indicator	23.0
Numerator	19,896
Denominator	86,365
Data Source	NSCH
Data Source Year	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	16.9	17.1

Evidence-Based or –Informed Strategy Measures

ESM BF.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals

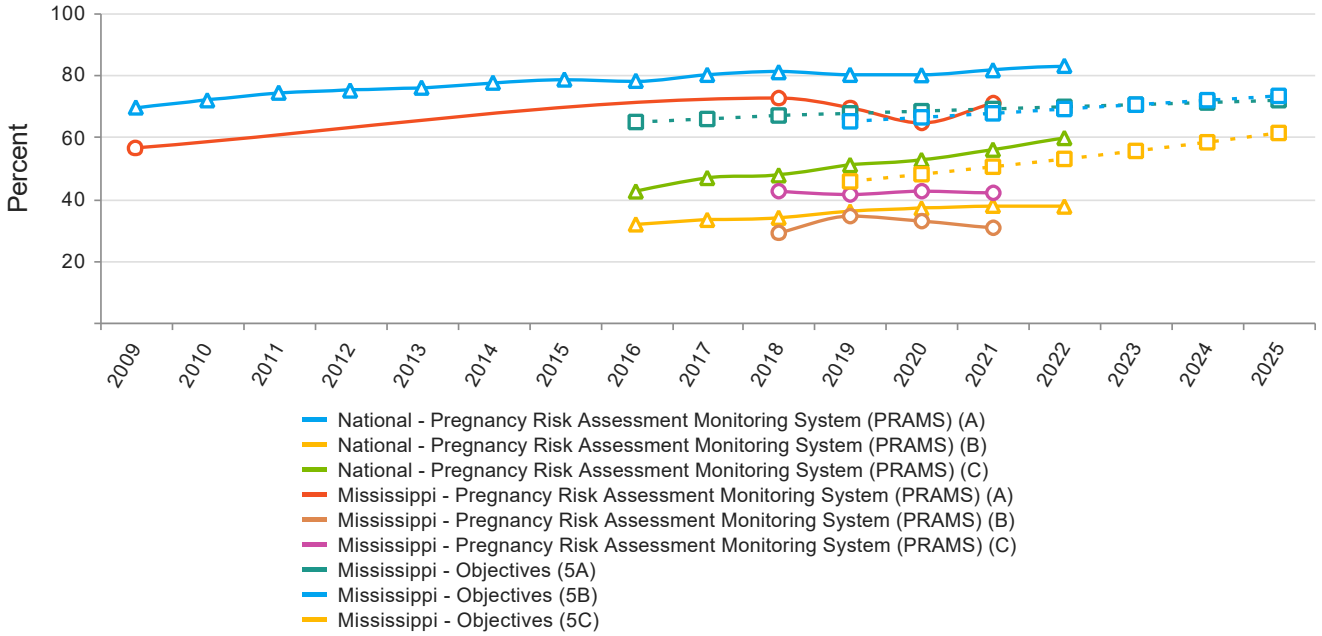
Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	4	5	6	24	26
Annual Indicator	18	21	22	25	29
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	Baby Friendly USA	Baby Friendly USA
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	28.0	30.0

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Indicators and Annual Objectives



NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	67.5	68.2	68.9	69.6	70.3
Annual Indicator	72.2	69.4	64.3	70.7	70.7
Numerator	23,861	22,384	20,451	21,727	21,727
Denominator	33,042	32,256	31,790	30,728	30,728
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	67.5	68.2	68.9	69.6	70.3
Annual Indicator	72.2				
Numerator	23,861				
Denominator	33,042				
Data Source	MS PRAMS				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives		
	2024	2025
Annual Objective	71.0	71.7

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	64.9	66.2	67.5	68.9	70.3
Annual Indicator	28.8	34.4	32.7	30.7	30.7
Numerator	9,167	10,964	10,154	9,166	9,166
Denominator	31,841	31,829	31,010	29,840	29,840
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	64.9	66.2	67.5	68.9	70.3
Annual Indicator	28.8				
Numerator	9,167				
Denominator	31,841				
Data Source	MS PRAMS				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives		
	2024	**2025**
Annual Objective	71.7	73.1

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.6	47.9	50.3	52.8	55.4
Annual Indicator	42.3	41.3	42.4	41.9	41.9
Numerator	13,523	12,948	13,078	12,497	12,497
Denominator	31,973	31,323	30,870	29,808	29,808
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.6	47.9	50.3	52.8	55.4
Annual Indicator	42.3				
Numerator	13,523				
Denominator	31,973				
Data Source	MS PRAMS				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives		
	2024	**2025**
Annual Objective	58.2	61.2

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

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

Evidence-Based or –Informed Strategy Measures

ESM SS.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	20,200	20,450	20,700	21,000	21,250
Annual Indicator	10,000	14,880	9,560	11,863	13,950
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	21,500.0	21,500.0

State Performance Measures

SPM 12 - Percent of women who are enrolled in WIC and initiate breastfeeding

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			51
Annual Indicator	49.3	54	55.9
Numerator		11,007	21,547
Denominator		20,401	38,512
Data Source	WIC Spirit database	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	51.5	52.0

SPM 17 - Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			78.5
Annual Indicator	75.6	77.9	77.3
Numerator	67,008	56,332	73,729
Denominator	88,608	72,327	95,345
Data Source	MS BRFSS	MS BRFSS	MS BRFSS
Data Source Year	2021	2019 2021	2021 2022
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	79.0	79.5

State Action Plan Table

State Action Plan Table (Mississippi) - Perinatal/Infant Health - Entry 1	
Priority Need	
Reduce Infant Mortality	
NPM	
NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	
Five-Year Objectives	
By September 30, 2025, produce the annual Child Death Review Report to include recommendations for preventing infant deaths	
By September 30, 2025, participate in at least 18 community outreach events to address infant mortality disparities and promote Child Death Review and FIMR Committee recommendations	
By September 30, 2025, expand the FIMR program to all 9 public health districts of Mississippi	
By September 30, 2024, add informant interviewing of family members/next-of-kin to the Child Death Review and FIMR case exploration processes	
Strategies	
Provide the administrative support for the death case abstraction, exploration, and determination process to fidelity for all maternal deaths through the Child Death Review Panel and FIMR	
MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving infant mortality based on CDR and FIMR recommendations	
ESMs	**Status**
ESM SS.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals	Active
NOMs	
NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM	
NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal	
NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID	

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

Priority Need

Increase Breastfeeding, Healthy Nutrition and Healthy Weight

NPM

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Five-Year Objectives

By September 30, 2025, increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support

Strategies

Increase breastfeeding initiation and duration rates through prenatal breastfeeding education, during delivery admission, and post discharge support

Assist in the creation and maintenance of Mississippi MILC Leagues across the state of Mississippi

ESMs	Status
ESM BF.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals	Active

NOMs

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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

Priority Need

Improve Access to Family-Centered Care

SPM

SPM 17 - Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year

Five-Year Objectives

By September 30, 2025, increase the number of infants participating in a case management/home visiting program by 30% (from 533 to 693)

By September 30, 2025, increase the number of outside MSDH referrals for the case management/home visiting program by 20% (from 1,867 to 2,240)

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to perinatal/infant health via media, social media, and other public-facing platforms.

Strategies

MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving perinatal/infant health.

Home visiting/case management programs will develop and improve relationships with internal and external partners to increase referrals to the program

MCH programs will collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of perinatal/infant health issues

State Action Plan Table (Mississippi) - Perinatal/Infant Health - Entry 4

Priority Need

Increase Breastfeeding, Healthy Nutrition and Healthy Weight

SPM

SPM 12 - Percent of women who are enrolled in WIC and initiate breastfeeding

Five-Year Objectives

By September 30, 2025, increase enrollment and participation in the WIC Program by 5% via partnerships and evidence-based initiatives

Strategies

Partner with other MCH-serving program on community innovation project activities

Perinatal/Infant Health
Annual Report - FY2023

The following section outlines strategies and activities implemented between 10/1/2022-9/30/2023 to meet the objectives and show improvement on the measures related to perinatal and infant health:

Activities in this domain were carried out by the following MSDH offices, bureaus, or programs during the reporting period:

- Healthy Moms/Healthy Babies of Mississippi (HM/HB)
- Maternal and Infant Health Bureau (MIHB)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Lead Poisoning Prevention and Healthy Homes
- Genetics/Newborn Screening Bureau

PRIORITY: Increase Breastfeeding, Healthy Nutrition, and Healthy Weight

NPMs, NOMs, SPM, and ESMs:

- Breastfeeding/NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months.
- IM/NOM 9.1: Infant mortality rate per 1,000 live births
- IM-Postneonatal/NOM 9.3: Post neonatal mortality rate per 1,000 live births
- IM-SUID/NOM 9.5: Sudden Unexpected Infant Death rate per 100,000 live births
- SPM 12: Percent of women who are enrolled in WIC and initiate breastfeeding
- Breastfeeding.1/ESM 4.1: Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals

Objectives:

- By September 30, 2023, increase the number of women who enroll in WIC and initiate breastfeeding by 5%
- By September 30, 2023, increase the number of children enrolled and participating in the WIC program by 5%.

Strategy: *Assist birthing hospitals on attaining the Baby Friendly designation*.

Completed Activities:

The Baby Friendly Hospital Initiative (BFHI) is a structured, comprehensive quality improvement strategy developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Its primary goal is to improve maternity care practices and create an optimal environment that supports breastfeeding.

To earn Baby Friendly designation, birth hospitals must demonstrate compliance with the following Ten Steps:

1. (a) Comply fully with the *International Code of Marketing of Breast-milk Substitutes* and relevant World Health Assembly resolutions. (b) Have a written infant feeding policy that is routinely communicated to staff and parents. (c) Establish ongoing monitoring and data-management systems.
2. Ensure that staff have sufficient knowledge, competence, and skills to support breastfeeding.
3. Discuss the importance and management of breastfeeding with pregnant women and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as

soon as possible after birth.
5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.
7. Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
8. Support mothers to recognize and respond to their infants' cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

As of September 30, 2023, 29 of the 41 birthing hospitals in Mississippi had been designated as Baby Friendly. To assist birthing hospitals in Mississippi to attain the Baby Friendly designation, the MSDH WIC Program established a standard memorandum of understanding (MOU) to be implemented with birthing hospitals to provide them support in achieving Step 3 related to prenatal breastfeeding education and Step 10 related to post-discharge support. WIC staff provided support in teaching prenatal breastfeeding education classes onsite at partnering hospitals

Approximately 40% of Baby Friendly hospitals (11 of the 29) have a formal MOU with the MSDH WIC program. These formal MOUS cover a 3-5 year time period, depending upon the birthing hospital. Between 2020-2022, the MSDH WIC Program was unable to provide services in the hospital setting as stated in the agreement due to COVID-19 restrictions. During the 10/1/2022-9/30/2023 project period, the MSDH WIC program focused on rebuilding relationships with the 11 hospitals to encourage the resumption of services and the renewal the formal agreements. Specifically, the MSDH WIC program reestablished contacts with the birthing hospitals, held meetings to discuss the level of services allowable, such as referrals, individual education, group education, and discharge coordination, and, beginning April 1, 2023, MSDH WIC transitioned to hybrid operations.

Strategy: *Assist in the creation and maintenance of Baby Cafés (Mississippi MILC Leagues) across the state of Mississippi*.

Completed Activities:
Despite their initial success, in-person Baby Café' support group meetings were discontinued in Mississippi due to the crippling impact of COVID-19 restrictions which led to a cascade of financial pressures and an inability to cover the annual fees, declining support for the cafe's facilitators, and limited evidence of effectiveness. As a result, the Mississippi Breastfeeding Coalition (MBFC) created Mississippi MILC (Making an Impact in the Lactation Community) Leagues to replace the Baby Cafés. The MILC League offers free peer support groups for new and expectant mothers virtually or in-person in communities throughout Mississippi. The MSDH WIC Program partners with MBFC to staff the MILC Leagues with breastfeeding peer counselors, certified lactation counselors, and International Board-Certified Lactation Consultants. These lactation professionals provide weekly meetings for breastfeeding mothers. To support the facilitators and ensure they understand the unique needs of their communities, the MILC League coaches also meet monthly to discuss community resources and what works well in their meetings.

The MILC Leagues aim to improve breastfeeding rates in Mississippi by offering access to equitable lactation support statewide. As of September 30, 2023, there were 5 MILC Leagues across the state serving new and expectant mothers with plans to open additional locations in 2024. As the MILC Leagues are a new initiative, reportable data on outcomes is limited. The MSDH WIC program is working with the MBFC to establish data collection processes with reporting to begin in FY 2024.

Strategy: *Increase access to certified lactation professionals*.

Completed Activities:
During the 10/1/2022-9/30/2023 project period, the MSDH WIC Program partnered with the Mississippi Breastfeeding Coalition (MBFC) and Mississippi Public Health Institute (MPHI) to implement the International Board-Certified Lactation Consultant (IBCLC) mentorship and scholarship program. Participants receive assistance with training and study materials. During this reporting period a total of 28 WIC staff received assistance, including 22 peer counsellors and 6 WIC nutritionists. Of these, 17 attained IBCLC certification by September 30, 2023.

MSDH WIC has rolled out a mandatory breastfeeding training program for staff. This curriculum is designed to build competencies among all levels of WIC staff in breastfeeding promotion and support strategies in the WIC Program. It relies on recent science, as well as best practices adopted by State and local WIC agencies across the country. WIC Breastfeeding Curriculum training will be provided to new hires through the agency learning management system in FY 2024. WIC participants will have continued access to the Pacify Mobile App for assistance and real time education when breastfeeding issues and questions arise.

MSDH WIC will continue to maintain partnerships with other support groups such as the Mississippi Breastfeeding Coalition, Le Leche' League, Mothers Milk Bank of MS, Delta Health Alliance, REACH Program and Healthy Moms Healthy Babies for additional referrals to the MSDH WIC Program.

WIC while continuing to provide education through individual telephone counseling sessions and virtual platforms when applicable.

The Mississippi Breastfeeding Coalition and The Mississippi Public Health Institute have partnered to implement an International Board-Certified Lactation Consultant (IBCLC) Mentorship and Scholarship program to benefit approximately 28 WIC peer counselors and/or registered dieticians. Participants have received assistance with training courses, study materials, mentorship, and exam fees. To date we have 8 new IBCLCs from participating peer counselors. Six additional peer counselors are awaiting test results from the exam administered in March 2023. We have 5 WIC registered dieticians and 4 breastfeeding peer counselors who should be eligible to sit for the exam in September 2023. All other participants must be eligible to sit for the Spring 2024 exam to successfully complete the program.

Strategy: *Partner with WIC to promote maternity and infant enrollment in WIC services*.

Completed Activities:
The WIC Community Innovation and Outreach project aims to increase WIC enrollment and participation for target populations annually through partnership, outreach, and promotion activities and address language, cultural, and environmental barriers. The WIC Program is partnering with the Office of Oral Health, Lead and Healthy Homes, Healthy Moms Healthy Babies, and Early Intervention. Program staff are assisting WIC with promotion of program and referrals to WIC to increase WIC enrollment by providing outreach materials to internal and external partners at outreach events, provider offices, community organizations, health fairs, places of worship, etc. The WIC CIAO Project started in May 2023. Partnerships were established in August 2023.

WIC used Red Cap to develop an electronic referral system to provide participant information to referring entities. Between June and September 2023, 1286 referrals were made, including 1154 to Healthy Moms Healthy Babies, 51 to Early Intervention, 22 to Lead and Healthy Homes, 2 to Opioid Prevention, and 57 to the Office of Oral Health.

PRIORITY: Improve Access to Family-Centered Care

NPMs, NOMs, SPM, and ESMs:

- SPM 17: Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year

Objectives:

- By September 30, 2025, increase enrollment of pregnant women in the Healthy Moms/ Healthy Babies of MS program by 5%
- By September 30, 2025, increase retention of women in the Healthy Moms/Healthy Babies of MS program by 10%
- By September 30, 2025, increase enrollment of infants in the Healthy Moms/Healthy Babies of MS program by 5%
- By September 30, 2025, increase retention of infants in the Healthy Moms/Healthy Babies of MS program by 10%

NEW Strategy: *Partner with health care providers to identify and intervene with pregnant women who tested positive for syphilis*

Completed Activities:

Starting in March 2023, congenital syphilis became a considerable focus for multiple programs within MSDH, including the Office of Communicable Disease and Healthy Moms/Healthy Babies. On March 7, 2023, through the issue of a Health Action Network (HAN) notice, providers across the state were advised that syphilis during pregnancy had been added as a reportable disease along with the requirement of testing during pregnancy. This HAN alerted providers to the requirements below:

- Perform syphilis testing for all pregnant people in their first trimester (or at the initial visit for prenatal care) and again in the third trimester (28-32 weeks).
- Perform syphilis testing for all pregnant people at the time of delivery if no documentation of syphilis testing during the current pregnancy is available or the patient has received no prior prenatal care in the current pregnancy.
- Ensure appropriate treatment for syphilis infections during pregnancy, per the most current Centers for Disease Control and Prevention (CDC) treatment guidelines (2021 STI Treatment Guidelines – Syphilis: Updated diagnostic, treatment, and screening recommendations for STIs (July 22, 2021)).
- Ensure appropriate reporting of syphilis infection in pregnancy to MSDH.

At the urging of the UMMC School of Population Health Dean and former State Health Officer, Dr. Thomas Dobbs and MSDH leadership, the HM/HB and the OCD began discussions on streamlining referrals on women testing positive for syphilis during pregnancy or at delivery, as well as infants testing positive or with prenatal exposure. A secure referral protocol between HM/HB and the OCD was designed and allowed for immediate referral from any Disease Intervention Specialist (DIS) to HM/HB for any woman/infant who had been reported under mandatory testing requirements. In April 2023, a repeat HAN was issued to cover the same guidance on syphilis testing during pregnancy and at delivery, as well as provided additional clarification on reporting requirements. In May 2023, MSDH issued an additional HAN regarding the nationwide Bicillin shortage. This HAN addressed appropriate treatment protocols for pregnant women, as well as referred providers to the Syphilis Hotline, coordinated by MSDH and UMMC, which provided syphilis diagnostic and treatment guidance. Also in May 2023, HM/HB partnered with the Office of Communicable Disease to train nurses on the protocol for treating congenital syphilis during the national Bicillin shortage to assure that pregnant women and exposed infants were

prioritized for care.

Under the streamlined protocol, initial referrals to HM/HB started in August 2023 with a total of 11 referrals made by the close of the reporting period (9/30/2023).

On September 11, 2023, 19 HM/HB staff participated in a virtual training titled Syphilis Screening and Management in the Perinatal and Neonatal Population conducted by the Nurse Midwife Consultant

Strategy: *Promote / Advocate for prenatal medical visits*

Completed Activities:
Throughout the project period, county health departments continued to screen women of reproductive age for pregnancy, providing prenatal vitamins to those with positive pregnancy tests and offering counselling and education to women regardless of their test results. Women who tested positive for pregnancy were screened for health risk factors that could affect their health or their baby's health. Those identified with risk factors were referred to the Healthy Moms/Healthy Babies (HM/HB) program. Women with positive pregnancy tests who did not have a medical provider were given resources to connect them with prenatal care providers. Additionally, prenatal vitamins were made accessible to any women having a positive pregnancy test provided through an MSDH clinic. During the period of October 1st, 2022, to September 30th, 2023, a total of 2,294 women received positive pregnancy test results and out of this number, approximately 50% (1,148 women) were given prenatal vitamins.

The HM/HB Program supports enrolled maternity patients in accessing prenatal medical visits and helps address financial barriers to access. Newly enrolled maternity patients are provided an initial comprehensive assessment which determines their access to prenatal care and health insurance coverage. If the patient currently does not have a medical provider or lacks health insurance, the case manager refers the patient to a medical provider for prenatal care and/or assists the patient to apply for coverage. HMHB case managers meet with patients monthly to discuss their care plan and follow-up on prenatal visits and concerns.

The HM/HB Program was unable to quantify the number of referrals for prenatal care or insurance access as these data are recorded in narrative case notes. To allow for easier tracking, the HM/HB Program began working to optimize data collection using discrete reportable fields. The HM/HB Program will be able to track and report on the number of women needing referrals to a prenatal care provider or medical home upon enrollment in the program after full implementation of these changes.

Strategy: *Promote / Advocate for postpartum medical visits for women 2-4 weeks following delivery*

Completed Activities:
HM/HB staff provide education to participants about what to expect during a postpartum medical visit as patients move closer to delivery, and they encourage patients to attend the postpartum visit. Also, HM/HB nurses provide postpartum home visits to maternity patients who opt-in to receive that assessment, education, and checkup. HM/HB has improved in monitoring data so that the number of PP visits and PPHV with an RN will be available for future reports.

HM/HB program nurses provide postpartum home visits (in some cases clinic visits) to women who have delivered during their enrolment in the HM/HB program. The Postnatal Assessment/Postpartum Home Visit typically occurs 2 to 4 weeks (but no later than 6 weeks) after delivery. This visit includes prevention, early

detection and assessment of any health complications. The HM/HB Extended Service Provider (ESP) Nurse will assess both the mother and baby during the home visit, including the mother's vital signs (i.e., weight, blood pressure), fundus, lochia, lacerations, and mental health. The ESP Nurse will also provide nutritional guidance, health education about postnatal care, family planning, breastfeeding, and newborn care. In the event further medical, psychosocial, nutritional or other needs are identified at the home visit, the ESP Nurse will take action on referral or follow-up immediately. If the postpartum mother or ESP Nurse identifies a risk in newborn, the infant is referred for risk screening for the program.

In addition, the HM/HB staff used educational materials available from the CDC's HEAR HER Campaign, which provide information in a culturally responsive and easy to understand approach on the urgent clinical and other signs that may point to a pregnancy or postpartum emergency. More information on the HEAR HER Campaign is available at: https://www.cdc.gov/hearher/index.html

Strategy: *Promote / Advocate for interconception care*

Completed Activities:
HM/HB Case Managers discusses family planning through the Initial Comprehensive Assessment, closer to each pregnant woman's delivery, at their postpartum visit, and at the enrollment of each infant. The HM/HB program is developing additional training related to family planning to be implemented in subsequent years.

Strategy: *Promote annual preventive medical visits for women of reproductive age*

Completed Activities:
During the reporting period, a total of 11,562 clients received annual wellness exam services through MSDH clinics. Of these clients, 3,887 were new clients. Fifty-nine (59) of these clients had abnormal Papanicolaou (Pap) smears, followed up and returned to the clinic for a repeat Pap test. The services provided included: Medical history, measuring height, weights and checking blood pressure, testing hemoglobin, urinalysis testing protein and glucose, urine pregnancy testing, and blood testing for STIs and HIV, Pap smears and Clinical breast exams. Additionally, staff provided counselling, education, treatment for STIs and referrals for extended care including mammograms and further STI/HIV counselling. Eligible clients were enrolled in the breast and Cervical Cancer Prevention (BCCP) program to receive additional services.

PRIORITY: Reduce Infant Mortality

NPMs, NOMs, SPM, and ESMs:
- Safe Sleep/NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
- IM/NOM 9.1 - Infant mortality rate per 1,000 live births
- IM-Postneonatal/NOM 9.3 - Post neonatal mortality rate per 1,000 live births
- IM-SUID/NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
- SS.1/ESM 5.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals

Objectives:
- By September 30, 2023, increase the number of women who enroll in WIC and initiate breastfeeding by 5%
- By September 30, 2023, increase the number of children enrolled and participating in the WIC program by 5%

Strategy: *Provide evidenced-based education, training, and/or technical assistance to internal and external partners to decrease risk factors for adverse outcomes, morbidity and mortality*

Completed Activities:
HMHB provided training on 3/6/2023 and 3/23/2023 on how to receive and process high risk maternity and infant referrals and how to provide targeted case management services to those at risk of maternal and infant mortality and morbidity. March 2023 HM/HB staff received several trainings on Perinatal /Congenital Syphilis and how to educate, treat and refer these patients. Especially participating in follow up of infant referrals for those infants who have been exposed to an STD/HIV or have been diagnosed with an STD/HIV. The HMHB Certified Nurse Midwife provides clinical consultation related to maternity and infant health to HMHB staff, she serves as a liaison between providers and HMHB, creates health education, leads Midwife Mondays – clinical updates and training to HMHB staff. HM/HB staff as well as other MSDH staff participated in a training hosted by HM/HB on the topic of Understanding and Coping with Complications with Infants (November 3, 2024). Approximately 60 staff participated in that training. HM/HB program director and epidemiologists participated in CDC/Harvard Practicum in January 2023 and Summer 2023 which educated and provided assistance with program of developing an evaluation plan, smart goals, implementation of work plan and identifying outcomes. January 2023 a cohort of HM/HB staff joined other MCH staff to participate in an Infant Mental Health Training Collaborative which will lead to HM/HB staff being trained and certified as Infant Mental Health Family Specialists.

The MIHB partnered with Amerigroup Mississippi (Ridgeland, MS) to implement a Safe Sleep Mississippi program. The program focused on reestablishing safe sleep outreach and community engagement efforts, conducting, and developing online trainings to educate the community, and providing continuing education for certified childcare center staff.

The MIHB also helped to sponsor the Black Maternal Health Conference hosted by Mom.me on April 13-14, 2023. This event provided educational sessions on topics such as midwifery, postpartum doulas, male inclusivity, and the state of maternal healthcare in Mississippi. During the conference, the film “Birthing Justice” was screened. “Birthing Justice” is a film/documentary that sheds the light on birthing among Black women. Also, during the conference, two of MSDH’s Obstetric Consultants (Dr. Michelle Owens & Dr. Jaleen Sims) received awards for their work in maternal health in Mississippi. Attendees consisted of various sectors of state government, community organizations, local vendors, and healthcare professionals.

Additionally, the MIHB partnered with subgrantee, Therapy Plus, to offer the Empower Symposium that was held on March 17, 2023. Plenary sessions/topics included Evaluating Racial Disparities in Maternal Health, Perinatal Mood and Anxiety Disorders, and the Importance of Self-Care. The major focus of this conference was to bring promotion to maternal health in the context of healthier families leading to healthier communities. Continuing education credits were provided to social workers. In addition to social workers, healthcare professionals, governmental representatives, and community leaders were also in attendance.

Strategy: *Conduct multidisciplinary case review meetings to understand the drivers of fetal and infant deaths in Mississippi*

Completed Activities:
During the reporting period, there were 20 Case Review Team and Community Action Team meetings in the Coastal Region FIMR program. During this period, the teams identified several drivers of fetal and infant deaths which included, but not limited to, maternal depression, health illiteracy, STDs, polysubstance abuse, and infant safe sleep. Additionally, for a brief time during the reporting period, maternal interviews were added to the

Coastal Region FIMR's case review process. However, this activity was not able to be continued when the contractor who provided the interviews unexpectedly resigned. Future inclusion of maternal interviews is being explored.

Informed partly by the work of the FIMR, the annual Infant Mortality and Child Death Review reports were produced through the MIHB and can be found at:

- Infant Mortality: https://msdh.ms.gov/page/resources/20111.pdf
- Child Death Review: https://msdh.ms.gov/page/resources/20053.pdf

In addition, the MIHB formed the Mississippi SIDS and SUID Prevention Task Force to address the number of SIDS/SUID deaths in the state. The Task Force made recommendations regarding statewide actions that should be taken to eliminate, or at least decrease, the number of SIDS/SUID deaths in the state.

Strategy: *Conduct multidisciplinary case review meetings to understand the drivers of child deaths in Mississippi*

Completed Activities:
During the project period, the Child Death Review Panel (CDRP) convened six times. During these meetings, the CDRP reviewed 88 of the 553 Mississippi infant and child deaths that occurred in 2019 and identified several drivers of child deaths in Mississippi.

The CDRP noted the following:

- Of the 553 child deaths in 2019, 222 (40.1%) were due to external or undetermined causes, such as injuries or violence related to accidents, homicides, suicides, and other causes. The majority were sudden unexpected infant deaths (72 cases, 32.4% of external causes) and motor vehicle/other transport accidents (50 cases, 22.5% of external causes).
- Firearm related deaths have been trending upwards since 2010 with 36 deaths in 2019, of which 77.8% of deaths occurred in ages 14-17 and 83.3% occurred in males.
- Homicide related deaths have increased since 2010 with 27 homicide child deaths in 2019, of which 81.5% occurred in Black, non-Hispanic children.
- Fire and drowning deaths have increased since 2010 with 21 cases in 2019.
- Suicides have increased from 1.1 per 100,000 children in 2010 to 2.7 in 2019.

Recommendations for preventing infant deaths included, but were not limited to infant safe sleep, gun safety, bike/motor vehicle safety for kids, and providing car seat technician contacts to parents/caregivers.

Strategy: *Support and assist the Mississippi FIMR Panel and CDR Panel in case review and developing and disseminating reports and recommendations for the legislature, state health department, community leaders, and families*

Completed Activities:
In March 2023, the CDRP submitted its annual Child Death Review report to the Mississippi State Legislature. The report included data and recommendations of child deaths that occurred in calendar year 2019.

The annual Child Death Review report was produced through the MIHB and was posted on the MSDH website to ensure it was accessible to the public, including families and community members can be found at:

- Child Death Review: https://msdh.ms.gov/page/resources/20053.pdf

Strategy: *Increase public awareness of preventable infant deaths due to suffocation or a sleep-related death*

Completed Activities:

Several MCH Programs provide education and resources to communities to promote awareness about preventable infant deaths due to suffocation or a sleep-related death including HM/HB, MIHB, and LPPHHP.

The HM/HB staff actively participated in community outreach events to promote safe sleep and to educate the public about the danger of SIDS and SUIDS. HM/HB provided health education and access to cribs (pack n plays) to enrolled families and demonstrated how to properly utilize a crib. During the project period, the HM/HB Central Office team participated in over 15 Community outreach events; in addition, the HM/HB field staff attended many more events to promote the program incorporating infant health and safe sleep education.

The MIHB collaborated with Amerigroup MS and other community organizations to promote safe sleep and other practical tips for families to ensure infants are placed to sleep safely at each sleeping time. In addition, the MIHB partnered with the Mississippi SIDS Alliance to promote and incorporate safe sleep practices across communities in Mississippi through community events, webinars, and meetings.

Both the MIHB and LPPHHPP distribute safe sleep resources for local communities.

- The MIHB distributed safe sleep materials and resources to community and health systems. Resources included pack-n-play cribs, sleep sacks, and safe sleep educational resources and tools. Twenty-one (21) cribs were distributed through MIHB to individuals during the reporting period.
- During the reporting period, the LPPHHP distributed a total of 13,650 safe sleep educational material packets to birthing hospitals statewide for distribution to new parents.

Perinatal/Infant Health
Application Year - FY2025

The following section outlines strategies and activities to be implemented between 10/1/2024-9/30/2025 to meet the objectives and show improvement on the measures related to perinatal and infant health:

PRIORITY: Increase Breastfeeding, Healthy Nutrition, and Healthy Weight

NPMs, NOMs, SPM, and ESMs:

- BF/NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
- IM/NOM 9.1: Infant mortality rate per 1,000 live births
- IM-Postneonatal/NOM 9.3: Post neonatal mortality rate per 1,000 live births
- IM-SUID/NOM 9.5: Sudden Unexpected Infant Death rate per 100,000 live births
- SPM 12: Percent of women who are enrolled in WIC and initiate breastfeeding.
- BF.1/ESM 4.1: Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals

Objectives:

- By September 30th, 2025, increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support.
- By September 30th, 2025, increase enrollment and participation in the WIC Program by 5% via partnerships and evidence-based initiatives.

Strategy: *Increase breastfeeding initiation and duration rates through prenatal breastfeeding education, during delivery admission, and post discharge support*.

Activities:

- Provide breastfeeding education and support to prenatal WIC participants and pregnant mothers enrolled in home visiting programs.
- Support hospitals in achieving Baby Friendly designation.
- Provide training and continuing education credits to lactation professionals

Strategy: *Assist in the creation and maintenance of MILC Leagues across the state of Mississippi*.

Activities:

- Maintain and create additional community partnerships as referral sources to the MSDH WIC Program.
- Provide WIC participants access to certified lactation consultants.
- Increase the number of International Board-Certified Lactation Consultants (IBCLCs) in the state

Strategy: *Partner with other MCH-serving program on community innovation project activities.*

Activities:

- Maintain and create additional community partnerships as referral sources between the MSDH Health Services programs.

- Educate community partners on approaches to recruiting new WIC enrollees and encouraging ongoing uptake of WIC services among enrolled population.

PRIORITY: Improve Access to Family-Centered Care

NPMs, NOMs, SPM, and ESMs:

- SPM 17: Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year

Objectives:

- By September 30, 2025, increase the number of infants participating in a case management/home visiting program by 30% (from 533 to 693).
- By September 30, 2025, increase the number of outside MSDH referrals for the case management/home visiting program by 20% (from 1,867 to 2,240).
- By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to perinatal/infant health via media, social media, and other public-facing platforms.

Strategy: *MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving perinatal/infant health*.

Activities:

- Extend existing or select by competitive RFP, subgrantees, including health systems or community-based partners, to execute specific activities for recruitment, referral, enrollment, direct services, and participant navigation to address SDOHs of MCH program participants that improve perinatal/infant health
- Engage with other MCH-serving programs to share lessons learned to advance program knowledge. Activities may include hosting or participating in local/regional meetings calls, participating in peer-to-peer calls, presentations delivered by webinar, mentoring other programs, technical assistance, etc.
- Develop and maintain local resource/referral directories with internal and external partners to collaborate on improving health for infants enrolled in home visiting programs and their families

Strategy: *Home visiting/case management programs will develop and improve relationships with internal and external partners to increase referrals to the program*.

Activities:

- Identify 3-4 potential healthcare settings, community-based, faith-based, social, volunteer service organizations, homeless/domestic violence shelters, residential programs, treatment programs, housing complexes, etc. to outreach per quarter. Request opportunities to share information with “gatekeepers” of (i.e., community health workers, patient navigators, care coordinators, case managers, faith leaders, non-profit social service workers, helpers, etc.) or to the target population
- Optimize MSDH electronic health record (Epic) and other platforms to create referral management processes and templates for use by external and internal referral sources to home visiting/case management programs

Strategy: *MCH programs will collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of perinatal/infant health issues*.

Activities:

- Submit work requests to the Office of Communications to promote CDC/HRSA/other approved messaging

related to perinatal/infant health issues etc. Prepare social media post schedules and templates for observance months/days
- Maximize available funding and in-kind support to develop or enhance direct health education approaches for consumers of MCH-serving programs focused on improving perinatal/infant health issues

PRIORITY: <u>Reduce Infant Mortality</u>

NPMs, NOMs, SPM, and ESMs:
- SS/NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep
- IM/NOM 9.1 - Infant mortality rate per 1,000 live births
- IM-Postneonatal/NOM 9.3 - Post neonatal mortality rate per 1,000 live births
- IM-SUID/NOM 9.5 - Sudden Unexpected Infant Death rate per 100,000 live births
- ESM SS.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals

Objectives:
- By September 30, 2025, produce the annual Child Death Review Report to include recommendations for preventing infant deaths.
- By September 30, 2025, participate in at least 18 community outreach events to address infant mortality disparities and promote Child Death Review and FIMR Committee recommendations.
- By September 30, 2025, expand the FIMR program to all 9 public health districts of Mississippi.
- By September 30, 2025, add informant interviewing of family members/next-of-kin to the Child Death Review and FIMR case exploration processes.

Strategy: *Provide the administrative support for the death case abstraction, exploration, and determination process to fidelity for all maternal deaths through the Child Death Review Panel and FIMR*.

Activity:
- Engage with other Child Death Review Panel, FIMRs, workgroups, and taskforces, to share lessons learned to advance program knowledge. Activities may include hosting or participating in local/regional meetings calls, participating in peer-to-peer calls, presentations delivered by webinar, mentoring other programs, technical assistance, etc.

Strategy: *MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving infant mortality based on CDR and FIMR recommendations*.

Activities:
- Extend existing or select by competitive RFP, subgrantees, including health systems or community-based partners, to execute specific activities for providing health promotion, health education, and health equity-focused activities that improve infant health
- Partner with other stakeholders to promote/expand offerings of safe sleep/infant safety training (i.e., car seat/travel safety) and material resources (i.e., cribs, sleep sacks, car seats) to professionals and

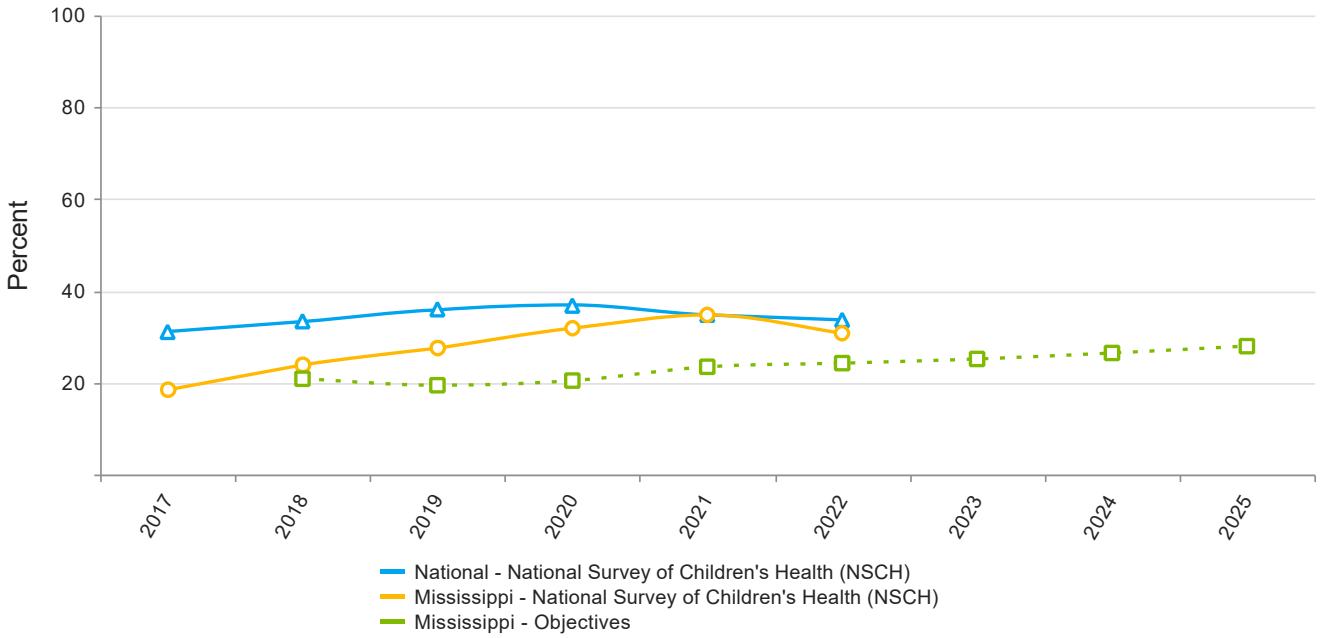
individuals/families

- Expand a statewide stillbirth awareness campaign (i.e., Count the Kicks ™)
- Continue partnership with National SIDS Alliance and Cribs for Kids ™ to establish centralized resource for Mississippi families in need of cribs/safe sleep environments

Child Health

National Performance Measures

NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	19.5	20.5	23.5	24.3	25.2
Annual Indicator	23.7	28.0	31.5	34.1	30.9
Numerator	16,993	19,663	25,115	28,605	25,435
Denominator	71,794	70,109	79,686	83,842	82,348
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	26.5	28.0

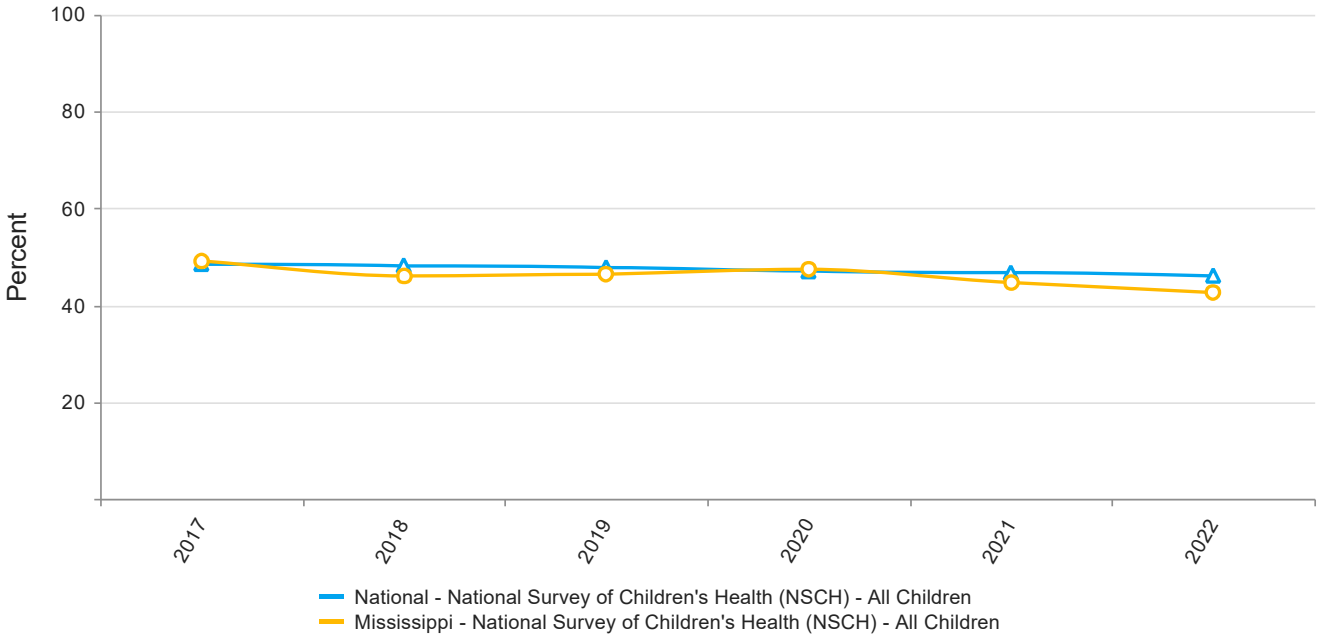
Evidence-Based or –Informed Strategy Measures

ESM DS.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			20
Annual Indicator	0	1,162	2,928
Numerator			
Denominator			
Data Source	Early Intervention Child Find Log	Early Intervention Child Find Log	Early Intervention Child Find Log
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	30.0	40.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	42.7
Numerator	293,703
Denominator	687,740
Data Source	NSCH-All Children
Data Source Year	2021_2022

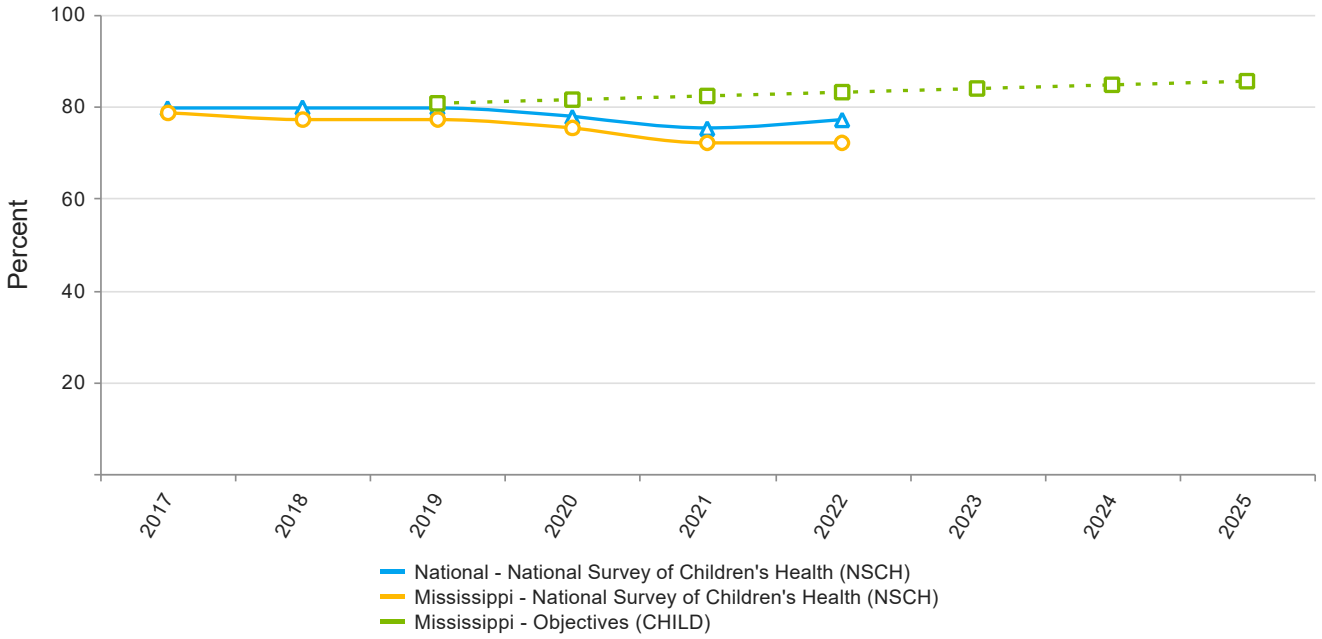
Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	48	50	52	54	56
Annual Indicator	100	100	0	30	51
Numerator					
Denominator					
Data Source	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	58.0	60.0

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child
Indicators and Annual Objectives



NPM PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	80.6	81.4	82.2	83	83.8
Annual Indicator	77.8	77.1	75.0	72.0	72.1
Numerator	525,080	500,754	484,100	468,061	474,563
Denominator	675,079	649,719	645,270	650,503	658,109
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	84.6	85.4

Evidence-Based or –Informed Strategy Measures

ESM PDV-Child.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	1,000	2,000	3,000	4,000	100
Annual Indicator	0	903	0	29	38
Numerator					
Denominator					
Data Source	Office of Oral Health	Office of Oral Health	Office of Oral Health	EPIC	EPIC
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	150.0	200.0

ESM PDV-Child.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	1,000	2,000	3,000	4,000	450
Annual Indicator	0	976	424	20	3
Numerator					
Denominator					
Data Source	EPIC	EPIC	EPIC	EPIC	EPIC
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	500.0	550.0

ESM PDV-Child.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	60	65	70	75	20
Annual Indicator	10	2	8	14	6
Numerator					
Denominator					
Data Source	Office of Oral Health	Office of Oral Health	Office of Oral Health	MSDH Office of Oral Health REDCAP	MSDH Office of Oral Health REDCAP
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	25.0	30.0

State Performance Measures

SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age

Measure Status:	Active

State Provided Data				
	2020	2021	2022	2023
Annual Objective			3.9	4
Annual Indicator		3.8	5	11.7
Numerator		5,554	7,297	16,977
Denominator		144,844	146,681	145,661
Data Source		Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program
Data Source Year		2021	2022	2023
Provisional or Final ?		Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	4.1	4.2

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			11.2
Annual Indicator	11.7	7.1	18.4
Numerator	5,221	2,995	7,342
Denominator	44,528	42,144	39,888
Data Source	WIC Spirit database	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	10.7	10.2

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			67
Annual Indicator	46.9	40.4	40.8
Numerator	30	23	20
Denominator	64	57	49
Data Source	EPIC	EPIC	EPIC
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	77.0	87.0

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			341
Annual Indicator	310	272	291
Numerator			
Denominator			
Data Source	EPSDT Visits in EPIC	EPSDT Visits in EPIC	EPSDT Visits in EPIC
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	375.0	413.0

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			100
Annual Indicator	100	93.2	90
Numerator	60	2,722	72
Denominator	60	2,922	80
Data Source	Newborn Screening data	MS Newborn screening database and EPIC database	EPIC database
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	100.0	100.0

SPM 21 - Percent of children with and without special healthcare needs who have a medical home

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			46.5
Annual Indicator	46.2	43.2	40.8
Numerator	72,719	68,226	64,583
Denominator	157,506	157,885	158,168
Data Source	National Survey of Childrens Health	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	46.7	47.0

State Action Plan Table

State Action Plan Table (Mississippi) - Child Health - Entry 1
Priority Need
Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings
NPM
NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS
Five-Year Objectives
By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss
By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually
Objective: By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation
Objective: By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results
By September 30, 2025, increase screening rates in low-resource areas of the state
By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs
By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings
Strategies
Develop a comprehensive, coordinated and integrated system of services for children
Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification
Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification
Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening
Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners
Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues
Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

ESMs	Status
ESM DS.1 - The number of participants who received training about Bright Futures Guidelines for Infants, Children, and Adolescents.	Inactive
ESM DS.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring	Active

NOMs
NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

Priority Need

Improve Access to Family-Centered Care

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

By September 30, 2025, increase the percentage of children enrolled into family-centered services in a medical home

By September 30, 2025, increase the percentage of the children who demonstrate improvements in their growth, health, and development through participation in MCH child health programs providing early intervening services (i.e., service/care coordination and/or home visiting programs) by 5%

By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5%

By September 30, 2025, increase the number of families of children who have access to peer-to-peer support and role models by 5%

Strategies

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners of MCH child health programs to improve timely referrals for early intervening services

Implement interventions with families to promote the adoption of home- and community-based strategies to promote the health and development of their children (e.g., safe sleep, healthy homes, nutrition, and physical activity)

Implement evidence-based approaches using family-centered practices to improve health and developmental outcomes for young children, including school readiness

Provide professional development opportunities for healthcare professionals to learn about family-centered care practices and medical homes

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionists, and specialists to implement family-centered care practices

Increase knowledge and awareness among families on family-centered care practices

ESMs	Status
ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care	Active

NOMs

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

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

Priority Need

Improve Oral Health

NPM

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Five-Year Objectives

By September 30, 2025, increase the percent of children with a preventive dental visit by 1% annually.

Strategies

Promote the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals and nondental providers

Support trainings of medical providers, including doctors, nurse practitioners, and physician assistants, on oral health assessments and use of fluoride varnish in the primary care setting

Work with internal and external partners to identify barriers and solutions to access and utilization of preventive dental services

ESMs	Status
ESM PDV-Child.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist	Active
ESM PDV-Child.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses	Active
ESM PDV-Child.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting	Active

NOMs

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

State Action Plan Table (Mississippi) - Child Health - Entry 4

Priority Need

Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

SPM

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Five-Year Objectives

By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

By September 30, 2025, increase screening rates in low-resource areas of the state

By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings.

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

State Action Plan Table (Mississippi) - Child Health - Entry 5

Priority Need

Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

SPM

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Five-Year Objectives

By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

By September 30, 2025, increase screening rates in low-resource areas of the state

By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

State Action Plan Table (Mississippi) - Child Health - Entry 6

Priority Need

Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

SPM

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Five-Year Objectives

By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

By September 30, 2025, increase screening rates in low-resource areas of the state

By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

State Action Plan Table (Mississippi) - Child Health - Entry 7

Priority Need

Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

SPM

SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age

Five-Year Objectives

By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

By September 30, 2025, increase screening rates in low-resource areas of the state

By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

State Action Plan Table (Mississippi) - Child Health - Entry 8

Priority Need

Improve Access to Family-Centered Care

SPM

SPM 21 - Percent of children with and without special healthcare needs who have a medical home

Five-Year Objectives

By September 30, 2025, increase the percentage of children enrolled into family-centered services in a medical home

By September 30, 2025, increase the percentage of the children who demonstrate improvements in their growth, health, and development through participation in MCH child health programs providing early intervening services (i.e., service/care coordination and/or home visiting programs) by 5%

By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5%

By September 30, 2025, increase the number of families of children who have access to peer-to-peer support and role models by 5%

Strategies

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners of MCH child health programs to improve timely referrals for early intervening services

Implement interventions with families to promote the adoption of home- and community-based strategies to promote the health and development of their children (e.g., safe sleep, healthy homes, nutrition, and physical activity)

Implement evidence-based approaches using family-centered practices to improve health and developmental outcomes for young children, including school readiness

Provide professional development opportunities for healthcare professionals to learn about family-centered care practices and medical homes

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionists, and specialists to implement family-centered care practices

Increase knowledge and awareness among families on family-centered care practices

State Action Plan Table (Mississippi) - Child Health - Entry 9

Priority Need

Increase Breastfeeding, Healthy Nutrition and Healthy Weight

SPM

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Five-Year Objectives

By September 30, 2025, decrease the percentage of children, ages 2-5 years, who receive WIC services and have a BMI at or above the 85th percentile

Strategies

Increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support to reduce childhood obesity

Implement evidence-based practices to decrease obesity in early childhood

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Activities in this domain were carried out by the following MSDH offices, bureaus, or programs during the reporting period:

- Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
- Mississippi First Steps Early Intervention Program (MSFSEIP)
- Lead Poisoning Prevention and Healthy Homes Program (LPPHHP)
- Genetics Services Bureau – Newborn Screening Program (NBS) and Mississippi Early Hearing Detection and Intervention Program (EHDI-MS)
- Office of Oral Health

The following section outlines strategies and activities implemented between 10/1/2022-9/30/2023 to meet the objectives and show improvement on the measures related to child health:

PRIORITY: Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

NPMs, NOMs, SPM, and ESMs:

- NPM 6: Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year
- SPM 3: Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age
- SPM 13: Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age
- SPM 14: Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit
- SPM 15: Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely
- NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
- NOM 19: Percent of children, ages 0-17, in excellent or very good health
- ESM 6.2: Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

Objective:

- By September 30, 2023, increase the knowledge of health professionals on collecting and submitting newborn screening for genetic/metabolic, critical congenital heart disease (CCHD), and hearing
- By September 30, 2025, increase the number of children receiving developmental screenings by 3% annually
- By September 30, 2025, increase screening rates in low-resource areas of the state
- By September 30, 2025, implement early childhood hearing screening program for children between 6-36 months of age to increase identification of children with late onset hearing loss
- By September 30, 2023, increase the number of infants with confirmed hearing loss who received confirmation of hearing status by 3 months to 67%
- By September 30, 2023, reduce the loss to follow-up and loss to documentation in screening programs
- By September 30, 2023, decrease the number of children less than six years of age identified with lead poisoning by 5%

- By September 30, 2025, increase the percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age by 0.5%

Strategy: *Develop a comprehensive, coordinated, and integrated system of services for children*

Completed Activities:
The CYSCHN Program implemented the use of universal referral form identifying all Health Service programs available to infant, children and adolescents with special health care needs to provide families and health care providers with a one-step opportunity to identify and/or connect them to the service that can best support their needs. The form can be submitted in varying ways, e.g. electronically, fax, hand mail and in-person. Submission can also be made over the phone. Once program is identified the care coordinator can began assisting/connecting families to needed supports.

The CAH Director served on the MDE Special Education Advisory Panel, the federally required advisory group for the provision of services according to the Individuals with Disabilities Education Act (IDEA). The SEAP addressed topics related to:
- Discipline: students being sent home but not counted as suspended
- Playground and campus accessibility in schools
- Regression during the pandemic and possible compensatory services
- Training for IDEA Hearing Officers

Using guidance developed by the National EHDI Outcomes Committee, the EHDI-MS and MSFSEIP implemented a data sharing agreement and process to track outcomes for infants identified as having confirmed hearing loss by EHDI and referred to the MSFSEIP. This agreement provides not only for the sharing of the IFSP date but also for type of intervention services received, specific providers, and language outcomes, with parental consent.

The MCH/Title V Child and Adolescent Health programs has worked extensively the University of Connecticut, Early Childhood Personnel Center (ECPC) to engage systems-building in Mississippi to serve infants, toddlers and children birth to eight years with and without disabilities and their families to ensure they have the resources and supports needed to aid their growth and development. The CAH Director and CYSHCN Director led a multiagency team in partnerships with the Mississippi Department of Education (MDE), Division of Medicaid, Institutions of Higher Learning, Head Start, Department of Human Services, and family leaders to revamp the state's Comprehensive System of Personnel Development (CSPD) for professionals serving these MCH populations. The CSPD Leadership team served on work groups to development of multiprong plan for personnel preparation both preservice and inservice, recruitment and retention, and evaluation. The goal of the plan was to collaborate and pool resources to support professionals who serve MCH populations so they were prepared to identify and support children with disabilities and developmental delays and families to mitigate the impact of the child's disability and/or resolve their delays. Due to these efforts, state leaders advocated for and secured funding for a CSPD Coordinator to be housed within the MDE to focus on implementation of the plan and continue to lead collaborative efforts with all state agencies serving children birth to eight years with and without disabilities and their families. This position was filled after the reporting period. Additional details will be shared in the FY24 report.

Part of the continued efforts of improving on our comprehensive system of supports, MCH/CAH staff (CYSHCN Director) has most recently participated in the ECPC leadership academy that connects early childhood systems of other states in the development of improved referrals and leveraging of financial partners to improve and

integrate care. As a result, it solidified the MCH programs commitment to a universal referral form to ensure that those seeking support get to the MCH program that best meets their need.

Children's Trust Funds play a leadership role with other organizations in the community when seeking to prevent child abuse and neglect before it occurs. Children's Trust Funds have demonstrated the capacity to serve as leaders of coalitions and collaborative efforts focused on prevention. Additional strengths include supporting and promoting innovative strategies to strengthen families and prevent abuse. Children's Trust Funds are well respected in the professional community for their leadership and commitment to prevention. It consists of a 13-member board including four state agencies: MSDH, MDE, DMH, and DHS. The MCH Engagement and Coordination Office Director is the MSDH representative on the Mississippi Children's Trust Fund Advisory Board.

Staff across Health Services participated in monthly American Cancer Society Mississippi Chapter HPV Roundtable meetings to receive/provide relevant updates. The work of the HPV Roundtable has gained national attention from NIH, NCI, and CDC for its work in supporting the larger STRIDES study, a partnership with the National Cancer Institute, University of Mississippi Medical Center, and Mississippi State Department of Health to evaluate risk and look for new biomarkers in women undergoing screening for cervical cancer.

Strategy: *Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for newborn screening (genetic/metabolic, CCHD, and hearing), lead screening, and developmental screening*

Completed Activities:
During the reporting period, the program through a partnership with the MSDH Pharmacy Program and the resident interns, contacted 81 provider clinics across the state to schedule one-on-one education regarding lead poisoning screening, testing, reporting and follow-up. Outreach with each provider was attempted 3 times each. Through this, 23 provider visits were scheduled with 20 visits completed (10 in-person, 5 virtually, 5 telephone). Three of the scheduled visits were no-shows.

October 19th-21st, 2022, Perkin Elmer and UMMC provided 3 virtual Newborn Screening (NBS) educational trainings for birthing hospitals and district health departments. Education was added to Health Streams for review. In addition, an evaluation tool was developed to assess learning and to receive recommendations. As a result of the evaluation recommendations, the October training agenda was adjusted to increase training from one hour to two hours to allow participants more time to ask questions and provided feedback. Certificates of completion were sent to all attendees.

In June 2023, the Office of Child & Adolescent Health and the Genetics Bureau partnered with St. Jude Research Hospital to host Sickle Cell and Trait Counseling training in each region of the state. This training reviewed characteristics of the disease and trait, evidence-based treatment and care, counseling education, training, family planning and family centered strategies. More than 100 participants consisting of health professionals, social workers, nurse case managers, parents of children with Sickle Cell, and community volunteers were in attendance.

In July 2023, the Genetics Bureau Director and MCH ECO partnered to develop a Standard Operating Procedures and train Care Coordinators and MS Social workers to support Mississippi Newborn Screening follow-up and provide education for sickle cell trait counseling for families of SCD patients and SCT carriers.

In addition, the Genetics Bureau met with the MSDH LMS management director to discuss current newborn

screening training and additions for future educational training materials resulting in updates to the “Newborn Screening Quality Assurance and Improvement” training. The purpose of the training is for users to:

- Understand the importance of timely screening/ specimen collection and reporting in relation to early identification and treatment of disease.
- Differentiate between acceptable and unacceptable specimen collection and reasons for unacceptability of the Dried Blood Spot card.
- Provide important points to remember about Newborn Screening.

These training modules are provided free of charge for hospital personnel who conduct NBS across the state.

To further extend virtual learning options, the training provided via St. Jude Children’s Research Hospital was incorporated into two education modules included in the MSDH LMS on Sickle Cell and Hemoglobin Disease and Sickle Cell Trait and Counseling and Management Practices. Thes modules provide educational support for genetic counselors, genetics nurses, hospitals, social workers, and other related practitioners in obtaining skills and providing education to families on the disease and holistic family centered counseling.

The EHDI-MS Program provides outreach and training to hospitals and diagnostic clinics to ensure timely reporting of hearing screenings and diagnostic reports.
We originally scheduled an EHDI-MS Conference for the spring of 2023, but it had to be postponed because it interfered with other spring conferences. Consequently, we rescheduled the EHDI-MS Conference for October 2023.

The EHDI-MS Program provides professional development opportunities through the yearly EHDI-MS Conference and virtual professional development with The CARE Project. We collaborated with The CARE Project to organize a virtual professional development opportunity titled "Empathy: Insights and Strategies" in August through September 2023 but scheduled for January 2024.

Strategy: *Improve newborn bloodspot, CCHD, and hearing screening and reporting, including specimen collection procedures among hospital nurseries and laboratory staff*

Completed Activities:
The Genetics/NBS Bureau collaborated with Revvity Omics to plan future training, including a comprehensive course titled, Newborn Screening A-Z. The goal is to develop professional videos and educational materials on the newborn screening process, reviewing the importance of newborn screening, early detection, and early diagnosis to provide better health outcomes and prevent permanent damage and death through early intervention and specialized treatment. The training module was submitted for review for inclusion in the LMS:

- MSDH Newborn Screening A-Z
  - Blood Spot Check
  - NBS Handling Procedures
  - NBS Today
  - Revvity Omics IT Support Solutions
  - Specimen Rejection
  - UPS Lab Pickup Point
  - UPS Ship Exec. Cloud User.

Upon completion of the course the learner will be able to:

- Relate to and identify genetic conditions that may affect a child’s long-term health outcome.
- Gain an overview of the complete newborn screening process.
- Review and expand on specific genetic conditions.

- Use educational tools to implement and refer to when completing newborn screening(s).

The planning process for this series began August 2023 with a go-live date after this project period. Detailed updates will be provided in the FY24 report.

The Genetics/NBS Bureau met monthly with PerkinElmer/Revvity to develop trainings that were conducted for hospital and health department staff in October 2022. These three newborn bloodspot collection trainings were held in Fall 2022 for health department staff to provide examples of proper specimen collection and timely transit to increase timely diagnosis reporting and treatment. Evaluations recommended edits to ensure virtual participants could have a more interactive process during these trainings.

In addition to these trainings:

- Bloodspot collection training was provided by UMMC and Perkin Elmer and uploaded into the MSDH LMS for future use on-demand.
- New Nurse orientation was provided by the Regional Nurse Case Coordinator.
- NBS education updates, and bloodspot collection review was/is available anytime and quarterly for low performing hospitals by regional Nurse Coordinators.

A bi-annual (September 2022, April 2023) Genetics Advisory Committee meeting made of Genetic Physicians, Genetic Counselors, Genetics Lab, Parent(s) of children with genetic conditions, MSHA, and meeting is open to the public and health network to provide genetic condition education, MS birth conditions screening status, and genetic adoption updates, recommendations, and cost analysis. Bi-annual meeting will continue.

Due to COVID restrictions, low performing hospitals were visited virtually, to provide NBS screening training, as well as a comprehensive improvement plan. Contact with birthing hospitals are scheduled quarterly for hospitals that need improvement in one of the following areas:

- Unacceptable Specimens
- Missing information
- Screening conducted < 24 hours after birth (unacceptable)
- Collection to receipt timelines
- Birth to collection timelines.

Revvity Omics website data was used to assess improvement or assistance needs for each hospital to prepare for targeted outreach. During hospital visits for low hospital performance the following forms are used during the visit: Hospital Quarterly Visit Checklist, Genetics Quarterly Hospital Reporting Form (GQHR), Corrective Action Plan Template, MSDH Sign-in Sheet, MSDH Agenda, Sample of Completed Hospital Visit Information. Education and expectations were provided during the visit and follow-up visits were scheduled as required to ensure performance improved.

In Summer 2023, EHDI and NBS partnered to review screening expectations and answer questions and concerns for NBS and Point-of-Care services.

The Genetics/NBS Bureau actively monitoring to identify bottle necks that prevent timely screening of newborns within 24-48 hours. Daily, NBS data is analyzed to ensure that all screened newborns receive timely screening and timely follow-up. These data are closely audited, disaggregated, and disseminated in efforts to promote quality improvement, to identify missing data, to observe for bottleneck(s) that prevent timely screening, and to clean data for providing accurate and valid real-time status of newborn screening data.

In March 2023, the Genetics/NBS Bureau worked with EPI/EPIC there on data conversion issues with ICD9 and ICD10 conversions of hemoglobin. We continue to work with EPI/EPIC and Perkin Elmer Labs to identify areas of strengths to build on and weaker areas to strengthen data reliability.

Strategy: *Increase timely screening and referral to tertiary centers for newborns and infants diagnosed with a genetic or metabolic condition*

Completed Activities:
The Genetics/NBS Bureau received an internal audit of NBS screenings, follow-ups, and referrals for over 2000 cases for purpose of quality improvement and quality assurance. The Genetics/NBS Bureau created, analyzed, and compared quarterly hospital performance, visiting hospitals virtually with low performance to discuss and develop corrective action plan and improvements.

Reports were extracted from EPIC for infants receiving NBS screenings prior to the 24 hour or after 48 hour recommended timeframe. Hospitals in question were contacted virtually to review protocols and expectations to ensure babies are screened timely. During the meeting, hospitals provided feedback regarding barriers that caused early or late screening reporting due to staff turnover, staff duties increase, staff shortages due to COVID reassignments, and new staff training needs. In addition, the hospital report card is updated to include a ranking report for newborn screening, critical congenital heart defect, and early hearing screenings performance and posted online.

The Genetics/NBS Bureau monitored and identified bottle necks that prevented timely transit of specimens to laboratory within 1 day after collection. Reports were pulled from the database and reviewed to advise several hospitals that did not meet the 1-day transit timeline to laboratory. The hospitals were alerted, and a virtual meeting ensued. Per hospital, the specimens were lost in transit. As a result, infants were rescreened; however, received a delayed diagnosis report.

The Genetics/NBS Bureau monitored and identified bottle necks that also prevented timely screening to report time with 7 days. Reports from the database reveal hospital met the metric timeline.

As a result of these reviews, the Genetics/NBS Bureau developed a Quality Improvement program using the PSDA Cycle and framework to manage and monitor all aspects of the Newborn Screening Program. Develop weekly, monthly, and quarterly status reports. Continued QI surveillance is conducted to review screening timeliness and referrals to tertiary centers. Currently weekly reports are provided to monitor program activities and progress, and provide report indicators on active case episodes, regional caseloads, and resolved cases.

During the project period, the Genetics/NBS Bureau worked with EPI/EPIC to create reports that allow for better monitoring. In September 2023, a report was developed on newborn screening caseloads by county and region, along with a detailed status report for follow-up actions. This allowed the department director to monitor timeliness of case closures, as well as identify variables preventing timely case closures. The report was reviewed weekly.

In addition, a status report was developed that outlines whether the program is operating at maximum aptitude and meeting outlined goals and objectives of the program. Weekly NBS staff meets to discuss, and report duties completed. In addition, EPIC provides a real-time review of active episodes. A summary report is provided to the Deputy Director regarding staff and department operations.

As a result, the program determined additional staff were needed and four additional Nurse Case Manager

(NCM) PINS were requested to hire nurses in Districts 2,4,6, and 8. A position was also placed to fill NBS/Birth Defects Registry position. Unfortunately, in July 2023, the Genetics/NBS Bureau lost the Epidemiologist who had supported the program by preparing the Annual NBS report and National Birth Defects reports, which were unfinished at the time.

Strategy: *Develop and implement plans to increase coordination and integration with early childhood programs to improve timely identification*

Completed Activities:
The CYSCHN Program partnered with the MS Parent Training Institute and MS Families for Kids to provide training to Parents, LEAs and childcare providers and healthcare professionals on the importance of referring children to the CYSHCN program and providing developmental screenings at health fairs to identify children who may be eligible for programs that support children with special healthcare needs.

The MSFSEIP Service Coordinators conduct monthly child find activities to childcare and Head Start facilities by providing developmental screenings and providing educational materials.

The EHDI Program developed plans led by the EHDI Advisory Committee Systems Building Work Group to extend screening between 6-36 months of age in partnership with Early Intervention, Early Care and Education Centers, EPSDT Providers, and Primary Care Providers. During the project period, the EHDI program partnered with the EI Program to purchase screening devices and provided training to Service Coordinators. The hearing screening was implemented after the project period; details will be provided in the FY24 report.

Strategy: *Expand infrastructure to conduct hearing screenings of children up to 36 months of age to identify late onset hearing loss, and to promote project sustainability*

Completed Activities:
EHDI-MS continued to work on expanding infrastructure to screen children up to 36 months for late-onset hearing loss and to ensure the project's sustainability. Because of the need for training in hospitals and diagnostic clinics, EHDI-MS could not implement the expanded screening plan during this time frame. EHDI-MS has arranged contracts with two Audiologists to train staff in selected Mississippi Head Start programs for CORTI OAE Screenings to identify children with late onset hearing loss. Early Intervention conducts CORTI OAE screenings during evaluations for all infants and toddlers without confirmed hearing loss. Lastly, it has been recommended that EPSDT start using CORTI OAEs as the hearing screening for babies from birth to three years old in the Mississippi State Department of Health clinics. We will continue to work toward meeting this goal

Strategy: *Work with Medicaid to identify rate of screenings and identify low-resource areas with gaps to be addressed through collectively through program improvement or development*

Completed Activities:
Through a partnership and MOU with the MS Division of Medicaid, the program receives quarterly data detailing the number of children enrolled in Medicaid and the number of children who received a lead test. Using this data for 2022, the program was able to develop draft provider report cards at the state and county level that detail the following: percentage of children 72 months or younger in each public health district enrolled in Medicaid, the percentage of children 72 months or younger in each county who received a blood lead level screening that was reported back to the health department, and the percentage of homes in each county that were built prior to 1978.

Strategy: *Increase knowledge and awareness among the public, public health professionals, childhood lead prevention workforce members, and other partners about childhood lead poisoning, new threshold blood lead levels, prevention, and intervention through tailored education and outreach*

Completed Activities:
HM/HB and the Lead and Healthy Homes program have partnered to educate HM/HB staff about childhood lead poisoning, new threshold blood lead levels, prevention, and intervention through formal presentation as well as health education.

During the reporting period, the Lead program through a partnership with the MSDH Pharmacy Program and the resident interns, contacted 81 provider clinics across the state to schedule one-on-one education regarding lead poisoning screening, testing, reporting and follow-up. Outreach with each provider was attempted 3 times each. Through this, 23 provider visits were scheduled with 20 visits completed (10 in-person, 5 virtually, 5 telephone). Three of the scheduled visits were no-shows.

MSDH Pharmacy residents attended a baby shower in Canton, MS sponsored by Magnolia Healthcare to distribute lead educational packets to new and expectant mothers. In partnership with Molina Healthcare, the residents attended two events at elementary schools reaching over 200 people in the Mississippi Delta with lead educational materials.

During the reporting period, meetings were held in-person and virtually with the Director of Lead Poisoning Prevention and Health Homes and the Director of the Office of Oral Health to discuss efforts to provide oral health education to the Healthy Home program. Twice per year, mass mailouts are sent to MS residents on information about reducing health hazards in the home and free mold and radon testing. The partnership resulted in one hundred packets on oral health educational consisting of information in both English and Spanish accompanying these mail outs. The program was careful to ensure the information covered a lifespan by including flyers on oral health needs for children, dry mouth symptoms, and solutions for older adults. In return, folders on lead poisoning and health homes were given to Regional Oral Health Consultants to give to residents during their participation in health screenings, school visits, and career fairs.

Strategy: *Increase identification of children exposed to lead*

Completed Activities:
HMHB and the Lead and Healthy Homes program have a Data Use Agreement (DUA) to where HM/HB shares their list of enrolled infants and Lead compares that list for those infants who may have been exposed to lead or who have already screened. Lead and Healthy Homes program makes referrals to HM/HB as needed as well as when HM/HB has identified an infant or family member that has been exposed to lead, they are referred to the Lead and Healthy Homes Program. HMHB nurse case managers ask about lead exposure to HM/HB new enrollees during the enrolment process. After a positive screening has been made, nurse case managers refer to Lead and Healthy Homes Program.

The Lead program identified 332 children less than 72 months of age with a venous blood lead level of 3.5 or higher qualifying the family for services such as care coordination services to include telephonic counselling, home visits, environmental assessments, referrals and education. Of this number, 173 families received telephonic counselling and the remaining 159 received educational materials through the mail. Six families of children accepted a home visit and environmental assessment.

Through a partnership with the Mississippi State Department of Health's Supplemental Nutrition Program for Women, Infants and Children's Nutrition (WIC), the program has incorporated lead-related questions on the WIC nutritional assessments for infants, children, pregnant women, and breastfeeding and non-breastfeeding women. The questions asked are listed below and vary slightly, based on the intended audience:

- Does your baby put objects in their mouth, such as keys, electrical cords, jewelry, vinyl (plastic) mini-blinds or bare soil outside near the home?
- Does your tap water come from a well?
- Do you or your baby live in an old house or attend daycare at an old building (built before 1978)? Have you noticed the paint chipping?
- Does your baby live in a household with someone who works with lead? Examples include construction, painting, welding, or bullet manufacturing?
- Does your baby have a family member or friend who has or did have an elevated blood lead level?

Standard lead educational materials are provided to each family enrolled in WIC to increase awareness about lead and the importance of testing. On February 1, 2023, the program started receiving referrals from WIC via REDCap for any family who answers yes to any of the lead questions. Once a referral is received, program staff contact the family to educate them about lead and to recommend that the child be tested for lead according to the American Academy of Pediatrics Bright Future Guidelines.

PRIORITY: <u>Increase Breastfeeding, Healthy Nutrition, and Healthy Weight</u>

NPMs, NOMs, SPM, and ESMs:

- SPM 11: Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Objective:

- By September 30, 2025, decrease the percentage of children, ages 2-5 years, who receive WIC services and have a BMI at or above the 85th percentile

Strategy: *Increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support to reduce childhood obesity*

Completed Activities:

WIC Peer Counselors continue to provide prenatal education and breastfeeding support to WIC participants. From October 2022 to September 2023, peer counsellors provided support via 64,435 telephone calls, 26,170 office visits, 284 hospital visits, and 1,228 home visits. WIC staff completed 4 levels of breastfeeding curriculum training based on their role within the WIC Program. Approximately 275 WIC staff members statewide received Level 1 training regarding the basics of breastfeeding and ways to support pregnant and breastfeeding families. WIC breastfeeding staff provide breastfeeding support group meeting facilitation for the MS MILC Leagues. Families receive peer support and have access to an IBCLC to address any complex breastfeeding issues during group meetings. The WIC Program continues to provide WIC participants with free access to the Pacify tele-lactation mobile app for after hours and weekend support of breastfeeding. In September 2023, 61 new WIC participants were enrolled for Pacify services and 27 calls were made to an IBCLC with 44% of those calls made after regular clinic working hours.

Strategy: *Implement evidence-based practices to decrease obesity in early childhood*

Completed Activities:

The WIC Program continues to provide nutrition assessment, goal-centered nutrition education, breastfeeding promotion and support, and referrals to other healthcare services. These activities are an integral part of the WIC mission and are used to prevent and reduce childhood obesity.

The CYSHCN Program, in collaboration with trusted partners, provides CYSHCN and their families with information regarding the benefits of healthy eating and exercise. Healthcare professionals also work closely with CYSHCN who have identified concerns related to obesity.

HM/HB staff, including perinatal nurses and registered dietitians, provide health education, modeling, and direct instruction for healthy family nutrition and infant feeding practices, which are staged according to the approaching developmental stages of infants. In the prenatal and throughout post-partum period, the HM/HB staff assess each family for food security, making referrals to the appropriate resources, including WIC as needed. Also, during this period, maternity patients are provided education and support aimed at increasing water consumption and increasing healthy food and nutrient consumption to prepare for breastfeeding and optimizing post-partum recovery. In the post-partum period, for breastfeeding infants, education and support is focused on the breastfeeding mother's nutrition and overall wellness, infant positioning, latch, and suck, number and length of feedings, infant signs of hunger and fullness, mother's breast health, and pumping/expression and breast milk storage. For formula-fed infants, education and support is focused on formula access and supply, preparation, and storage. Staff counsel families on the need to avoid a too soon introduction of water, juice, and other non-breast milk or non-formula items to the infant without a medical professional's recommendation, as well as bottle-propping, as this is a risk for choking/aspiration, dental caries, and excessive weight gain in infants. For all infants, HM/HB staff check their weight at each in-person interaction, monitoring it closely to assure steady and appropriate weight gain. When anomalies in the infant's weight (either too little weight gain or too much weight gain) are suspected, the staff work with the caregiver to engage the infant's medical home for further assessment. As infants progress through developmental stages, weaning from the breast or bottle and teething is addressed, as well as the introduction of solids (i.e., cereal, pureed baby foods, etc.). The addition of finger-foods, self-feeding/drinking tools, and transition to cow's milk follows as the infant approaches her first birthday. There is also support and education for the mother provided around returning to a healthy weight, including consumption of macro nutrients, avoidance of excess fast food and empty calories, and engaging in tolerable physical activity throughout the 12 months post-partum. Educational materials used include those from WIC and the Partners for A Healthy Baby Home Visiting Curriculum (Florida State University).

PRIORITY: <u>Improve Access to Family-Centered Care</u>

NPMs, NOMs, SPM, and ESMs:

- SPM 21: Percent of children with and without special healthcare needs who have a medical home

Objectives:

- By September 30, 2025, increase the number of infants and toddlers enrolled into family-centered services in a medical home to 2.15%
- By September 30, 2025, increase the percentage of the children who exit early intervention at or near age expectations: (1) in cognitive and language/ communication skills to 52.5% (2) in social-emotional development to 64.5% (3) in motor and adaptive skills to 58%
- By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5%
- By September 30, 2025, increase the number of families of children who have access to peer-to-peer support

and role models by 5%

Strategy: *Improve hospital and primary care provider family-centered care practices*

Completed Activities:
The CYSHCN Program has a long-standing partnership with community health care clinics and tertiary clinics that provide services to the CYSCHN population. As a result of these partnerships, quarterly meetings are held to identify ways to increase enrollment through identification and referrals to the CYSHCN programs, as well as supporting, via funding the roles of Care Coordinator and Parent Consultants with those strategic partners. Supporting opportunities for other training opportunities to meet the specific needs of the particular groups and connecting them to other external groups that can help them develop skills to serve CYSCHN.

Strategy: *Develop and distribute resources among early childhood partners and families regarding early identification of infants and toddlers who may be eligible for services*

Completed Activities:
HM/HB Central Office team has participated in over 15 Community outreach events between October 2022 and September 2023 this does not include the numerous events that the HM/HB field staff attend to promote the program to the public as well as community agencies and early childhood partners. HM/HB is also apart of the Early Childhood Development Coalition and had established relationships with MS Department of Human Services (Healthy Families of MS) at the time.

The CYSCHN Program participated in multiple health fairs and community events to provide knowledge of the CYSHN program and the support that it offers to families. The CYSHCN Program revised and improved informational materials that promote the CYSHCN program and how it can assist families in identifying and/or obtaining resources to better support their needs. CYSHCN partnered with the MS Parent Training Institute and MS Families for Kids to provide training to Parents, LEAs and childcare providers and healthcare professionals on the importance of referring children to the CYSHCN program and providing developmental screenings at health fairs to identify children who may be eligible for programs that support children with special healthcare needs.

First Steps Early Intervention contracted with Maris, West & Baker (MWB) to develop and co-brand educational material for the program. The program adopted the CDC's *Learn the Signs. Act Early.* for its public awareness campaigns to educate early childhood partners and families on signs of developmental delay and how to refer children for evaluation. Resources are currently being printed and will be sent to referral sources. MWB developed both a 15- and a 30-second commercial for the program that ran on local TV stations for 3 months and was placed on YouTube (https://youtu.be/6P9dZnxghxc) and other social media sites in order for the program to be able to continue using them. CDC's *Learn the Signs. Act Early.* brochures were edited to include the contact phone numbers for First Steps and the website of the Mississippi Department of Education Office of Special Education to contact local school districts. As a result of this media campaign, the program received 9,642,239 impressions across all media outlets in which 23,217 individuals clicked on the ad to learn more.

Strategy: *Collaborate with the Mississippi Department of Education to implement a statewide Child Find public awareness campaign*

Completed Activities:
In Spring 2023, the Child & Adolescent Health Director/Part C Coordinator partnered with the State 619 Early

Childhood Special Education Director to lead nine trainings across the state reaching more 350 educators about transition from early intervention (Part C) to special education (Part B) IDEA services. During the training, materials were shared and guidance was provided about joint public awareness campaigns between local education agencies/school districts and local early intervention programs.

The materials prepared by the First Steps Early Intervention, including brochures and social media, were shared with the MDE Office of Special Education to share broadly with all partners, including families who may have multiple children of various ages.

The CYSHCN Director collaborated with the MDE Office of Special Education and Office of Early Childhood to provide inservice training to teachers, paraprofessional, and parents on the supports available for CYSHCN, process for identification and referral, resources regarding symptoms of diagnosed conditions not readily identified, and the interaction of health on student performance.

The CYSHCN Director also engaged with the Special Education Advisory Panel (SEAP) to discuss effective transition of CYSHCN from Part C to Part B for those who are eligible. Topics included:

- For those who decided not to receive school-based services, what community supports are available and what are the rights of the parents/caregivers to later access school-based services.
- What are the supports provided to educators, especially new educators to aid them in working with children/families who are eligible for special education services and for those who have 504 and/or Health Plans.
- How are they monitored for effectiveness, when and what tools.

Strategy: *Implement family-centered early intervention practices to improve development outcomes, including school readiness*

Completed Activities:

The MSFSEIP restarted the coaches training of the Routine-Based Model. The Routines-Based Model for Early Intervention developed by Robin McWilliam is a comprehensive model for the delivery of early intervention services that is family-focused, routines-based, and uses transdisciplinary approaches. The model consists of six key practices: assessing family systems using Ecomaps, gathering individual family information through the Routines-Based Interview (RBI), development of participation-based functional child and family goals, use of transdisciplinary practices for service delivery, procedures for conducting supportive home visits, and use of collaborative consultation in childcare settings. During this time frame 15 coaches are going through the training.

Strategy: *Implement interventions with families to reduce children's exposure to lead and other environmental hazards*

Completed Activities:

HMHB and the Lead and Healthy Homes program have a Data Use Agreement (DUA) to where HM/HB shares their list of enrolled infants and Lead compares that list for those infants who may have been exposed to lead or who have already screened. Lead and Healthy Homes program makes referrals to HM/HB as needed as well as when HM/HB has identified an infant or family member that has been exposed to lead, they are referred to the Lead and Healthy Homes Program. HMHB nurse case managers ask about lead exposure to HM/HB new enrolees during the enrolment process. After a positive screening has been made, nurse case managers refer to Lead and Healthy Homes Program. During the reporting timeframe, HM/HB staff issued 3 referrals to the HHLPPS.

Strategy: *Link children exposed to lead to recommended family-centered services*

Completed Activities:
HMHB and the Lead and Healthy Homes program have a Data Use Agreement (DUA) to where HM/HB shares their list of enrolled infants and Lead compares that list for those infants who may have been exposed to lead or who have already screened. Lead and Healthy Homes program makes referrals to HM/HB as needed as well as when HM/HB has identified an infant or family member that has been exposed to lead, they are referred to the Lead and Healthy Homes Program. HMHB nurse case managers ask about lead exposure to HM/HB new enrollees during the enrolment process. After a positive screening has been made, nurse case managers refer to Lead and Healthy Homes Program.
During the reporting timeframe, HM/HB staff issued 3 referrals to the HHLPPS.

During the time frame the Lead and Healthy Homes Program referred 38 families to the early intervention program.

Strategy: *Recruit a diverse team of family advisors located in each of the three regions of the state to provide assistance and support to families*

Completed Activities:
The CYSHCN Program has partnered with community health clinics across the state to fund parent Consultants, to support the needs of CHYSCHN families, as well as a Parent Engagement Coordinator at the State level.

Strategy: *Expand the EHDI family peer support program with Family Advisors and Deaf/Hard of Hearing Role Models*

Completed Activities:
The EHDI-MS Program houses a Family Support Program (FSP) comprised of Family Advisors, who are parents of children who are Deaf/Hard of Hearing (D/HH), as well as D/HH Role Models, who can provide parents information about their lived experiences navigating the world with hearing loss. The EHDI-MS Program receives confirmed hearing loss diagnoses and sends the referral directly to MS First Steps EI Program, as well as the EHDI-MS Program Family Support Program. A family advisor is then assigned to the incoming family to begin making contact a guiding the family in making decisions for their child. During the project period, the EHDI Program recruited additional Family Advisors, bringing the total to four, and recruited a D/HH Role Models, to onboard after the project period, to support additional families. These FSP personnel participated in training and supervision to enhance their ability to meet the informational and emotional needs of families of children who were recently diagnosed with permanent hearing loss.

PRIORITY: <u>Improve Oral Health</u>

NPMs, NOMs, SPM, and ESMs:
- NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
- NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
- NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

- ESM 13.2.1: Number of children 0-3 years who had a preventive dental visit with referred dentist
- ESM 13.2.2: Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses
- ESM 13.2.3: Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting

Objective:

- By September 30, 2023, increase the percent of children with a preventive dental visit by 1%

Strategy: *Promote the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals*

Strategy: *Support trainings on use of fluoride varnish in the primary care setting*

Completed Activities:

A total of six Cavity Free in MS trainings occurred during the period between November 2022 and September 2023. In November, one training was held in Simpson County with seven medical staff members trained. In January 2023, Eupora Pediatric Clinic in Smith County received training for two Family Nurse Practitioners (FNP) and one Licensed Practical Nurse (LPN). Mississippi Medical in Webster County also received training in January 2023 for two Registered Nurses (RN). In March 2023, two medical staff members received training in Scott County. In August 2023, Lucedale Pediatrics received training for one RN, one Nurse Practitioner, Certified (NP-C), one Nurse Practitioner (NP), and one Medical Assistant (MA). In September 2023, Hattiesburg Children's Clinic received training for nine Doctors, one RN, two FNP, one Certified Pediatric Nurse Practitioner-Primary Care (CPNP-PC), two FNPs, and one additional staff member.

Child Health
Application Year - FY2025

The following section outlines strategies and activities to be implemented between 10/1/2024-9/30/2025 to meet the objectives and show improvement on the measures related to child health:

PRIORITY: Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

NPMs, NOMs, SPM, and ESMs:

- DS/NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
- SR/NOM 13: Percent of children meeting the criteria developed for school readiness
- CHS/NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
- SPM 3: Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age
- SPM 13: Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age
- SPM 14: Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit
- SPM 15: Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely
- DS.2/ESM 6.2: Number of health professionals and parents/families who receive training on developmental screening and/or monitoring

Objectives:

- By September 30, 2025, extend the early childhood hearing screening program for children between 6-36 months of age to increase identification of children with late onset hearing loss
- By September 30, 2025, increase screening rates in low-resource areas of the state
- By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results
- By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually
- By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation
- By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings
- By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

Strategy: *Develop a comprehensive, coordinated, and integrated system of services for children*

Activities:

- Implement updated policies and procedures in child health programs into onboarding and professional development to support a comprehensive, coordinated, and integrated system of services for children
- Develop and implement agreements with state and local agencies, community-based and family-based organizations, and public and private health providers to support a comprehensive, coordinated, and integrated system of services for children
- Develop improved functionality and reports in data systems to support a comprehensive, coordinated, and

integrated system of services for children

Strategy: *Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification*

Activities:

- Coordinate with the state lab, birthing hospitals, tertiary centers, and other specialists to maintain a robust newborn screening program
- Expand the number of healthcare providers, interventionists, and specialists who provide screening and ongoing monitoring for timely identification of medical, environmental, or developmental concerns
- Refer families to local primary healthcare providers for screening and monitoring for timely identification of medical, environmental, or developmental concerns
- Provide information to families and primary health care providers supporting timely follow-up

Strategy: *Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification*

Activities:

- Collaborate with traditional and non-traditional early childhood partners in assisting families with accessing screenings, evaluations, and referrals to family-centered services for follow-up
- Provide tailored education and outreach with traditional and non-traditional early childhood partners.

Strategy: *Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening*

Activities:

- Invite screening providers to participate in training and education sessions on screening using HealthStream, conferences, workshops, lunch-and-learns, learning communities, and other educational opportunities.
- Provide tailored education and outreach to communities, partner organizations, and stakeholders to address identified issues and concerns.

Strategy: *Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners*

Activities:

- Assess hospital performance, including specimen collection, screening, and reporting procedures among hospital and laboratory staff to determine gaps with the newborn screening program and intervene with improvement efforts
- Analyze data on screening rates and identify low-resource areas with gaps to be addressed collectively through program improvement or development
- Analyze root causes of loss to follow up and loss to documentation with internal and external partners to implement quality improvement efforts
- Refine agency data systems to document and track screening, diagnosis, and other follow-up activities, including referral and linkage to family-centered medical, environmental, developmental, and social services
- Develop improved functionality and reports in program databases to support data-driven quality improvement

efforts
- With technical assistance from local, state, and national partners, engage stakeholders in quality improvement using the Model for Improvement: Plan-Do-Study-Act (PDSA) methodology

Strategy: *Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues*.

Activities:
- Collaborate with the Office of Communications to promote national and state messaging related to child health issues to prepare social media post schedules and templates for observance months/days.
- Conduct outreach and public awareness campaigns to increase awareness of child health issues

Strategy: *Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings*

Activities:
- Collaborate with the Office of Communications to promote national and state messaging related to child health issues to prepare social media post schedules and templates for observance months/days.
- Conduct outreach and public awareness campaigns to increase awareness of child health issues
- Provide ongoing training for MCH personnel on health and developmental screenings

PRIORITY: Improve Access to Family-Centered Care

NPMs, NOMs, SPM, and ESMs:
- MH/NPM 11: Percent of children with and without special health care needs, ages 0-17, who have a medical home
- SPM 21 Percent of children with and without special healthcare needs who have a medical home

Objectives:
- By September 30, 2025, increase the percentage of children enrolled into family-centered services in a medical home
- By September 30, 2025, increase the percentage of the children who demonstrate improvements in their growth, health, and development through participation in MCH child health programs providing early intervening services (i.e., service/care coordination and/or home visiting programs) by 5%
- By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5%
- By September 30, 2025, increase the number of families of children who have access to peer-to-peer support and role models by 5%

Strategy: *Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners of MCH child health programs to improve timely referrals for early intervening services*

Activities:
- Develop and distribute promotional materials about early intervening services through a variety of approaches

including personal contacts with referral sources; exhibitions and/or presentations at MSDH meetings, community meetings, public events, and/or conferences; distribution of Public Service Announcement to local media venues, social media, and in print
- Review data to identify areas with low or late referrals and provide tailored outreach to communities, partner organizations, and stakeholders

Strategy: *Implement interventions with families to promote the adoption of home- and community-based strategies to promote the health and development of their children (e.g., safe sleep, healthy homes, nutrition, and physical activity)*

Activities:
- Provide tailored education to families on home- and community-based strategies to promote the health and development of their children
- Provide ongoing support for families to implement home- and community-based strategies to promote the health and development of their children.
- Provide ongoing peer-to-peer support for families to promote the health and development of their children.

Strategy: *Implement evidence-based approaches using family-centered practices to improve health and developmental outcomes for young children, including school readiness*

Activities:
- Provide professional development on evidence-based approaches using family-centered practices that improve health and developmental outcomes for young children (e.g., *Routines-Based Model* for Early Intervention and *Parents As Teachers Model* for MIECHV)
- Provide ongoing support for personnel to implement adopted evidence-based models with fidelity

Strategy: *Provide professional development opportunities for healthcare professionals to learn about family-centered care practices and medical homes*

Activities:
- Invite screening providers to participate in training and education sessions on screening using learning management software (LMS), conferences, workshops, lunch-and-learns, learning communities, and other educational opportunities.
- Provide tailored education and outreach to healthcare providers, interventionists, and specialists to promote family-centered care practices.

Strategy: *Coordinate and collaborate with birthing hospitals, healthcare providers, interventionists, and specialists to implement family-centered care practices*

Activities:
- Expand the number of birthing hospitals, healthcare providers, interventionists, and specialists who implement family-centered care practices
- Link children with potential and identified needs to local primary healthcare providers, interventionists, and specialists who implement family-centered care practices

Strategy: *Increase knowledge and awareness among families on family-centered care practices*

Activities:

- Provide tailored education and outreach to families, communities, partner organizations, and stakeholders about medical homes and family-centered care practices.
- Refer families to local primary healthcare providers, interventionists, and specialists who implement family-centered care practices and can serve as a medical home
- Promote self-advocacy by families on demanding family-centered care practices in their systems of care and medical homes

PRIORITY: Improve Oral Health

NPMs, NOMs, SPM, and ESMs:

- PDV-Child/NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
- TDC/NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
- SOC/NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- CHS/NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
- PDV-Child.1/ESM 13.2.1: Number of children 0-3 years who had a preventive dental visit with referred dentist
- PDV-Child.2/ESM 13.2.2: Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses
- PDV-Child.3/ESM 13.2.3: Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting

Objective:

- By September 30, 2025, increase the percent of children with a preventive dental visit by 1%

Strategy: *Promote the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals and nondental providers*

Activities:

- Increase oral health awareness regarding oral disease indicators
- Coordinate efforts with the WIC program to improve access for WIC recipients (both children and pregnant mothers) to dental care
- Monitor dental care coordination efforts among children 1-17 years
- Strengthen the collaborative partnership with the Division of Medicaid

Strategy: *Support trainings of medical providers, including doctors, nurse practitioners, and physician assistants, on oral health assessments and use of fluoride varnish in the primary care setting*

Activity:

- Continue to build connections and strengthen opportunities with the UMMC SOD and with other schools offering dental hygiene degree programs

Strategy: *Work with internal and external partners to identify barriers and solutions to access and utilization of preventive dental services*

Activities:

- Increase oral health awareness regarding oral disease indicators
- Coordinate efforts with the WIC program to improve access for WIC recipients (both children and pregnant mothers) to dental care
- Monitor dental care coordination efforts among children 1-17 years
- Strengthen the collaborative partnership with the Division of Medicaid
- Continue to build connections and strengthen opportunities with the UMMC SOD and with other schools offering dental hygiene degree programs

PRIORITY: <u>Increase Breastfeeding, Healthy Nutrition and Healthy Weight</u>

NPMs, NOMs, SPM, and ESMs:

- SPM 11: Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Objective:

- By September 30, 2025, decrease the percentage of children, ages 2-5 years, who receive WIC services and have a BMI at or above the 85th percentile

Strategy: *Increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support to reduce childhood obesity*

Activities:

- Maintain and create additional community partnerships as referral sources to the MSDH WIC Program
- Provide breastfeeding education and support to prenatal WIC participants
- Provide WIC participants access to certified lactation consultants

Strategy: *Implement evidence-based practices to decrease obesity in early childhood*

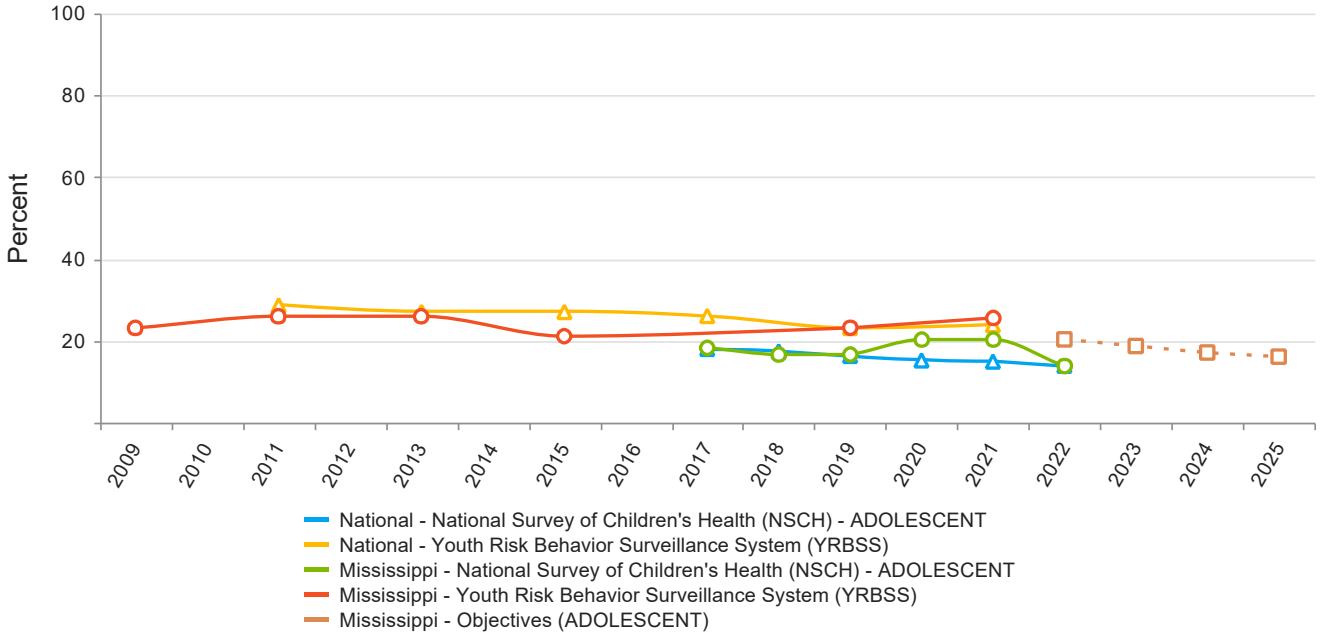
Activities:

- Maintain and create additional community partnerships as referral sources to the MSDH WIC Program
- Provide breastfeeding education and support to prenatal WIC participants
- Provide WIC participants access to certified lactation consultants

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent
Indicators and Annual Objectives



Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2020	**2021**	**2022**	**2023**
Annual Objective			20.4	18.8
Annual Indicator	23.4	23.4	25.5	25.5
Numerator	29,043	29,043	31,054	31,054
Denominator	123,981	123,981	121,794	121,794
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2019	2019	2021	2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT				
	2020	**2021**	**2022**	**2023**
Annual Objective			20.4	18.8
Annual Indicator	16.7	20.6	20.5	14.0
Numerator	38,663	48,356	48,374	34,225
Denominator	231,717	234,684	235,476	243,942
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	17.2	16.2

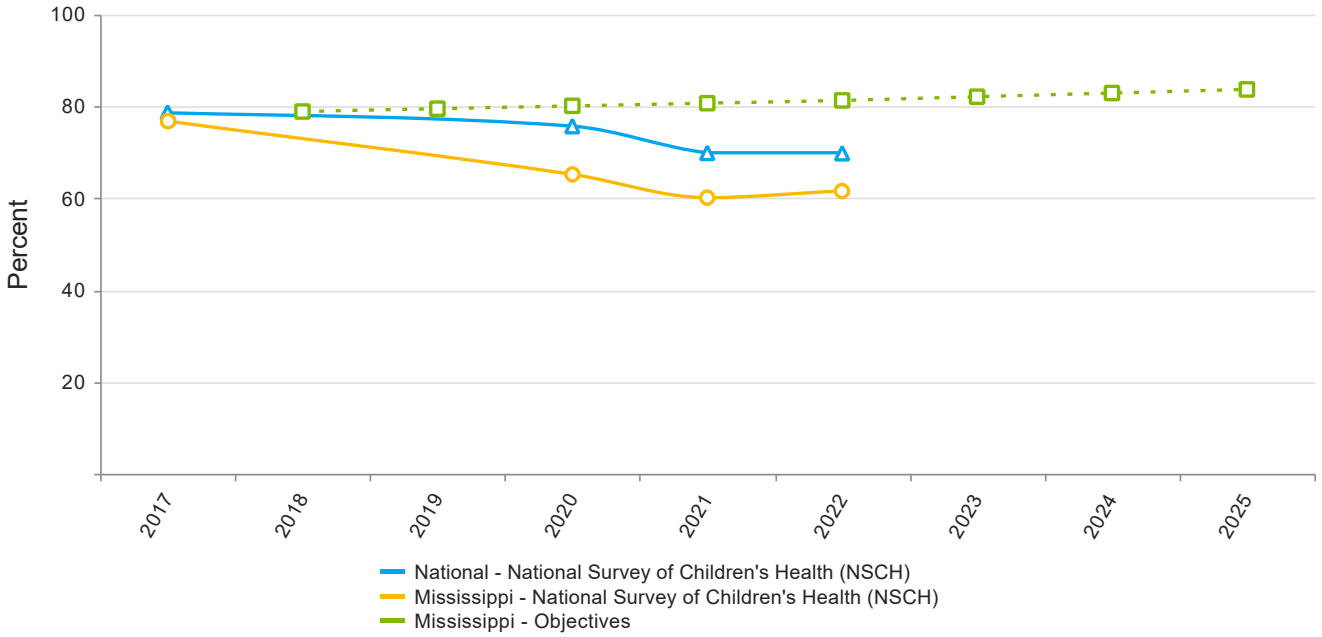
Evidence-Based or –Informed Strategy Measures

ESM PA-Adolescent.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide

Measure Status:	Active			
State Provided Data				
	2020	**2021**	**2022**	**2023**
Annual Objective			22	23
Annual Indicator	20.6		20.5	14
Numerator	48,356		48,374	34,225
Denominator	234,684		235,476	243,941
Data Source	National Survey of Childrens Health		National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2019-2020		2020-2021	2021-2022
Provisional or Final ?	Final		Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	24.0	25.0

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	79.4	80	80.6	81.2	82
Annual Indicator	77.0	66.2	65.1	60.5	61.6
Numerator	188,821	155,497	155,882	145,341	148,228
Denominator	245,226	234,939	239,310	240,226	240,436
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	82.8	83.6

Evidence-Based or –Informed Strategy Measures

ESM AWV.2 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			100
Annual Indicator	100	100	100
Numerator			
Denominator			
Data Source	MSDH County Health Department information	MSDH County Health Department information	MSDH County Health Department information
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	100.0	100.0

State Action Plan Table

State Action Plan Table (Mississippi) - Adolescent Health - Entry 1	
Priority Need	
Improve Access to Care	
NPM	
NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	
Five-Year Objectives	
By September 30, 2025, increase percentage of youth who complete an annual EPSDT visit	
By September 30, 2025, increase HPV vaccination rate among youth 9-13 years and 14-17 years	
Strategies	
Provide professional development opportunities for healthcare professionals to learn about best practices in teen-friendly care	
Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of adolescent health issues and preventative care and the importance of medical homes	
Educate transitioning youths and their families about accessing adult care, healthcare coverage options, health literacy, and self-advocacy	
ESMs	**Status**
ESM AWV.1 - Number of clinic sites engaged in youth-centered care quality improvement cycles.	Inactive
ESM AWV.2 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years	Active

NOMs

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

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

Priority Need

Increase Breastfeeding, Healthy Nutrition and Healthy Weight

NPM

NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent

Five-Year Objectives

By September 30, 2025, increase the percent of adolescents, ages 12-17 years who are physically active at least 60 minutes per day

Strategies

Develop partnerships and work with internal and external partners and schools to complete the School Health Index (SHI) Self-Assessment and Planning Guide

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase daily physical activity among adolescents ages 12-17

Provide professional development opportunities for healthcare and education professionals to learn about best practices to promote daily physical activity among adolescents ages 12-17

ESMs	Status
ESM PA-Adolescent.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide	Active

NOMs

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

Adolescent Health
Annual Report - FY2023

Activities in this domain were carried out by the following MSDH offices, bureaus, or programs during the reporting period:

- Adolescent Health Program (AH)
- Children and Youth with Special Healthcare Needs Program (CYSHCN)
- Early Periodic Screening Diagnosis and Treatment (EPSDT) Program
- Family Planning/Comprehensive Reproductive Health (FP/CRH)
- Northeast Mississippi Healthy Start Collaborative
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The following section outlines strategies and activities implemented between 10/1/2022-9/30/2023 to meet the objectives and show improvement on the measures related to child health:

PRIORITY: Improve Access to Care

NPMs, NOMs, SPM, and ESMs:

- Adolescent Well-Visit/NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- AM/NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000
- AM-Motor Vehicle/NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
- AM-Suicide/NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000
- SOC/NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- MHTx/NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
- CHS/NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
- OBS/NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
- VAX-Flu/NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
- VAX-HPV/NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
- VAX-TDAP/NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
- VAX-MEN/NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
- TB/NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
- AWV.2/ESM 10.2: Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counselling to adolescents, ages 12-17 years

Objectives:

- By September 30, 2023, increase the number of male family planning users by 10%

- By September 30, 2025, increase access and utilization of quality family planning services in MSDH county health departments
- By September 30, 2025, increase HPV vaccination rate among youth 9-13 years and 14-17 years

New Strategy: *Work with youth and health care providers to understand barriers to adolescent health and implement efforts to address these barriers*

In 2022, the Office of Child and Adolescent Health and the CYSHCN/Adolescent Health program formed a formal partnership with Teen Health Mississippi (THMS), a community-based organization dedicated to building capacity within youth and communities to attain equitable health outcomes. During the Summer 2023, THMS conducted multiple focus groups with key constituent groups to (1) identify adolescent attitudes towards healthcare and how to minimize barriers and improve access to integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling, and (2) understand, from a healthcare provider perspective, what barriers existed for teens accessing services and why. Using a health equity lens, the focus group questions were developed to elicit information about any biases that were perceived, from the points of view of both youth receiving services and providers engaged in their care.

- **Focus Group 1:** This healthcare provider focus group was conducted via Zoom and had 9 participants: 7 black women, 1 white woman, and 1 black man. The types of providers included Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Registered Nurse (RN), Licensed Practical Nurse (LPN), and Certified Nursing Assistant (CNA).

- **Focus Group 2:** This youth-based focus group was conducted via Zoom and had 11 participants, ages 17-24: 9 black women and 2 black men.

- **Focus Group 3:** This youth-based focus group was conducted with youth via Zoom and had 8 participants, ages 18-22: 7 black women and 1 white woman.

The findings from the focus groups and recommendations for interventions were reported in ***Beyond the Bias: Empowering Youth Through Equitable Healthcare: Addressing Implicit Bias in Healthcare to Enhance Access and Support for Youth***.[1] Key findings are:

1. The personal values of healthcare providers and their support staff can negatively impact the experiences of youth, decrease their likelihood of access services, and contribute to poor health outcomes for youth.
    - *Youth participating in the youth focus group shared several stories and experiences of not receiving the care they expected. From their perspective, the personal values of the healthcare providers and staff hampered their ability to provide high-quality care to youth.*
    - *Several participants reported feeling judged by healthcare providers and staff for the reason why they were seeking care.*
    - *Several youth shared experiences of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) youth not receiving the same type of care as their non-LGBTQ youth peers.*
    - *Youth shared experiences of healthcare providers insisting their parents join the visit, even at federally qualified health centers.*

2. The power and privilege of healthcare providers can negatively impact the experiences of youth, decrease their likelihood of access services, and contribute to poor health outcomes for youth.

- *During the focus groups, young people shared several experiences of healthcare providers talking at them rather than talking with them.*
- *They shared instances where providers and staff would not give options for next steps and the pros and cons of each option, but would tell the patient what to do, leaving the youth out of the decision-making process.*
- *Participants reported perceiving that providers and staff did not believe a young person should or could make such decisions for themselves.*
- *Youth shared that the healthcare providers and staff often did not look like them and/or did not come from the same communities (i.e., most youth participants were African American and they reported providers and staff in the healthcare spaces they encountered were mostly or all White)*
- *Youth reported they often did not feel understood by the provider and the provider made assumptions about why they were there/what they needed.*

3. Youth experience intentional and implicit bias related to race, gender, sex, sexual orientation, age, socioeconomic status, education level, and geographic location that negatively impact their access to services and contribute to poor health outcomes for youth.

4. Youth experience a lack of empathy from healthcare providers that leave them with negative emotions that decrease their likelihood of accessing services and contribute to poor health outcomes for youth.
   - *Youth stated they felt their healthcare providers did not care about them.*
   - *Youth shared stories and experiences of healthcare providers and staff being unsympathetic to what they had to do to get access to healthcare.*
   - *Youth reported feelings of being misunderstood and being discriminated against.*
   - *Youth reported their experiences led them to change healthcare providers or to stop seeing healthcare providers altogether.*

Healthcare provider trainings will be developed and distributed to address these issues.

Strategy: *Offer adolescent males a range of integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling*

Completed Activities:
Health services for adolescent males is provided through EPSDT at county health departments and a variety of MCH Programs including, Family Planning/ Comprehensive Reproductive Health, Northeast Mississippi Healthy Start Collaborative, and Children and Youth with Special Healthcare Needs Program (CYSHCN).

The FP/CRH program implemented outreach strategies targeting males statewide to increase their awareness and access to services. The FP/CRH also provided education and counseling to adolescent males about reproductive health, safe sex practices, and assisted them with information to access the Family Planning Waiver (FPW) to increase the number of male clients with access to integrated health services. During the reporting period, county health Departments provided family planning services to a total of 13 adolescent males under FPW and 10 additional adolescent males under Title X.

In 2023, the Maternal and Infant Health Bureau (MIHB) was awarded funding to implement the Northeast Mississippi Healthy Start Collaborative in Chickasaw, Clay, Lee, Lowndes, Monroe, and Prentiss Counties in the northeastern area of the state (see *Attachment 1: Regional and Program Maps*). Healthy Start provides a combination of direct and enabling services, including screening for health and behavioral health issues, referrals

for services, ongoing case management and care coordination, health and parenting education, and linkage to clinical care Beginning September 2023, the NE MS Healthy Start Program began offering select integrated preventive health services and education to young men and women in their preconception phases of life. This activity will be expanded to colleges and universities.

The CYSHCN/Adolescent Health program provided direct outreach to adolescents and partnered with a community-based organization to determine best practices for improving their engagement with adolescents. CYSHCN/Adolescent Health personnel participated in health fairs to provide information about human development, including safe sex practices and abstinence, and literature and guidance on how to access services provided by the health department.

Strategy: *Empower low-income users to make informed decisions about family planning and preventive health services*

Completed Activities:
Outreach efforts were implemented to connect with clients ages 19 or younger to provide counseling and education on family planning and preventive health were made during clinic visits, health fair events, and other community engagements.

During the reporting period, approximately 3,545 adolescents received FP services from county health departments. Staff provided family planning and preventive health services to adolescents in a youth friendly manner to ensure comfortability in discussing their sexual health and reproductive health concerns; that means the services provided are reasonable, accessible, acceptable, appropriate and effective. For adolescents younger than 18 years of age (minors), Mississippi state law requires parental consent or notification before receiving contraceptive services unless they are married or are a parent, or if they have been referred by a physician, clergyman, family planning clinic, school or state or local agency. However, if a minor is seeking services at a Title X funded site, the provider must allow the minor to obtain family planning services on their own consent, even if the law explicitly requires parental consent or notification for such services.

Please also see *Women/Maternal Health-Improve access to care*.

The CYSHCN/Adolescent Health program provided literature to community partners that serve low-income users about family planning and establishing healthy living practices, including nutritional choices, and making referrals to the WIC to aid families in supporting nutritional needs. Many of the adolescents seeking care, expressed unsatisfied reactions to providers, as they felt that their concerns were either diminished or dismissed because of their socioeconomic status and/or race. Many expressed fear in discussing their concerns because of limited access to care and the cost of seeking care in other areas. Due to these concerns, even when provided with information about transportation resources or alternative care providers, the access to services was limited. As a result, adolescents often did not seek preventive care, due to the perceived attitudes from the providers, even when they understood the importance of receiving the care

Strategy: *Work with internal and external partners, academic institutions, providers and organizations to improve awareness and purpose of HPV vaccination*

Completed Activities:
AS HPV is linked with 70% of mouth and throat-related cancers, the Office of Oral Health participated with and/or provided trainings to several community organizations and professional entities to increase awareness about

HPV and oral health and to promote HPV vaccination between February and September 2023.

February 2023

- National Children's Dental Health Month Table National Children's Dental Health Month Table (9 participants – Bolivar County)
- What's the Tea? Teen Health Event (24 participants- Coahoma County)
- Mississippi Dental Association Meeting (61 participants – Forrest County)
- MSU Junior Master Wellness Volunteer program (148 participants – Kemper County)_
- MCC Dental hygiene public health lecture (12 participants – Lauderdale County)
- Oral Health and Heart Awareness Day: Hinds Community College Vicksburg Branch (96 participants – Warren County)

March 2023

- MPHA Conference (57 participants – Hinds County)
- East Jasper School District fair-Heidelberg High (205 participants – Jasper County)

April 2023

- Kids Zone Crystal Springs Blues Fest (57 participants – Copiah County)
- Forrest General Hospital Oral Cancer Awareness Event (80 participants – Forrest County)
- Early Head Start Jones Head start Community Event (79 participants – Jones County)
- Wayne Co MSU Extension Service (147 participants – Wayne County)

May 2023

- MSU Ext Service Jasper Co Community Fair (74 participants – Jasper County)
- Empowering Communities Conference (43 participants – Hinds County)

June 2023

- UMMC S.M.I.L.E. U - Shaping Minds to Inspire Lead and Explore (S.M.I.L.E. U) Hinds Co. (35 participants).

July 2023

- UMMC School of Dentistry letter of support for the expansion of services to provide HPV vaccinations administration by dentists, dental hygienists, and dental/dental hygiene students at UMMC under approved UMMC programs. Mississippi State Dental Examiner Board vote 7-0 for approval.

September 2023

- MS SHINE Hispanic Festival donation (75 participants – Forrest County)

In addition, county health departments provided education to clients on HPV and the importance of completing the series of HPV vaccines and collaborated with the MSDH Office of Immunization to provide HPV vaccines to youth 9-13 years, 14-17 years, and eligible family planning clients.

PRIORITY: Increase Breastfeeding, Healthy Nutrition and Healthy Weight

NPMs, NOMs, SPM, and ESMs:

- Physical Activity-Adolescent/NPM 8.2: Percent of adolescents, ages 12 through 17 who are physically active at

least 60 minutes per day
- CHS/NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
- OBS/NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
- PA-Adolescent.1/ESM 8.2.1: Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide

Objective:
- By September 30, 2025, increase the percent of adolescents, ages 12-17 years who are physically active at least 60 minutes per day

Strategy: *Develop partnerships and work with internal and external partners and schools to complete the School Health Index (SHI) Self-Assessment and Planning Guide*

Completed Activities:
To build healthy communities, school personnel, parents, children and adolescents (i.e., students), and the community must collaborate to encourage the adoption of life-long healthful behaviors. Adolescent academic achievement and health outcomes are significantly impacted by what supports and/or barriers for healthy behaviors occur in their schools.

The Mississippi Department of Education's Office of Healthy Schools provides programming and technical assistance and services to schools to promote health and wellness across the state. In November 2021, the Office of Healthy Schools published new guidance on the development and implementation of required local school wellness policies, including requirements related to physical activity. Local school districts are required to

1. Gather input to assess their current situation using the School Health Index (SHI) to assess school health needs[2]
2. Develop and approve a school wellness policy
3. Implement and evaluate their school wellness policy

In the guidance document the following policies related to physical activity were *required* for inclusion in local school wellness programs:

- Provide 150 minutes per week of activity-based instruction for all students in grades K-8[3]
- Provide Physical Education/Activity in accordance with the Physical Education Rules and Regulations as approved by the State Board of Education in compliance with the Mississippi Healthy Students Act[4].
- Require fitness testing for all 5th grade students.
- Require fitness testing for high school students; during the year they acquire the ½ Carnegie unit in physical education as required for graduation by the Mississippi Healthy Students Act[5].
- Offer a planned sequential program of physical education instruction incorporating individual and group activities, which are student centered and taught in a positive environment.
- Instruction must be based on 2013-2014 Mississippi Physical Education Frameworks.
- Implement the requirements of the Mississippi Healthy Students Act of 2007[6].
- Graduation requirements for 9th through 12th grade students shall include ½ Carnegie unit in physical education.
- Beginning with 9th graders in school year 2015-2016, provide instruction in Cardiopulmonary Resuscitation (CPR) and use of Automated External Defibrillator (AED) for students in grades 9-12 in the school year they earn their ½ Carnegie Unit for physical education or health Education.[7]

- Address concussions by adopting and implementing a policy for students in grades 7-12 who participate in activities sanctioned by the Mississippi High School Activities Association (MHSAA). This policy will include a concussion recognition course that has been endorsed by the Mississippi Department of Health that provides information on the nature and risk of concussions for students participating in athletics. Also included in the policy, parents/guardians will be provided with a concussion policy before the start of regular school athletic season.[8]

The guidance document further *recommended* the following policies related to physical activity be included in local school wellness programs:

- Schedule recess (or physical education) before lunch times to increase food consumed, decrease plate waste, and improve cafeteria behavior.
- Incorporate 5 to 10-minute physical activity sessions in classrooms to teach subject areas and to make transitions between different lessons[9]
- Participate in a yearly fitness test for all students[10]
- Establish or enhance physical activity opportunities (like walking clubs or fitness challenges) for staff and/or parents.
- Provide staff-monitored recreational activities that promote moderate physical activity during all outdoor and indoor recess times.
- Encourage active transportation to/from schools by assessing the safest routes for students to walk or bike to school, and by installing bike racks at school buildings.[11]
- Collaborate with local recreational departments and youth fitness programs to promote participation in lifelong physical activities.
- Create opportunities for students to voluntarily participate in before- and after-school physical activity programs like intramurals, clubs, and at the secondary level, interscholastic athletics
- Do not use any type of physical activity as a means of punishment.

Despite these supports for implementation of health, the MSDH AH Program has not yet been able to establish partnerships with local schools in their conducting of assessments and development of local policies due to staff shortages and competing health priorities faced by local school districts related to the continued COVID pandemic. This strategy is expected to be implemented during the FY24 program year.

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[1] Source: https://msdh.ms.gov/page/41,0,304,63.html
[2] MS Code 37-11-71; using tools located online at: https://www.cdc.gov/healthyschools/shi/index.htm
[3] MS Code 37-13-134; 2014 Mississippi Public Schools Accountability Standards 27.1.
[4] State Board of Education Policy 4012
[5] State Board of Education Policy 4012
[6] Senate Bill 2369
[7] MS Code 37-13-134 (Senate Bill 2185)
[8] House Bill 48
[9] Examples can be found at www.movetolearnms.org
[10] Examples are: Fitness Gram® www.fitnessgram.net or Presidential Youth Fitness Program https://pyfp.org/
[11] Program descriptions and assessment tools available at: https://www.cdc.gov/healthyyouth/whatworks/what-works-safe-and-supportive-environments.htm

Adolescent Health Domain
Application Year – FY2025

The following section outlines strategies and activities to be implemented between 10/1/2024-9/30/2025 to meet the objectives and show improvement on the measures related to adolescent health:

PRIORITY: Improve Access to Care

NPMs, NOMs, SPM, and ESMs:

- AWV/NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
- AM/NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000
- AM-Motor Vehicle/NOM 16.2: Adolescent motor vehicle mortality rate, ages 15-19, per 100,000
- AM-Suicide/NOM 16.3: Adolescent suicide rate, ages 15-19, per 100,000
- SOC/NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0-17, who receive care in a well-functioning system
- MHTX/NOM 18: Percent of children, ages 3-17, with a mental/behavioral condition who receive treatment or counseling
- CHS/NOM 19: Percent of children, ages 0-17, in excellent or very good health
- OBS/NOM 20: Percent of children, ages 2-4, and adolescents, ages 10-17, who are obese (BMI at or above the 95th percentile)
- VAX-Flu/NOM 22.2: Percent of children, ages 6 months-17 years, who are vaccinated annually against seasonal influenza
- VAX-HPV/NOM 22.3: Percent of adolescents, ages 13-17, who have received at least one dose of the HPV vaccine
- VAX-TDAP/NOM 22.4: Percent of adolescents, ages 13-17, who have received at least one dose of the Tdap vaccine
- VAX-MEN/NOM 22.5: Percent of adolescents, ages 13-17, who have received at least one dose of the meningococcal conjugate vaccine
- TB/NOM 23: Teen birth rate, ages 15-19, per 1,000 females
- AWV.2/ESM 10.2: Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years

Objectives:

- By September 30, 2025, increase percentage of youth who complete an annual EPSDT visit
- By September 30, 2025, increase HPV vaccination rate among youth 9-13 years and 14-17 years

Strategy: *Provide professional development opportunities for healthcare professionals to learn about best practices in teen-friendly care*

Activity:

- Partner with internal and external partners to disseminate professional development to healthcare professionals about teen-friendly health practices

Strategy: *Collaborate on health promotion activities, health observances, and other outreach/engagement*

strategies to increase awareness of adolescent health issues and preventative care and the importance of medical homes

Activities:

- Collaborate with the Office of Communications to promote national and state messaging related to adolescent health issues to prepare social media post schedules and templates for observance months/days
- Collaborate with the Mississippi Department of Education's Offices of School Nutrition and Healthy Schools to disseminate information about the importance of medical homes and preventative care, including vaccinations, for adolescent health

Strategy: *Educate transitioning youths and their families about accessing adult care, healthcare coverage options, health literacy, and self-advocacy*

Activities:

- Provide education to young adults on healthcare coverage options and coverage literacy
- Provide education to parents and caregivers to encourage them to share decision making responsibilities with their youth and teach them advocacy skills

PRIORITY: Increase Breastfeeding, Healthy Nutrition and Healthy Weight

NPMs, NOMs, SPM, and ESMs:

- PA-Adolescent/NPM 8.2: Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
- CHS/NOM 19: Percent of children, ages 0-17, in excellent or very good health
- OBS/NOM 20: Percent of children, ages 2-4, and adolescents, ages 10-17, who are obese (BMI at or above the 95th percentile)
- PA-Adolescent.1/ESM 8.2.2: Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide

Objective:

- By September 30, 2025, increase the percent of adolescents, ages 12-17 years who are physically active at least 60 minutes per day

Strategy: *Develop partnerships and work with internal and external partners and schools to complete the School Health Index (SHI) Self-Assessment and Planning Guide*

Activities:

- Identify a School Health Champion at 1 high school or college in each MSDH District.
- Partner with the School Health Champion at 1 high school or college in each MSDH District and provide support for conducting or reviewing the School Health Index (SHI) Self-Assessment according to the Planning Guide

Strategy: *Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of adolescent health issues and preventative care and the importance of medical homes*

Activities:

- Collaborate with the Office of Communications to promote national and state messaging related to adolescent health issues to prepare social media post schedules and templates for observance months/days
- Collaborate with the Mississippi Department of Education's Offices of School Nutrition and Healthy Schools to disseminate information about the importance of physical activity for adolescent health

Strategy: *Provide professional development opportunities for healthcare and education professionals to learn about best practices to promote daily physical activity among adolescents ages 12-17*

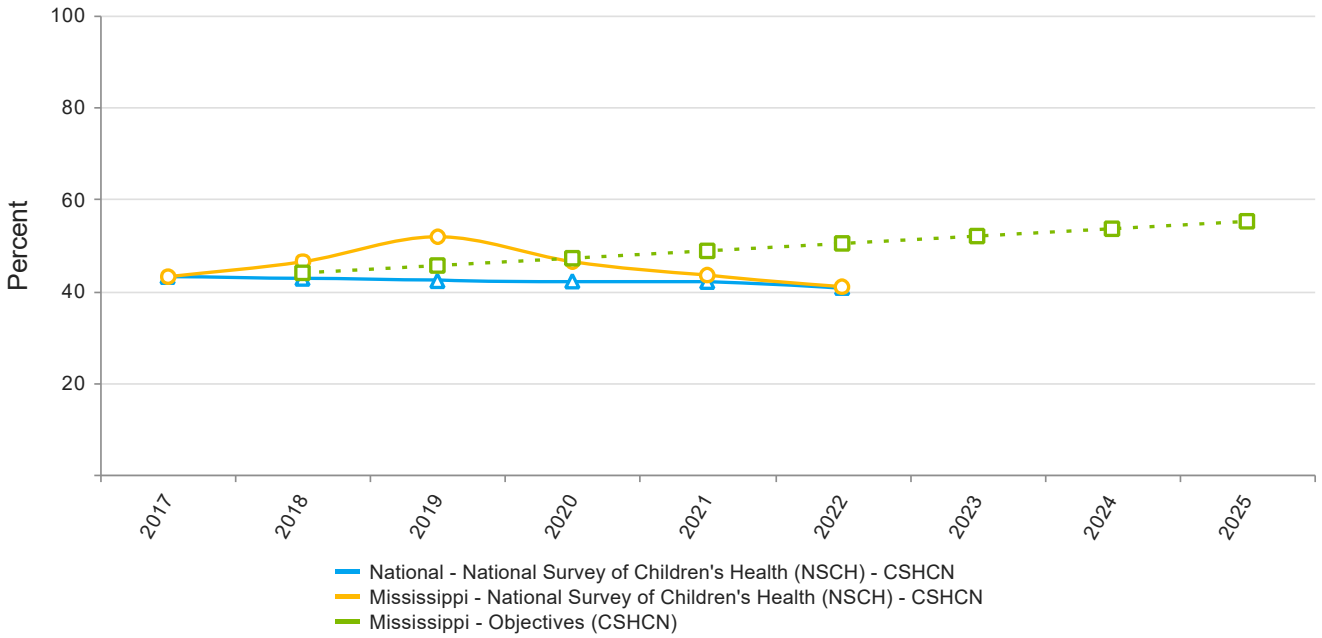
Activity:

- Partner with internal and external partners to disseminate professional development materials to healthcare professionals about best practices to promote daily physical activity among adolescents

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.5	47.1	48.7	50.3	51.9
Annual Indicator	46.9	51.4	46.2	43.2	40.8
Numerator	78,448	82,086	72,719	68,226	64,583
Denominator	167,120	159,664	157,506	157,885	158,168
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	53.5	55.1

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	48	50	52	54	56
Annual Indicator	100	100	0	30	51
Numerator					
Denominator					
Data Source	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	58.0	60.0

State Performance Measures

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			67
Annual Indicator	46.9	40.4	40.8
Numerator	30	23	20
Denominator	64	57	49
Data Source	EPIC	EPIC	EPIC
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	77.0	87.0

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			341
Annual Indicator	310	272	291
Numerator			
Denominator			
Data Source	EPSDT Visits in EPIC	EPSDT Visits in EPIC	EPSDT Visits in EPIC
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	375.0	413.0

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			100
Annual Indicator	100	93.2	90
Numerator	60	2,722	72
Denominator	60	2,922	80
Data Source	Newborn Screening data	MS Newborn screening database and EPIC database	EPIC database
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	100.0	100.0

SPM 18 - Percent of children with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			17.2
Annual Indicator	16.2	15.4	12.4
Numerator	8,954	9,208	8,155
Denominator	55,176	59,681	65,978
Data Source	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	18.2	19.2

State Action Plan Table

State Action Plan Table (Mississippi) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Assure Medical Homes for Children and Youth With/Without Special Health Care Needs	
NPM	
NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	
Five-Year Objectives	
By September 30, 2025, increase the percentage of CYSHCN who receive care coordination services by 10%	
Strategies	
Ensure the delivery of high-quality care coordination services across the state through alignment of practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) in internal and partnering MCH programs, including in FQHCs and specialty clinics	
Provide education to CYSHCN and families on the importance of medical homes, family-centered care, healthcare coverage options, and health literacy	
Work with internal and external partners to increase referrals to home visiting/care coordination programs	
ESMs	**Status**
ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care	Active
NOMs	
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC	
NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX	
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	
NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC	

State Action Plan Table (Mississippi) - Children with Special Health Care Needs - Entry 2

Priority Need

Assure Medical Homes for Children and Youth With/Without Special Health Care Needs

SPM

SPM 18 - Percent of children with and without special health care needs who received services necessary to make transitions to adult health care

Five-Year Objectives

By September 30, 2025, increase the percentage of CYSHCN participating in home visiting/care coordination programs who have plans for transitioning to adult care in place by age 16 years

Strategies

Ensure the delivery of high-quality care coordination services across the state through alignment of practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) in internal and partnering MCH programs, including in FQHCs and specialty clinics

Educate transitioning youths with special health care needs and their families on accessing adult care, healthcare coverage options, health literacy, and self-advocacy

CYSHCN Domain
Annual Report – FY2023

Activities in this domain were carried out by the following MSDH offices, bureaus, or programs during the reporting period:

- Children and Youth with Special Health Care Needs (CYSHCN) Program
- Early Periodic Screening Diagnosis and Treatment (EPSDT) Program
- Mississippi Early Hearing Detection and Intervention (EHDI-MS) Program
- Mississippi First Steps Early Intervention Program (MSFSEIP)

The following section outlines strategies and activities implemented between 10/1/2022-9/30/2023 to meet the objectives and show improvement on the measures related to child health:

Priority: Assure Medical Homes for C/YSHCN

NPMs, NOMs, SPM, and ESMs:

- Medical Home/NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
- SPM 18: Percent of children with and without special health care needs who received services necessary to make transitions to adult health care
- SOC/NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- MHTx/NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
- CHS/NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
- FHC/NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
- MH.1/ESM 11.1: Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

Objectives:

- By September 30, 2023, increase the percentage of CYSHCN who receive care coordination services by 10%
- By September 30, 2023, increase the percentage of Parent Consultants, a parent of a child with special health care needs who can help parents and caregivers navigate a comprehensive system of care, hired by systems participating in the Cares 2 Initiative to 85%
- By September 30, 2023, increase the percentage of participating CYSHCN Cares 2 healthcare systems with policies to transition youths with special health care needs to an adult provider from to 90%

Strategy: *Maintain Cross Systems of Care Coordination with partners and CYSHCN and families*

Completed Activities:

The Children and Youth with Special Health Care Needs (CYSHCN) Program has maintained a long-standing partnership with several state FQHCs and multiple tertiary clinics by supporting a Care Coordinator to ensure that families are maintaining appointments and/or have access to needed resources. The CYSHCN Program has a long-standing history of partnerships with FQHCs, state flagship hospital, respite providers, and parent training

programs that support the work of the MCH/Title V program by providing essential supports to serve the large population of CYSHCN throughout the state. This support is reflected by supporting a Care Coordinator position for five tertiary clinics in the state flagship hospital that serve high volume CYSHCN. The clinics for some are the medical home and are the physicians that these consumers see most. The University of Mississippi Medical Center (UMMC) Asthma, Hematology, Cardiac, Neurology, and Endocrinology/Diabetes clinics partnerships allow MCH/Title V to expand its capacity to support those in the state that are in most need of care coordination and follow up. The Care Coordinator also assists the consumer in the development of a transition plan from pediatric to adult health care which is an essential component to ensuring proactive care for chronic conditions.

The MCH/Title V CYSHCN program provides similar support via partnerships with the FQHCs by not only funding a Care Coordinator position, but partial funding for a Parent Consultant. These three FQHCs serve some of the states' most rural consumers and those who often lack the resources to get to larger medical facilities. Because of the development of these essential partnerships, it affords the opportunity of the MCH/Title V to increase the capacity to service more Mississippians in an efficient manner and develop more long-term relationships with the community. The three FQHCs, G.A. Carmicheal, Family Health Center, and Central MS Health Center each serve very socially and economically diverse populations expanding the reach of the MCH/Title V internal staff and strengthening the capacity and relationship with the community.

Care Coordinators document, beginning at age thirteen, conversations and supplying of resources to CYSHCN and their family's information regarding healthcare options, assistance with resources. During transition, CYSHCN and their caregivers are also informed about insurance requirements and options, educational resources and supports, including information regarding long-term CYSHCN caregiver planning. The CYSHCN State Family Leader host voluntary monthly parent zoom calls as a forum for parents to discuss concerns that they have experienced with getting financial coverage for their CYSHCN and allows and open opportunity for them to discuss with their peers how they have navigated barriers and provide support to each other in a safe space.

Strategy: *Implement standardized population-based strategies to improve care coordination services and quality reporting*

Completed Activities:
All CYSHCN partners were trained on the reporting template that identifies CYSHCN participates by age categories and identifies which activities are provided monthly for participates and their families to address concerns or improve access to supports. Reports are submitted monthly via REDCap and narrative of activities are also included. Monthly narratives are to include outreach conducted by the Parent Consultants and/or Care Coordinators in the FQHCs to identify CYSHCN in the community what types of resources were provided. It is also to include any specific trainings provided and/or received by the CYSHCN partners that promote the mission of the MCH/Title V grant.

Ongoing care coordination reinforces CYSHCN and families/caregivers' understanding of the diagnosis and compliance with medical treatment and regimen. Ongoing reassessments facilitate health education, additional referrals, stresses the importance of the medical/dental home and tertiary treatment. These activities are also addressed by CYSHCN enrolled in the Early Intervention, Early Hearing Detection and Intervention, and Genetics programs. All contacts with CYSHCN and families/caregivers are documented in the CYSHCN program database, agency electronic health record system of EPIC.

A three-tier approach was designed to effectively meet the continuously changing needs of CYSHCN and families/caregivers. Contacts and home visits are based on the three-tier evaluation/assessment of services required and level of intervention from a multidisciplinary team and the age of the CYSHCN:

Tier I: CYSHCN fall in this tier if:

- The medical condition is mostly stable and requires out-patient care with a primary care physician and visits to a specialist.
- Families/caregivers have the ability to understand, with support, all aspects of childcare needs and understand their role of being involved in the multidisciplinary decision-making process.
- Families/caregivers are capable of managing the continuous change in care that may arise and the identification of appropriate support system needed.
- Educational resources with minimal reinforcement may be required.

Tier II: CYSHCN fall in this tier if:

- Significant primary medical condition that has long-term effects on health is present that requires regular primary care and specialist visits to maintain health. Complications can be anticipated and may involve frequent short hospitalizations and use of medical devices.
- Families/caregivers struggle to understand all aspects of the childcare needs are not always able to be involved in the decision-making process.
- Follow-up may be inconsistent.
- Educational resources and moderate reinforcement may be required to identify appropriate support systems.

Tier III: CYSHCN fall in this tier if:

- Medical conditions are complex and involve major body systems. At least one specialty provider is involved in care. Complications are not always predictable and may require frequent emergency room visits, hospitalizations, and medical devices.
- Families/caregivers experience multiple barriers which impede the team approach.
- Educational resources with significant reinforcement and multiple referrals assist them to identify appropriate support systems.

In addition, the following guidelines were implemented regarding follow-up based on the age of the CYSHCN to provide more intensive supports for the youngest CYSHCN who are most vulnerable and at risk for infant mortality:

Newborn – 6 months of age: minimum monthly affirmative contact with the family and at least one face to face home visit each quarter. This contact assures the parent/caregivers' understanding of the diagnosis and compliance with medical treatment/treatment regimen. Coordinate efforts with other program staff (Newborn Screening, Genetics, HM/HB, Early Intervention, WIC) interacting with the family.

7 months - 12 months of age: minimum monthly affirmative contact with the family and at least one face to face home visit each quarter. Coordinate efforts with other program staff (i.e. Genetics, HM/HB, Early Intervention) interacting with the family.

12 months of age - 24 months of age: minimum monthly affirmative contact with the family and at least one face to face home visit two times yearly to assess establishment of medical home, compliance with medications, appointments at the tertiary center, follow-up to referrals, update/renew assessment, etc.

2 years – 21 years of age: minimum of at least one affirmative contact with the family quarterly and one face to face visit annually to assess establishment of medical home, compliance with medications, appointments, follow-

up to referrals, update/renew assessment, etc.

Strategy: *Provide education to young adults on healthcare coverage options and coverage literacy*

Completed Activities:
Care Coordinators document, beginning at age thirteen, conversations and supplying of resources to CYSHCN and their family's information regarding healthcare options, assistance with resources. The CYSHCN/Adolescent Health program provided literature to community partners that serve low-income users about family planning and establishing healthy living practices, including nutritional choices. Making referrals to the WIC to aid families in supporting nutritional needs of CYSHCN. Through a series of town halls conducted by Teen Health Mississippi and health fairs with Medicaid and managed care providers, families were given information on how to access financial resources to improve their health outcomes, as well as, how to establish and maintain long-term health goals.

Strategy: *Establish and implement protocols/policies for transitioning youths with special health care needs to adult care and adulthood*

Completed Activities:
The MCH/Title V CYSHCN program provides annual training to all its partners around Care Coordination and the value of consistent practices, regardless of where reports are provided. All partnering program directors, care coordinators and parent consultants are required to be present with guidance given by the AMCHP Care Coordination Standards of Practice. This ensures that if CYSHCN moves to a different medical home, the care practice should be similar. It also focuses on the importance of transitioning from pediatric to adult care, not only for the CYSHCN, but for the caregiver as well.

The CYSHCN Program developed policies and procedures that address transition services beginning at age thirteen. Because families are the constant in the CYSHCN life, it is necessary to engage them in taking a leading role in the decision making. Introduce the process to them and if the program is accepted, the families/caregivers should maintain input in the ongoing process.

Early planning and education with CYSHCN and their family/caregiver is vital in developing a life plan. Transition is based on skill level and complexity of illness. Identify readiness to transition and discuss process and formulate a plan. Appropriate adult health care options must be provided in the appropriate setting. Obtain referrals to appropriate adult health care providers and include the provider in the transition process. Good communication throughout this process is vital to a successful transition. The goal is for the CYSHCN to take charge of their health care and therefore lead a productive life.

CYSHCN Domain
Application Year – FY2025

The following section outlines strategies and activities to be implemented between 10/1/2024-9/30/2025 to meet the objectives and show improvement on the measures related to Children and Youth with Special Health Care Needs (CYSHCN):

PRIORITY: Assure Medical Homes for C/YSHCN

NPMs, NOMs, SPM, and ESMs:

- MH/NPM 11: Percent of children with and without special health care needs, ages 0-17, who have a medical home
- SOC/NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0-17, who receive care in a well-functioning system
- MHTX/NOM 18: Percent of children, ages 3-17, with a mental/behavioral condition who receive treatment or counseling
- CHS/NOM 19: Percent of children, ages 0-17, in excellent or very good health
- FHC/NOM 25: Percent of children, ages 0-17, who were unable to obtain needed health care in the past year
- SPM 18: Percent of children with and without special health care needs who received services necessary to make
- MH.1/ESM 11.1: Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

Objectives:

- By September 30, 2025, increase the percentage of CYSHCN who receive care coordination services by 10%
- By September 30, 2025, increase the percentage of CYSHCN participating in home visiting/care coordination programs who have plans for transitioning to adult care in place by age 16 years

Strategy: *Ensure the delivery of high-quality care coordination services across the state through alignment of practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) in internal and partnering MCH programs, including in FQHCs and specialty clinics*

Activities:

- Disseminate the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) with internal and external partners
- Promote the alignment of program policies, procedures, and practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) with internal and external partners

Strategy: *Provide education to CYSHCN and families on the importance of medical homes, family-centered care, healthcare coverage options, and health literacy*

Activities:

- Conduct monthly meeting with CYHCN Care Coordinators, Parent Consultants and Specialty clinic partners about healthcare transition education for both CYHCN and their caregivers

- Invite screening providers to participate in training and education sessions on screening using learning management software (LMS), conferences, workshops, lunch-and-learns, learning communities, and other educational opportunities.
- Provide tailored education and outreach to healthcare professionals to promote medical homes, family-centered care practices, healthcare coverage options, and health literacy

Strategy: *Work with internal and external partners to increase referrals to home visiting/care coordination programs*

Activities:
- Participate in health fairs and other outreach activities to inform public about home visiting and care coordination programs
- Develop and implement an online referral system to increase referrals to and among home visiting/care coordination programs

Strategy: *Educate transitioning youths with special health care needs and their families on accessing adult care, healthcare coverage options, health literacy, and self-advocacy*

Activities:
- Provide education to young adults on accessing adult care, healthcare coverage options, health literacy, and self-advocacy
- Provide education to parents and caregivers to encourage them to share decision making responsibilities with C/YSHCN and teach them advocacy skills

Cross-Cutting/Systems Building

State Performance Measures

SPM 19 - Adolescent suicide rate

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			11.3
Annual Indicator	11.6	10.8	8.7
Numerator			
Denominator			
Data Source	CDC WONDER Multiple Cause of Death Files	Office of Vital Records and Public Health Statisti	Office of Vital Records and Public Health Statisti
Data Source Year	2017-2019	2021	2022
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	11.0	10.6

SPM 20 - Number of MCH programs that have developed a written plan to address health equity

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			3
Annual Indicator	1	3	3
Numerator			
Denominator			
Data Source	MCH program data	MCH program data	MCH program data
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	6.0	9.0

State Action Plan Table

State Action Plan Table (Mississippi) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Improve Access to Mental Health Services Across MCH Populations
SPM
SPM 19 - Adolescent suicide rate
Five-Year Objectives
By September 30, 2025, reduce the percentage of suicide attempts among high school student by 1%
By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities on mental health for MCH workforce, partners, and providers serving MCH populations
Strategies
Promote, provide, sponsor, or facilitate education, training, and reflective supervision on mental health for MCH workforce, partners, and providers serving MCH populations
Engage with Regional Department of Mental Health MAP Teams to coordinate home/community-based services for children and youth with mental health or behavioral disorders at risk of institutional placement
Promote mental health awareness in children, youth, young adults, and families and linkages to resources to support positive mental/behavioral health

State Action Plan Table (Mississippi) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Ensure Health Equity by Addressing Implicit Bias, Discrimination, and Racism

SPM

SPM 20 - Number of MCH programs that have developed a written plan to address health equity

Five-Year Objectives

By September 30, 2025, establish partnerships or collaborations with at least 10 new MSDH program areas, providers, or external organizations and businesses to improve equitable access to services and care

By September 30, 2025, communicate with health care professionals, service providers, and families to address diversity and inclusion across MCH programs

By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities to support providers in delivering culturally and linguistically appropriate healthcare setting.

Strategies

Ensure language access through interpretation for public meetings and service delivery and translation of program materials

Partner and collaborate with internal and external partners, providers, organizations, and businesses across the state to improve equitable access to services and care

Use language, images, graphics, and messaging that is both responsive to diversity and health literacy

Conduct PDSA cycles to improve systems, programs, and outcomes to decrease health inequities

Educate MCH workforce, partners, and providers on implicit bias, discrimination, racism, and implementing culturally and linguistically appropriate practices in healthcare settings.

Cross-Cutting Issues
Annual Report – FY2023

Activities in this domain were carried out by all MSDH MCH offices, bureaus, and programs during the reporting period.

The following section outlines strategies and activities implemented between 10/1/2022-9/30/2023 to meet the objectives and show improvement on the measures related to child health:

Priority: Improve Access to Mental Health Services Across MCH Populations

NPMs, NOMs, SPM, and ESMs:
- SPM 19: Adolescent suicide rate

Objectives:
- By September 30, 2023, partner with a community-based perinatal and postpartum program to provide services to at least 30 women on maternal mental health
- By September 30, 2025, reduce the percentage of suicide attempts among high school student by 1%
- By September 20, 2023, screen 100 youth with special health care needs, ages 12-21, for mental health concerns

Strategy: *Provide Mental Health First Aid training to MSDH health care professionals.*

Completed Activities:

In 2022, the Office of Child and Adolescent Health entered into an agreement with the national Alliance for the Advancement of Infant Mental Health and the newly formed Mississippi Association for Infant Mental Health to support personnel in MCH programs who work directly with families of infants and toddlers with earning endorsement as Infant Family Specialists. In January 2023, all service coordinators, care coordinators, and case managers from home visiting and follow-up programs (e.g., Early Intervention, Healthy Moms/Healthy Babies, Genetics/Newborn Screening, Early Hearing Detection and Intervention, Lead Poisoning Prevention, and CYSHCN) were enrolled in year-long cohorts to receive 10 training modules (4 hours each) and monthly reflective supervision (2.5 hours each) on topics related to the mental health of diverse infants/toddlers and their families. Using the curriculum developed by the Michigan Alliance of Infant Mental Health, national leaders and reflective supervisors provided readings, didactic training, case studies, and discussion on the following ten modules:

- **Relationship Focused Practice**: Overview of the principles of infant mental health, establishment of work relationships, principles of relationship-focused practice, and diversity-informed tenets for working with infants, children and families
- **Informal Assessment, Observation, and Listening**: Practices for conducting informal assessments, including verbal and nonverbal communication, interview techniques, and observation skills to assess children, parents, and their interaction within the family context
- **Pregnancy, Early Parenthood, and Typical Early Development**: Psychology of pregnancy, birth, and recognizing red flags, pregnancy and health inequities, understanding perinatal mood disorders and trauma, postpartum adjustment and the interaction of a baby's temperament and mother's adjustment
- **Secure Attachment**: Theories of attachment from Bowlby and Ainsworth, caregiver qualities, principles of secure attachment, circle of security, Polyvagal theory and social engagement system

- **Atypical Development and Formal Assessment**: Principles of atypical development including developmental delays, regulation disorders of sensory processing, failure to thrive, and significant health concerns, barriers to relationship development, potential attachment barriers for caregivers, and the role of the home visitor
- **Insecure Attachment**: Internal working models of attachment, principles of insecure attachment, including behaviors and emotion regulation with avoidant and ambivalent/resistant attachment, adult attachment types, connection between attachment and therapy
- **Separation, Trauma, Grief, and Loss**: Theories of loss and separation from Bowlby, stages of separation and loss, relationship-based work to address separation and loss, trauma and Adverse Childhood Experiences (ACEs), impacts of trauma on health, behavior, emotions, cognition, and self-concept, risk and protective factors, trauma treatment for children, families
- **Focusing on Intervention: Use of Tools and Techniques (2-Part module)**: Foundations of culturally-sensitive interventions for building alliance and working relationships, meeting material needs and advocacy, providing developmental guidance, and encouraging social supports and life coping skills
- **Reflective Supervision, Termination, and Pulling It All Together**: Connecting home visitor personal/emotional responses to families and family response to their children, parents personal/emotional responses to challenges, core processes of reflective supervision/consultation, termination of home visitation and therapeutic intervention, challenges to termination, next steps for home visitors to complete credentialing and maintain learning

On January 10, 2023, the first wave began as a cohort of 22 personnel from Early Intervention, Healthy Moms/Healthy Babies, Genetics/Newborn Screening, Early Hearing Detection and Intervention, Lead Poisoning Prevention, and CYSHCN programs, including 5 individuals who were identified to complete a "Train-the-Trainer" course of study with external trainers as the state did not have credentialed trainers to lead the modules and provide reflective supervision. In January 19, 2023, the second wave began as a cohort of 41 personnel from Early Intervention programs again supported by external trainers who led the modules and provided reflective supervision. A third wave was scheduled to begin January 2024, led by the newly credentialed internal trainers and supported by the external trainers. These internal trainers will be available to train and provide reflective supervision for new staff as they are onboarded and move into programs serving families with young children.

In April and July 2023, 10 personnel from MCH programs, including the CYSCHN Program, WIC, Lead Poisoning Prevention and Healthy Homes, and MCH Engagement Office, participated in a one-day training was provided by Mental Health First Aid USA with support from the Mississippi Department of Mental Health. The curricula focused on supporting teens, young and older adults, and those with diverse lifestyles. Participants were instructed to identify, understand and respond to signs or symptoms of mental health or substance use challenges.

Strategy: *Coordinate and partner with community organizations to provide mental health services to perinatal and postpartum women*

Completed Activities:
The Maternal and Infant Health Bureau (MIHB) and Healthy Moms/Healthy Babies (HM/HB) program maintained an informal partnership with Mom.Me to provide a safe place for mothers to support and uplift one another through the organic bonds of motherhood and access to mental health support and parenting education to participating mothers.

During the project period, the HM/HB program partnered with Mom.Me, a community-based organization that serves to uplift mothers and the struggles of motherhood through peer-led support groups, to enroll 23

participants in their Cares Therapeutic Program. This program offers mental healthcare assessment/treatment support services. In addition, participants received individualized mental health care plans for mothers and families referred. Their devised plans included referrals to specific in-house programs as well as referrals to state and other community-based organizations based on needs.

In addition, the HM/HB program maintained its partnership with the Child Access to Mental Health and Psychiatry (CHAMP) for Moms operated by the University of Mississippi Medical Center (UMMC). The UMMC's CHAMPS for Moms program provides pediatricians, case managers, obstetrician/gynecologists, nurses, social workers access to UMMC mental health professionals to address mothers' perinatal and postnatal mental health challenges. The HM/HB and UMMC CHAMPS for Moms programs routinely share referrals between the programs, as appropriate. During the program year, the HM/HB program expanded their engagement by serving as a participant in stakeholder meetings with UMMCH CHAMPS program and providing education about perinatal and postpartum services to six substance use/mental health facilities across the state who accept pregnant women and parenting women with small children.

Strategy: *Support policy and partnerships to promote youth mental or behavioral health in schools and community.*

Completed Activities:
In 2022, the Office of Child and Adolescent Health and the CYSHCN/Adolescent Health program formed a formal partnership with Teen Health Mississippi (THMS), a community-based organization dedicated to building capacity within youth and communities to attain equitable health outcomes. During the Summer 2023, THMS conducted multiple focus groups with key constituent groups to (1) identify adolescent attitudes towards healthcare and how to minimize barriers and improve access to integrated health services and (2) understand, from a healthcare provider perspective, what barriers existed for teens accessing services and why. Using a health equity lens, the focus group questions were developed to elicit information about any biases that were perceived, from the points of view of both youth receiving services and providers engaged in their care.

The findings from the focus groups and recommendations for interventions were reported in *Beyond the Bias: Empowering Youth Through Equitable Healthcare: Addressing Implicit Bias in Healthcare to Enhance Access and Support for Youth*.

See Adolescent Health-Improve Access to Care for more detailed information about this effort.

Strategy: *Promote mental health awareness amongst CYSHCN families and improve access to resources*

Completed Activities:
The Children and Youth with Special Health Care Needs (CYSHCN) Program has maintained a long-standing partnership with several state FQHCs, tertiary clinics, the state hospital, respite providers, and parent training programs to support the work of the MCH/Title V program for children and adolescents. The Care Coordinators, including those with the MSDH and those funded in partnerships with FQHCs and tertiary clinics are provided information and resources to support mental health of CYSHCN and their families as an essential component to ensuring proactive care for chronic conditions.

Families are provided access to respite services through a partnership with Mississippi Families for Kids. Respite services provide families, based on their needs, up to six hours per visit of home care for their CYSHCN and up to two additional minor children, so families/caregivers can attend to their personal matters (e.g., address

financial or legal matters), complete work assignments, or just have an emotional break from the burden of providing constant care. The number of visits a family may receive depends upon the unique needs of the family in consultation with their assigned care coordinator.

PRIORITY: Ensure Health Equity by Addressing Implicit Bias, Discrimination, and Racism

NPMs, NOMs, SPM, and ESMs:

- SPM 20: Number of MCH programs that have developed a written plan to address health equity

Objectives:

- By September 30, 2023, continue collaboration with the Office of Policy Evaluation, Health Equity, and Government Relations to educate providers on promoting a culturally and linguistically appropriate healthcare setting
- By September 30, 2023, develop and implement MCH Workforce Development policies regarding professional development for the MSDH Title V and Health Service program staff and subgrant partners to include topics of implicit bias, discrimination, diversity, inclusion, and racial equity
- By September 30, 2023, collaborate with national leaders to identify 3 professional development offerings on implicit bias, diversity, inclusion, and racial equity
- By September 30, 2023, establish partnerships or collaborations with at least 10 new MSDH program areas, providers, or external organizations and businesses to improve equitable access to services and care
- By September 30, 2023, address birth equity in all MSPQC Quality Improvement Initiatives, AIM initiatives, and the Maternal Mortality Reviews
- By September 30, 2023, develop and implement plans to communicate with health care professionals, service providers, and families to address diversity and inclusion in the EHDI system

Strategy: *Explore resources for translating program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information*

Strategy: *Use language, images, graphics, and messaging that is both responsive to diversity and health literacy*

Completed Activities:

In 2022, the Office of Child and Adolescent Health collaboratively created guidelines for brochures and educational materials for parents and stakeholders considering language access, health literacy, and equity. Throughout 2023, MCH Programs revisited their brochures and worked with the Office of Communications to create and update education materials to align better with these guidelines and promote health for all families served. This included updating images to include a variety of races, ethnicities, abilities, genders, etc. Materials were also to be translated in Spanish, Vietnamese, and other languages as needed to promote linguistic inclusiveness and health equity.

In 2022, the Genetics/NBS Program reviewed and revised their brochures and educational materials for parents and stakeholders on newborn screening and screens added to the Recommended Universal Screening Panel (RUSP) developed through MSDH Office of Communications. These resources were translated into Spanish and provided on the MSDH website: https://msdh.ms.gov/page/41,0,101,86.html.

During the project period, the MIHB program provided resources to Healthy Birthday, Inc. to translate English *Count the Kicks* literature to Spanish. Spanish literature and resources were provided through the website and

printed materials: https://countthekicks.org/order-materials/store/?state=MS. The MIHB was purposeful in developing culturally appropriate literature for communities throughout the state.

The Office of Oral Health has all our commonly used operating forms translated into Spanish and Vietnamese: http://msdhweb/intranet7/links.aspx.

The CYSHCN Program has all its promotional material translated in both Spanish and Vietnamese. Care Coordinators also have access to a language line to assist with any other languages.

Early Intervention partnered with MSDH Office of Health Equity to have all its documents translated in Spanish and Vietnamese. The Program also uses the CDC's *Learn the Signs. Act Early.* materials which are culturally appropriate and have been translated into Spanish and Vietnamese as part of our outreach campaign.

Strategy: *Ensure MCH workforce and subgrant partners receive training on implicit bias, discrimination, and racism*

Strategy: *Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and sub-recipient staff*

Completed Activities:
During the report period, in depth trainings with medical facilities were conducted statewide to increase knowledge, awareness, and skills for reducing the impact of bias, racism, and discrimination in maternity care. The trainings were tailored to medical providers (i.e. physicians, nurses, social workers, etc.).

During Spring and Fall 2023, three meetings were conducted with Six Dimensions to provide workforce training with modules to address implicit bias, discrimination, diversity, inclusion, and race equality in the workplace, and in partnering facilities that serve families. MSDH Health Services Directors and employees participated to receive education and training to address implicit bias, discrimination, diversity, inclusion, and race equality. A series of workshops are to come for the next 2 years. Results reveal vulnerabilities in the workplace and provided examples of possible infractions that can occur when providing patient care.

The series is designed to apply strategies that will promote equality and equality and eliminate workplace and patient care discrimination and provide an atmosphere of equity and inclusion and evaluate opportunities that build strong relationships and encourage self-advocacy, successful disease self-management, and family centered care.

Strategy: *Identify opportunities for partnerships and collaboration with internal and external partners, providers, organizations, and businesses across the state to improve equitable access to services and care*

Strategy: *Partner with national organizations to provide training, assessments, and technical assistance in building a strategic plan to address birth equity*

Completed Activities:
During the reporting period, the MIHB partnered with the American College of Obstetricians and Gynecologists (ACOG), Alliance for the Innovation on Maternal Health (AIM), Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA) to address various components of birth equity. In turn, the resources and information received were communicated to local partners.

The Office of Child and Adolescent Health established a contract with St. Jude Research Hospital to increase professional health knowledge. On June 13-15, 2023, in-person regional workshops were hosted by the MSDH with internal and external nurses, hospital professionals, provider network, specialist, physicians, mid-level providers (PA's and NP's), nursing/social work care coordinators, academic coordinators, child life specialists, genetics counselors, nutritionists, SCD patients, family members, and community members. This regional training focused on Sickle Cell Disease (SCD) and trait counseling education, appropriate identification and risk, and family-centered strategies for treatment and management.

In addition, the Genetics/NBS and CYSCHN programs collaborated with UMMC, EPIC, and Genetics ECHO committee to collaborate in discussion of Genetic Screening data, Birth Defects data, provide educational opportunities, receive related recommendations and educational updates in Genetics Counseling, etc.

The Genetics/NBS program further partnered with St. Jude and PerkinElmer/Revvity to discuss, plan, and actively address birth equity specifically in Mississippi. In 2022-2023, PerkinElmer/Revvity and EPIC staff provide ongoing trainings, and updates to increase database knowledge and improvements and eliminate bias and improve health equality.

In June 2023, regional workshops were conducted throughout the state, on SCD education and trait counseling. An agenda, with educational materials and training was provided on SCD, trait counseling, social determinants, inheritance patterns, inequities, etc. SCD trait counseling education is geared to educate families about Sickle Cell Disease, trait inheritance counseling, family planning, and promote family centered advocacy and care within 100% MSDH health departments and throughout the community.

Genetics/NBS personnel attended several national conferences, including the 2023 Sern/Sergg, CDC NBDD, and National CMV conference to discuss Genetics related updates and partner in planning continuous improvements. In addition, personnel attended virtual webinars provided by HRSA that offered professional development on diversity and inclusion.

Strategy: *Support quality improvement and evaluation efforts to improve systems, programs, and outcomes and decrease health inequities*

Completed Activities:
During the reporting period, MIHB was funded by AIM to support quality improvement efforts for birthing hospitals participating in the program.

Strategy: *Convene a workgroup of stakeholders to develop a diversity plan for EHDI-MS*

Completed Activities:
Note: This work was completed in 2021 and documented in the FY22 report.

The Early Hearing and Detection Intervention (EHDI) program established an Inclusion and Diversity Plan. The purpose of this plan is to promote and foster a culture that values diversity, equity, and inclusion throughout the EHDI program and the diverse communities that the program serves.

The Family Engagement work group, including family members and adults who were Deaf/Hard of Hearing (DHH), prepared this plan[1]. The plan provided agreed upon definitions for diversity, equity, and inclusion. The

state infrastructure and data were analyzed to identify health disparities, the most significant of which was geographic. Based on these analyses, the following recommendations were made:

1. Commit to diversity in leadership, culture and climate, recruiting and hiring, training and professional development, and service delivery
    a. Identified working partners and targets for community collaboration
2. Be intentional with images and language to be more inclusive, including general guidance around communications, images, and how to address ability/disability, mental/behavioral health, race/ethnicity/nationality, and sexual orientation/gender identity/gender expression
    a. Considerations to improve inclusivity and cultural responsiveness in communications
3. Implement efforts to increase access to timely and equitable diagnostic services across the regions
    a. Presented and shared with advisory committee
    b. Implemented efforts throughout rest of the year – reviewed materials to update as needed to be more inclusive, reviewed letters to be more responsive, discussed how to address geographic disparities in service provision.

Throughout the project period, the EHDI worked to implement these recommendations in its materials, hiring practices, and promotion of services.

New Strategy: *Provide support and education to MCH Title V regional and central office staff, and interagency staff on planning and implementing MCH programs with attention to racial equity and upstream factors*

Completed Activities:

With Health Services, the MCH Engagement and Coordination Office hosted various webinars on topics of diversity and racial equity, including the following:

- Declaring Racism as a Public Health Crisis
- Best Practices in Public Health Communications to Promote Equity and Inclusion
- Mindfulness as a Support for Healing Conversations and Actions Toward Social Justice and Equity
- Cross Cultural Communication, Cognition and Language
- Ensuring the Data System used for Public Health Centers Equity and Well-Being
- Race as a Social Construct in Data and Practice
- Health Equity Action Summit – Addressing Digital Health Equity
- Exploring the Maternal Experience: Addressing Racism and Informing New Models of Maternal Care to Promote Health Equity
- Creating Excellent CX: The Need for Updated Customer Service Management
- How to Measure Your Customer Experience

In addition, the MCH Engagement and Coordination Office partnered with the MSDH Office of Health Equity to host a five-module series to develop the capacity to communicate a social, economic, and environmental approach to health experiences and outcomes. The series included:

- **Module 1: What is Health Equity 101:** Introduction to health equity discussing principles, key concepts, and applications using a broad definition of health. (70 participants)
- **Module 2: Defining Social Determinants of Health:** Discuss non-medical factors that influence health outcomes reflecting on how conditions of power shape inequities. (61 participants)
- **Module 3: Title VI Compliance:** Explore Language Access as a determinant of health for individuals with Limited English Proficiency (49 participants)
- **Module 4: Navigating Differences through Cultural Competency:** Promote respect and understanding of diverse cultures, backgrounds, and individual life experiences. (51 participants)

- **Module 5: Cultural Inclusion and Unconscious Bias:** Create empathy and understanding of how actions and words can be perceived by reducing bias. (61 participants)

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[1] Source: https://msdh.ms.gov/page/41,0,174,833.html

Cross-Cutting Issues
Application Year - FY2025

The following section outlines strategies and activities to be implemented between 10/1/2024-9/30/2025 to meet the objectives and show improvement on the measures related to cross-cutting issues:

PRIORITY: Improve Access to Mental Health Services Across MCH Populations

NPMs, NOMs, SPM, and ESMs:

- SPM 19: Adolescent suicide rate

Objectives:

- By September 30, 2025, reduce the percentage of suicide attempts among high school student by 1%
- By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities on mental health for MCH workforce, partners, and providers serving MCH populations

Strategy: *Promote, provide, sponsor, or facilitate education, training, and reflective supervision on mental health for MCH workforce, partners, and providers serving MCH populations*

Activities:

- Identify and share professional development opportunities on the MCH Engagement and Coordination Office Professional Development Opportunities Calendar for internal and external stakeholders
- Provide access to training and reflective supervision for MSDH Care/Service Coordinators and Public Health Social Workers who work with programs serving infants and toddlers and their families to earn the Infant Family Specialist Credential from the Alliance for Infant Mental Health.
- Provide access to training and reflective supervision for home visitors on evidence-based practices to support the mental health of MCH populations

Strategy: *Engage with Regional Department of Mental Health MAP Teams to coordinate home/community-based services for children and youth with mental health or behavioral disorders at risk of institutional placement*

Activity:

- Identify home/community-based resources for children and youth with mental health or behavioral disorders to support their health and wellbeing as part of a comprehensive plan to prevent institutional placement.

Strategy: *Promote mental health awareness in children, youth, young adults, and families and linkages to resources to support positive mental/behavioral health*

Activity:

- Identify and compile mental health resources for pregnant/parenting women and families for the Mississippi Access to Maternal Assistance (MAMA) for a one-stop website and mobile app
- Develop and maintain local resource/referral directories with internal and external partners to collaborate on improving mental health awareness and resources for MCH populations
- Early Intervention families will be provided mental/behavioral resource and services based on a multi-disciplinary evaluation and family needs

PRIORITY: Ensure Health Equity by Addressing Implicit Bias, Discrimination, and Racism

NPMs, NOMs, SPM, and ESMs:

- SPM 20: Number of MCH programs that have developed a written plan to address health equity

Objectives:

- By September 30, 2025, establish partnerships or collaborations with at least 10 new MSDH program areas, providers, or external organizations and businesses to improve equitable access to services and care
- By September 30, 2025, communicate with health care professionals, service providers, and families to address diversity and inclusion across MCH programs
- By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities to support providers in delivering culturally and linguistically appropriate healthcare setting

Strategy: *Ensure language access through interpretation for public meetings and service delivery and translation of program materials*

Activities:

- Collaborate with the Office of Communications to ensure all educational materials, guidance, and resources for families are translated
- Collaborate with the Office of Health Equity to provide interpretation during public meetings and service delivery

Strategy: *Partner and collaborate with internal and external partners, providers, organizations, and businesses across the state to improve equitable access to services and care*

Activities:

- Establish a new partnership agreement focused on improving equitable services and care for populations experiencing health disparities
- Identify 3-4 potential healthcare settings, community-based, faith-based, social, volunteer service organizations, homeless/domestic violence shelters, residential programs, treatment programs, housing complexes, etc. to outreach per quarter

Strategy: *Use language, images, graphics, and messaging that is both responsive to diversity and health literacy*

Activity:

- Use the guidance document developed by the Office of Child and Adolescent Health to ensure all new materials have had their language, image, graphics, and messaging reviewed to ensure they will be accessible and appropriate for use with diverse populations.

Strategy: *Conduct PDSA cycles to improve systems, programs, and outcomes to decrease health inequities*

Activity:

- Analyze program data on enrollments and/or service utilization to identify areas or populations of need to be addressed collectively through program improvement or development

Strategy: *Educate the MCH workforce, partners, and providers on implicit bias, discrimination, racism, and implementing culturally and linguistically appropriate practices in healthcare settings*

Activities:

- In partnership with community-based organizations, provide training for MCH professionals on teen-friendly care, particularly for culturally and linguistically diverse populations experiencing health disparities (e.g., individuals with disabilities, people of color, LGBTQ youth)
- In partnership with community-based organizations, provide training for MCH professionals on birth conditions and ongoing disease management through the provision of family-center care and best practices to promote health equity.
- Identify and share professional development opportunities on the MCH Engagement and Coordination Office Professional Development Opportunities Calendar for internal and external stakeholders

III.F. Public Input

The Mississippi MCH Title V Program has implemented various mechanisms to solicit public input, not only during the statewide needs assessment process, but also during ongoing MCH-related activities, including sharing during public meetings with advisory boards and committees and posting reports and applications on the agency website and opportunities to submit feedback via an online form and by phone.

The MCH Advisory Board serves as a critical venue for providing feedback to the Title V Program on planned activities and implementation. The Maternal and Child Health Advisory Board assists all MCH programs by: reviewing the development, implementation, and adoption of programs, policies, and strategies to ensure integration across agencies and systems; advising on methods of integration at the local and state level; advising use of block grant funds to address needs in local communities based on state measures and supported by data; and assisting in the development of information on MCH services and activities to ensure information is created in a culturally, literacy-level, and linguistic manner. In addition, some MCH programs also have program-specific advisory boards or committees based on federal or state requirements. (See *Family Partnership* for more information)

One main way opportunity for the public to learn about the MCH Block Grant and provide input is on the dedicated MCH Block Grant webpage on the agency website (https://msdh.ms.gov/page/44,0,407,1017.html). Embedded within the page is a book for feedback, including the statement, "*Your input is important. We want to hear from you about maternal and child health needs, the MCH Block Grant, and programs in Mississippi. Take a moment to share your comments, ideas, and concerns with us.*" Submission of an email address with comments is optional for individuals who wish to receive a reply. All comments are immediately sent to the MCH Block Grant/Health Service Director. During the 2023 reporting year, there were 466 hits to the State Title V website. In addition, 21 Health Service programs provide the following language on their webpage: *For more information about Maternal and Child Health Programs and the MCH Block Grant, call 1-800-721-7222*." In reporting year of 2023, the 1-800 number received 520 calls.

Through these approaches, the MCH Title V program provides two-communication between programs and the populations that they serve as well as establish an environment within the agency and outside the agency to support family and consumer engagement that will allow our programs to provide resources and services to MCH populations that are both beneficial and relevant to their needs.

III.G. Technical Assistance

As the MSDH, Division of Health Services, and Title V/MCH Program has experienced changes in leadership and has begun restructuring, the following technical assistance is desired to strengthen the agency and MCH programs:

Increase Data-Driven Decision-Making
During the MCH Needs Assessment year, we would like to focus on empowering directors and managers to use key metrics and data for program decision-making. The MSDH Title V/MCH Program requests support for enhancing the knowledge and skills of program directors for data-driven decision-making.

Adolescent Health and Engaging Youth to Center Lived Experiences
The MSDH Title V/MCH Program will be growing an adolescent health unit under Dr. Whitt, such as including teen advisory boards modelled after other states. The MSDH Title V/MCH Program requests connection with states with strong adolescent health programs.

MCH Finances
The MSDH Title V/MCH Program has had some difficulty tracking MCH finances and compiling match dollars as these funds a recorded on multiple budgets throughout the agency. Our state accounting system, MAGIC, does provide timely reports of expenditures; however, the system does not currently have coding allowing for the sensitive disaggregation funding as needed for new report requirement easily. Further, given the new required Form 7, the MSDH needs support for establishing procedures for tracking personnel positions (i.e., existing, new, vacant, eliminated positions) paid using MCH and MCH-match funding.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Combined BAA-IAA btwn MSDH-DOM.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Attachment 1-Regional and Program Maps.pdf

Supporting Document #02 - Attachment 2-Additional Success Stories FY23-FY25.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - VI. Organizational Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Mississippi

	FY 25 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,738,802	
A. Preventive and Primary Care for Children	$ 2,921,641	(30%)
B. Children with Special Health Care Needs	$ 2,921,641	(30%)
C. Title V Administrative Costs	$ 973,880	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,817,162	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,028,134	
5. OTHER FUNDS (Item 18e of SF-424)	$ 6,130,968	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 145,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 7,304,102	
A. Your State's FY 1989 Maintenance of Effort Amount $ 6,576,655		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 17,042,904	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 94,229,078	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 111,271,982	

OTHER FEDERAL FUNDS	FY 25 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 435,947
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 420,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 666,666
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,038,018
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,100,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 4,417,559
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 300,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 76,661,620
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 683,636
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 200,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Infrastructure	$ 3,870,632

	FY 23 Annual Report Budgeted		FY 23 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,272,183 (FY 23 Federal Award: $ 9,738,802)		$ 9,738,802	
A. Preventive and Primary Care for Children	$ 2,781,655	(30%)	$ 2,950,323	(30.2%)
B. Children with Special Health Care Needs	$ 2,781,655	(30%)	$ 2,941,716	(30.2%)
C. Title V Administrative Costs	$ 927,218	(10%)	$ 885,346	(9.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,490,528		$ 6,777,385	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 731,224		$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,095,262		$ 1,821,870	
5. OTHER FUNDS (Item 18e of SF-424)	$ 3,871,552		$ 5,328,005	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,256,100		$ 154,227	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 6,954,138		$ 7,304,102	
A. Your State's FY 1989 Maintenance of Effort Amount $ 6,576,655				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 16,226,321		$ 17,042,904	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 113,758,690		$ 40,601,553	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 129,985,011		$ 57,644,457	

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 3,314,750	$ 1,662,526
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 300,000	$ 271,174
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 300,000	$ 255,623
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 4,417,559	$ 2,318,137
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 258,453
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 92,664,998	$ 33,468,737
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 736,470	$ 732,374
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,989,913	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants		$ 279,176
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program		$ 3,921
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start		$ 184,445
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program		$ 104,089

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)		$ 330,524
Department of Justice > Other > Comprehensive Opioid Abuse Site Program (COSSAP)	$ 6,000,000	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive Opioid Overdose Reduction Program (CORP)	$ 800,000	$ 0
US Department of Agriculture (USDA) > Food and Nutrition Services > Infrastructure		$ 732,374

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Budget base on prior year award. These funds are budgeted to MCH Block Grant-_ Child Health. Grant # 10721 Internal Order # 3000035714 B51O	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Budget base on prior year award to MCH Block Grant - Children w/Special Health Care Needs. Grant # 10722 Internal order 3000035715 C51O	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Budget based on total expenditure budgeted 10% which is administer by our Finance and Accounting Department	
4.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: 003S Local County offices funds This is a cumulative total of all counties each county is responsible for the budgeting and spending of their funds generated	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**

	Field Note: 08PS Perinatal Risk Management (Medicaid) reimbursement 93% 007S Genetic Screening Fee (Newborn Screening Fees) 93%	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: 059S EPSTDT Screening & Follow-up Fees	
7.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Fund expended under award # B04MC47427 ending 9/30/2024 Grant # 9895 Internal Order 3000033530 MCH Block Grant -Child Health	
8.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Funds was expended on grant award # B04MC47427 ending 9/30/2024 grant # 9896 Internal order # 3000033392 MCH Block Grant - Children w/Special Health Care Needs	
9.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Based on actual expenditures spent on the 3 programs calculated and charged by Office of Finance and Accounting	
10.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: These funds are obligated to be spent by 9/30/2024	

11.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**

Field Note:
These are fund that was generated and expended out in the local county office

003S Local Funds Grant # 5399 Internal order 3000021377

The county also receives Funds for the local counties base on population and appropriation per capital. The combined total for all counties is $7,549,091 these amounts are not used the formular for our match

12.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**

Field Note:
Funds expended using 007S (Genetic Screening Fees) $3,100,707and 08PS (Perinatal Risk Management (Medicaid) funds $2,227,349 only use 93% of each funds expended

13.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**

Field Note:
These are income that was generated from our (EPSDT Screening & Follow-up grant
08PS grant # 5418 Internal Order 3000021366

14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**

Field Note:
Mississippi Breast, Cervical, and other Cancer Control Program
Award # 5 NU58DP007129
Budget Period 6/30/2023 - 6/29/2024
CFDA # 93.898

068N

15.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)**

	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Mississippi Breast, Cervical, and Other Cancer Control Program Award # 5NU58DP007129 Budget Period 6/30/2023 - 6/29/2024 CFDA # 93.898 B68N	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Preventing Maternal Deaths: Supporting Maternal Mortality Review Committee in MS Award # 5 NU58SP006696 Budget Period 9/1/2023 9/29/2024 CFDA # 93.478 212M	
17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Mississippi WISEWOMAN Program Award # NU58DP007661 Budget Perion 9/30/2023 - 9/29/2024 CFDA: 93.436 296M	
18.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**

	Field Note: Maternal, Infant and Early Childhood Homevisiting Grant Program Award # X10MC49102 Budget Period 4/1/2023 - 9/29/2024 CFDA # 93.870 282M	
19.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Healthy Start Initiative=Elimination Racial/Ethnic Disparities Award # H49MC52119 Budget Period 9/30/2023 - 9/29/2024 CFDA # 93.926 293M	
20.	**Field Name:**	**Other Federal Funds, US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Infant & Toddlers/Families (Part C) Award # H181A220334 Budget Period 7/1/2022 = 9/30/2024 CFDA # 84.181A 004O	
21.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**

	Field Note: MS Lead Poisoning Prevention and Healthy Homes Award # NUE2EH001427 Budget Period 9/30/2023 - 9/29/2024 CFDA # 93.197 077N	
22.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Universal Newborn Hearing Screening and Intervention Award # H61MC00052 Budget Period 4/1/2023 - 3/31/2024 CFDA # 93.251 055N	
23.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Alliance for Innovation on Maternal Health State Capacity Program Award # A30MC49995 Budget Period 9/1/2023 - 8/31/2024 CFDA # 93.110 298M	
24.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures as of 6/14/2024 Mississippi Breast, Cervical, and other Cancer Contral Program Cfda # 93.898 068N	
25.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 6/14/2024 Preventing Maternal Deaths: Supporting Maternal Mortality Review Award # NU58DP006696 Cfda 93.478 212M	
26.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 6/14/2024 MS Lead Poisoning Prevention and Healthy Homes Award # NUE2EH001427 cfda: 93.197	
27.	**Field Name:**	**Other Federal Funds, US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 6/14/2024 Infant & Toddlers/Families (Part C) Cfda 84.181A 004O	

28.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 6/14/2024 Universal Newborn Hearing Screening Award # H61MC00052 cfda 93.251 055N	
29.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: No Longer have this grant	
30.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 6/14/2024 Maternal, Infant and Early Childhood Homevisiting Grant (MIECHV) Award # X10MC49102 Cfda 93.870 282M	
31.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures as of 6/14/2024 Alliance for Innovation on Maternal Heath State Capacity Award # A30MC49995 cfda 93.110 298M	
32.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 6/14/2024 Healthy Start Initiative-Elimination Racial/Ethnic Disparities Award # H49MC52119 cfda 93.926 293M	
33.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 6/14/2024 Mississippi WiseWoman Adward # NU58DP007661 cfda 93.436 296M	
34.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures as of 6/14/2024 Mississippi Breast, Cervical, and other Cancer Control Program Award # NU58DP007129 cfda 93.898 B68N	
35.	**Field Name:**	**Other Federal Funds, Department of Justice > Other > Comprehensive Opioid Abuse Site Program (COSSAP)**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: No longer have this grant in the Office of Health Services	
36.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive Opioid Overdose Reduction Program (CORP)**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: No longer have this grant in the Office of Heatlh Services	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Mississippi

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 2,921,640	$ 2,961,417
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 2,921,641	$ 2,950,323
4. CSHCN	$ 2,921,641	$ 2,941,716
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 8,764,922	$ 8,853,456

IB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 1,471,728	$ 1,471,728
2. Infants < 1 year	$ 4,317,786	$ 4,317,786
3. Children 1 through 21 Years	$ 695,819	$ 695,819
4. CSHCN	$ 818,769	$ 818,769
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 7,304,102	$ 7,304,102
Federal State MCH Block Grant Partnership Total	$ 16,069,024	$ 16,157,558

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: 30% base on what was awarded for FY23 grant award	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: 30% budget base on what was awarded on FY23 grant award	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: 30% budget is based on what was awarded foy FY23 grant award	
4.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: This is a projection budget base on what allotted for matching on the FY23 grant award. Funds to be used will be Genetic Screening Fee, Perinatal Risk Management (Medicaid), Health Department Local County office funds, and State General Funds, if needed	
5.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: This is a projection budget base on what allotted for matching on the FY23 grant award. Funds to be used will be Genetic Screening Fee, Perinatal Risk Management (Medicaid), Health Department Local County office funds, and State General Funds, if needed	
6.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**

	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: This is a projection budget base on what allotted for matching on the FY23 grant award. Funds to be used will be Genetic Screening Fee, Perinatal Risk Management (Medicaid), Health Department Local County office funds, and State General Funds, if needed	
7.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: This is a projection budget base on what allotted for matching on the FY23 grant award. Funds to be used will be Genetic Screening Fee, Perinatal Risk Management (Medicaid), Health Department Local County office funds, and State General Funds, if needed	
8.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: These expenditures are recorded under MCH Block Grant # 9893 Period ending 9/30/2024	
9.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Children 1 through 21 years has been obligated through 9/30/2024 These expenditures are recorded under MCH Block Grant-Child Health grant # 9895 period ending 9/30/2024	
10.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: CSHCN has been obligated through 9/30/2024 These expenditures are recording under MCH Block Grant-Children w/Special Health Care Needs Grant # 9896 period ending 9/30/2024	
11.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2023**

	Column Name:	**Annual Report Expended**
	Field Note: Administrative cost will be liquidated by 9/30/2024	
12.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures will be liquidated by 9/30/2024	
13.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Local funds 003S grant # 5321 $1,821,870 Gentic Screening Fees (007S) grant # 5326 2,227,349 Perinatal Risk Management (Medicaid) 08PS grant # 5415 3,100,707 20% of total funds expended was on Pregnant Women	
14.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Local funds 003S grant # 5321 $1,821,870 Gentic Screening Fees (007S) grant # 5326 2,227,349 Perinatal Risk Management (Medicaid) 08PS grant # 5415 3,100,707 59% expended was Infant >1 year	
15.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Local funds 003S grant # 5321 $1,821,870 Gentic Screening Fees (007S) grant # 5326 2,227,349 Perinatal Risk Management (Medicaid) 08PS grant # 5415 3,100,707 10% of expended was for Children 1 through 21 years	
16.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2023**

Column Name:	Annual Report Expended

Field Note:
Local funds 003S grant # 5321 $1,821,870
Gentic Screening Fees (007S) grant # 5326 2,227,349
Perinatal Risk Management (Medicaid) 08PS grant # 5415 3,100,707
10% of expenditures was for CSHCN

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Mississippi

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 2,921,642	$ 2,578,322
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 667,797	$ 718,120
B. Preventive and Primary Care Services for Children	$ 1,151,356	$ 947,926
C. Services for CSHCN	$ 1,102,489	$ 912,276
2. Enabling Services	$ 2,921,641	$ 2,724,893
3. Public Health Services and Systems	$ 3,895,519	$ 4,435,587
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Nursing Services		$ 2,578,322
Direct Services Line 4 Expended Total		$ 2,578,322
Federal Total	$ 9,738,802	$ 9,738,802

IIB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 3,102,089	$ 3,102,089
3. Public Health Services and Systems	$ 4,202,013	$ 4,202,013
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 7,304,102	$ 7,304,102

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Based on the 30-30-30 the amount $2,921,642 for each 23% of this amount is budgeted for Primary Care Services	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Based on the 30-30-30 the amount $2,921,642 for each 39% of this amount is budgeted for Primary Care Services for Children	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Based on the 30-30-30 the amount $2,921,642 for each 38% of this amount is budgeted for Services for CSHCN	
4.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Based on amount that was awarded for FY23 grant award	
5.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: budgeted base on what was received on FY23 grant award plus the 10% admin Fee	
6.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**

	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Local funds 003S grant # 5321 $1,821,870 Gentic Screening Fees (007S) grant # 5326 2,227,349 Perinatal Risk Management (Medicaid) 08PS grant # 5415 3,100,707 42% of funds are budget for Enabling Services	
7.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Local funds 003S grant # 5321 $1,821,870 Gentic Screening Fees (007S) grant # 5326 2,227,349 Perinatal Risk Management (Medicaid) 08PS grant # 5415 3,100,707 48% of funds are budgeted for Public Health Services & Systems	
8.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Out of All three grants MCH Block (9893) / MCH Block-Child Health (9895) / MCH Block Grant - Children w/Special Health Care Needs (9896) 26% of total expenditures was Direct Service	
9.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures was made off MCH Block grant 9893 of the $2,961,417 of the amount 24% was expended on Women Health direct services	
10.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures was made off MCH Block Grant - Child Heatlh 9895 of the $2,950,323 of the amount 32% was expended on Child Health direct services	

11.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures was made off MCH Block Grant CSHCN grant #9896 of the $2,941,716 of the amount 31% was expended on CSHCN direct services	
12.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Out of All three grants MCH Block (9893) / MCH Block-Child Health (9895) / MCH Block Grant - Children w/Special Health Care Needs (9896) 28% of total expenditures was Enabling Services	
13.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Out of All three grants MCH Block (9893) / MCH Block-Child Health (9895) / MCH Block Grant - Children w/Special Health Care Needs (9896) 46% of total expenditures was Public Health Services and System	
14.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Local funds 003S grant # 5321 $1,821,870 Gentic Screening Fees (007S) grant # 5326 2,227,349 Perinatal Risk Management (Medicaid) 08PS grant # 5415 3,100,707 42% of funds are expended for Enabling Services	
15.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Local funds 003S grant # 5321 $1,821,870 Gentic Screening Fees (007S) grant # 5326 2,227,349 Perinatal Risk Management (Medicaid) 08PS grant # 5415 3,100,707 42% of funds are expended for Public Health Services and System	

16.	**Field Name:**	**IIA. - Other - Nursing Services**
	Fiscal Year:	**2025**
	Column Name:	**Annual Report Expended**

Field Note:
Nurses did all direct services

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Mississippi

Total Births by Occurrence: 33,665 **Data Source Year: 2023**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	33,350 (99.1%)	116	69	69 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis
Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)
Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency
Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy		

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Isobutyrylglycinuria	33,350 (99.1%)	0	0	0 (0%)
Methylmalonic acidemia with homocystinuria	33,350 (99.1%)	0	0	0 (0%)
Malonic acidemia	33,350 (99.1%)	0	0	0 (0%)
2,4 Dienoyl-CoA reductase deficiency	33,350 (99.1%)	0	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	33,350 (99.1%)	0	0	0 (0%)
2-Methylbutyrylglycinuria	33,350 (99.1%)	0	0	0 (0%)
Argininemia	33,350 (99.1%)	0	0	0 (0%)
Benign hyperphenylalaninemia	33,350 (99.1%)	0	0	0 (0%)
Biopterin defect in cofactor biosynthesis	33,350 (99.1%)	0	0	0 (0%)
Biopterin defect in cofactor regeneration	33,350 (99.1%)	0	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	33,350 (99.1%)	0	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	33,350 (99.1%)	0	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	33,350 (99.1%)	0	0	0 (0%)
Citrullinemia, type II	33,350 (99.1%)	0	0	0 (0%)
Galactoepimerase deficiency	33,350 (99.1%)	0	0	0 (0%)
Galactokinase deficiency	33,350 (99.1%)	0	0	0 (0%)

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Glutaric acidemia type II	33,350 (99.1%)	0	0	0 (0%)
Hypermethioninemia	33,350 (99.1%)	0	0	0 (0%)
Medium/short-chain L-3-hyrdroxy ACYL-CoA dehydrogenase deficiency	33,350 (99.1%)	0	0	0 (0%)
Medium-chain ketoacyl-CoA thiolase deficiency	33,350 (99.1%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	33,350 (99.1%)	1	1	1 (100.0%)
T-cell related lymphocyte deficiencies	33,350 (99.1%)	0	0	0 (0%)
Tyrosinemia, type II	33,350 (99.1%)	0	0	0 (0%)
Tyrosinemia, type III	33,350 (99.1%)	0	0	0 (0%)
Various other hemoglobinopathies	33,350 (99.1%)	7	7	7 (100.0%)
3-Methyglutaconic aciduria	33,350 (99.1%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Expanded Hearing Screening	0	0	0	0

4. Long-Term Follow-Up

Regional Genetic Nurses coordinate with local primary care providers and medical subspecialty providers to identify infants with confirmed diagnoses. These children are referred for long-term care coordination (LTCC) through the Healthy Moms/Healthy Babies, Early Intervention, and/or CYSHCN programs depending upon the specific diagnoses and needs. These programs provide LTCC for 1 to 21 years of age when they are transitioned to adult health care. LTCC helps minimize barriers to health care and consists of assessing health care needs (i.e., medical, dental, and specialty medical providers) ; ensuring access to medical coverage or payor source (i.e., insurance, CHIP, or Medicaid) ; Ensuring appropriate well care (e.g., screenings, immunizations) in a medical home; assessing a shared plan of care (e.g., services, medications, or special diets/foods) ; reviewing plans (e.g., transition or emergency/disaster plans) ; and other needs.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2023**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Counts are provisional and may change	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2023**
	Column Name:	**Data Source Year Notes**
	Field Note: The data period is from October 2022-September 2023	
3.	**Field Name:**	**Expanded Hearing Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2023**
	Column Name:	**Older Children & Women**
	Field Note: We are unable to provide a number at this time. The Program is working with the data system vendor to create a report that will assist with reporting this information in the future.	
4.	**Field Name:**	**Expanded Hearing Screening - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2023**
	Column Name:	**Other Newborn**
	Field Note: We are unable to provide a number at this time. The Program is working with the data system vendor to create a report that will assist with reporting this information in the future.	
5.	**Field Name:**	**Expanded Hearing Screening - Total Number Confirmed Cases**
	Fiscal Year:	**2023**
	Column Name:	**Other Newborn**
	Field Note: We are unable to provide a number at this time. The Program is working with the data system vendor to create a report that will assist with reporting this information in the future.	

6.	**Field Name:**	**Expanded Hearing Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2023**
	Column Name:	**Other Newborn**

Field Note:
We are unable to provide a number at this time. The Program is working with the data system vendor to create a report that will assist with reporting this information in the future.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Mississippi

Annual Report Year 2023

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,173	76.1	0.1	5.4	18.4	0.0
2. Infants < 1 Year of Age	3,326	32.0	0.0	7.0	60.0	1.0
3. Children 1 through 21 Years of Age	34,383	41.7	2.2	9.6	40.9	5.6
3a. Children with Special Health Care Needs 0 through 21 years of age^	19,179	0.0	0.0	0.0	0.0	100.0
4. Others	43,186	21.0	0.0	17.0	62.0	0.0
Total	82,068					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	34,675	Yes	34,675	81.2	28,156	1,173
2. Infants < 1 Year of Age	33,676	Yes	33,676	11.8	3,974	3,326
3. Children 1 through 21 Years of Age	810,664	Yes	810,664	36.0	291,839	34,383
3a. Children with Special Health Care Needs 0 through 21 years of age^	193,596	Yes	193,596	10.0	19,360	19,179
4. Others	2,094,658	Yes	2,094,658	2.8	58,650	43,186

^Represents a subset of all infants and children.

Form Notes for Form 5:

1* If coverage was “Pending Medicaid” or “Other State Medicaid”, those individuals were included in the “Title XIX (Medicaid)” category.

2* Molina Chip. Magnolia CHIP, and United Health Care CHIP are all included in the category of “Title XXI (CHIP)”.

3* Medicare which is Title XVIII is included under Private/Other Category.

4* If the field “Coverage” was blank, patient was considered to not have insurance and therefore considered in the “None” category.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2023**
	Field Note: The number of deduplicated pregnant women enrolled in Healthy Moms/Healthy Babies reported in EPIC	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2023**
	Field Note: The number of infants comes from infants who received a genetic consult due to newborn screening and infants enrolled in Healthy Moms/Healthy Babies as recorded in EPIC. It also includes infants enrolled in intervention with an IFSP as recorded in MIT	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: The number of children one through twenty-one comes from the number of children with an immunization consult documented in the EPIC database and referrals for early intervention services over the age of 1 documented in MITI.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: The number comes from the number of CYSHCN served by specialty clinics, MSDH Care Coordinators, and CYSHCN Cares II Cohorts.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2023**
	Field Note: This number comes from the deduplicated number of males and females 21 years of age and older who had at least one county health department clinic visits from the EPIC database and sub-grantee data for Title X.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2023**
	Field Note: The population of pregnant women served by Title V comes from the deduplicated number of women who gave birth in baby-friendly hospital plus the women who participated in Healthy Moms/Healthy Babies as documented in EPIC.	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2023**
	Field Note: The number of infants served by Title V comes from the number of infants in the 2021 birth cohort who received newborn screening surveillance as documented in EPIC.	
3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**
	Field Note: The number of children one through twenty-one comes from the number of children and adolescents who participated in family planning, received vaccination as documented in the MIIX database, received blood lead screening, and enrolled and/or participated in WIC services.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**
	Field Note: The CYSHCN program only documents enabling services that occurred within specialty clinics, MSDH Care Coordinators, and CYSHCN Cares II Cohorts. The program was unable to document their reach for children not participating in these systems. The percentage served was 9.9%. To clarify and meet validation requirements, the percentage was rounded up to 10%.	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2023**
	Field Note: This number comes from the number of males and females 21 years of age and older who had at least one county health department clinic visit for STI/HIV testing, who had a clinical breast exam or cervical cancer screening, families reached with safe sleep information, webinar participants (topics including parenting, intimate partner violence, and human trafficking), and participants in Title X family planning services.	

Data Alerts:

1.	Children with Special Health Care Needs 0 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Mississippi

Annual Report Year 2023

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	35,069	17,664	14,243	2,057	243	436	4	385	37
Title V Served	1,173	464	552	27	2	3	0	7	118
Eligible for Title XIX	19,807	7,217	11,267	757	219	100	0	244	3
2. Total Infants in State	34,727	17,564	14,029	2,039	243	431	4	384	33
Title V Served	3,300	1,390	1,539	167	8	16	3	60	117
Eligible for Title XIX	22,573	11,417	9,119	1,325	158	280	3	250	21

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Data from vital statistics	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Data from vital statistics; includes deliveries of live born infants.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Data from the Mississippi Division of Medicaid	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Data from vital statistics	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Data from vital statistics; includes deliveries of live born infants who should have received at least one newborn screening service (note: not all infants survived, and newborn screening may not have been completed)	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Data from the Mississippi Division of Medicaid	

Form 7
Title V Program Workforce

State: Mississippi

Reporting on Form 7 in the 2025 Application/2023 Annual Report is optional. The state has opted-out of providing Form 7 data. Reporting on Form 7 is mandatory for 2026 Application/2024 Annual Report.

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Mississippi

1. Title V Maternal and Child Health (MCH) Director	
Name	AnnaLyn Whitt
Title	Title V Maternal and Child Health (MCH) Director
Address 1	570 E. Woodrow Wilson, O-200
Address 2	
City/State/Zip	Jackson / MS / 39216
Telephone	(601) 576-7465
Extension	
Email	AnnaLyn.Whitt@msdh.ms.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Valecia Davis
Title	CYSHCN Director
Address 1	570 E. Woodrow Wilson, O-211
Address 2	
City/State/Zip	Jackson / MS / 39216
Telephone	(601) 576-7485
Extension	
Email	Valecia.Davis@msdh.ms.gov

3. State Family Leader (Optional)	
Name	Natasha Roberts
Title	Family Engagement Coordinator
Address 1	570 E. Woodrow Wilson, O-211
Address 2	
City/State/Zip	Jackson / MS / 39216
Telephone	(601) 576-7289
Extension	
Email	Natasha.Roberts@msdh.ms.gov

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Ellen Agho, DrPH, MPH
Title	Director, Health Services Epidemiology and Biostatistics
Address 1	570 E. Woodrow Wilson
Address 2	
City/State/Zip	Jackson / MS / 39216
Telephone	(601) 576-7038
Extension	
Email	ellen.agho@msdh.ms.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(800) 721-7222

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Mississippi

Application Year 2025

No.	Priority Need
1.	Reduce Infant Mortality
2.	Assure Medical Homes for Children and Youth With/Without Special Health Care Needs
3.	Improve Access to Care
4.	Reduce Maternal Morbidity and Mortality
5.	Increase Breastfeeding, Healthy Nutrition and Healthy Weight
6.	Improve Access to Mental Health Services Across MCH Populations
7.	Ensure Health Equity by Addressing Implicit Bias, Discrimination, and Racism
8.	Improve Oral Health
9.	Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings
10.	Improve Access to Family-Centered Care

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Decrease infant mortality.	New
2.	Increase access to health care/medical homes for children and youth with special health care needs (CYSHCN).	New
3.	Increase access to comprehensive health care for children.	New
4.	Reduce teen pregnancy and teen birth rate.	Continued
5.	Increase health insurance coverage.	New
6.	Reduce low birth weight and premature birth.	Continued
7.	Increase access to prenatal care.	New
8.	Increase child nutrition and early childhood obesity prevention	Continued

Form 10
National Outcome Measures (NOMs)

State: Mississippi

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM - Percent of pregnant women who receive prenatal care beginning in the first trimester (Early Prenatal Care, Formerly NOM 1) - PNC

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	77.5 %	0.2 %	26,548	34,267
2021	77.6 %	0.2 %	26,988	34,788
2020	77.3 %	0.2 %	27,079	35,050
2019	78.0 %	0.2 %	28,161	36,109
2018	78.3 %	0.2 %	28,308	36,171
2017	78.5 %	0.2 %	29,110	37,075
2016	78.3 %	0.2 %	29,182	37,265
2015	78.6 %	0.2 %	29,666	37,761
2014	77.5 %	0.2 %	29,681	38,311
2013	75.5 %	0.2 %	28,214	37,361

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PNC - Notes:

None

Data Alerts: None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	94.2	5.3	319	33,862
2020	69.9	4.5	240	34,322
2019	72.4	4.6	252	34,786
2018	74.7	4.6	265	35,458
2017	80.6	4.8	291	36,092
2016	63.1	4.3	222	35,155
2015	78.8	5.5	210	26,636
2014	80.8	4.8	286	35,409
2013	72.7	4.8	229	31,503
2011	55.1	3.9	197	35,755
2010	53.2	4.0	182	34,233

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2022	39.1	4.7	70	178,940
2017_2021	38.0	4.6	69	181,622
2016_2020	26.0	3.8	48	184,394
2015_2019	21.4	3.4	40	187,315
2014_2018	15.3	2.8	29	189,415

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM MM - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	12.7 %	0.2 %	4,400	34,655
2021	12.3 %	0.2 %	4,339	35,138
2020	11.8 %	0.2 %	4,192	35,445
2019	12.3 %	0.2 %	4,510	36,598
2018	12.1 %	0.2 %	4,484	36,973
2017	11.6 %	0.2 %	4,333	37,340
2016	11.5 %	0.2 %	4,345	37,909
2015	11.4 %	0.2 %	4,387	38,374
2014	11.3 %	0.2 %	4,374	38,727
2013	11.5 %	0.2 %	4,458	38,618
2012	11.6 %	0.2 %	4,502	38,654
2011	11.8 %	0.2 %	4,710	39,849
2010	12.1 %	0.2 %	4,852	40,021
2009	12.2 %	0.2 %	5,249	42,877

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	14.8 %	0.2 %	5,129	34,651
2021	15.0 %	0.2 %	5,257	35,140
2020	14.2 %	0.2 %	5,032	35,463
2019	14.6 %	0.2 %	5,340	36,621
2018	14.2 %	0.2 %	5,269	36,983
2017	13.6 %	0.2 %	5,061	37,347
2016	13.6 %	0.2 %	5,174	37,911
2015	13.0 %	0.2 %	5,008	38,385
2014	12.9 %	0.2 %	5,000	38,728
2013	13.1 %	0.2 %	5,070	38,590
2012	13.8 %	0.2 %	5,331	38,616
2011	13.5 %	0.2 %	5,387	39,771
2010	13.8 %	0.2 %	5,524	39,941
2009	13.9 %	0.2 %	5,945	42,749

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	34.6 %	0.3 %	11,983	34,651
2021	33.1 %	0.3 %	11,627	35,140
2020	32.7 %	0.3 %	11,614	35,463
2019	32.7 %	0.3 %	11,963	36,621
2018	31.6 %	0.2 %	11,685	36,983
2017	30.5 %	0.2 %	11,395	37,347
2016	30.6 %	0.2 %	11,590	37,911
2015	30.2 %	0.2 %	11,576	38,385
2014	30.3 %	0.2 %	11,724	38,728
2013	32.9 %	0.2 %	12,686	38,590
2012	35.7 %	0.2 %	13,798	38,616
2011	35.9 %	0.2 %	14,274	39,771
2010	35.6 %	0.2 %	14,233	39,941
2009	36.1 %	0.2 %	15,424	42,749

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM ETB - Notes:

None

Data Alerts: None

NOM - Percent of non-medically indicated early elective deliveries (Early Elective Delivery, Formerly NOM 7) - EED

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022/Q1-2022/Q4	3.0 %			
2021/Q4-2022/Q3	3.0 %			
2021/Q3-2022/Q2	2.0 %			
2021/Q2-2022/Q1	2.0 %			
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	4.0 %			
2015/Q3-2016/Q2	4.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	4.0 %			
2015/Q1-2015/Q4	4.0 %			
2014/Q4-2015/Q3	4.0 %			
2014/Q3-2015/Q2	5.0 %			
2014/Q2-2015/Q1	5.0 %			
2014/Q1-2014/Q4	8.0 %			
2013/Q4-2014/Q3	10.0 %			
2013/Q3-2014/Q2	13.0 %			
2013/Q2-2014/Q1	21.0 %			

Legends:

NOM EED - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	8.6	0.5	302	35,313
2020	8.6	0.5	307	35,645
2019	8.6	0.5	315	36,802
2018	9.4	0.5	351	37,187
2017	9.9	0.5	372	37,542
2016	8.3	0.5	317	38,091
2015	8.1	0.5	313	38,550
2014	8.4	0.5	326	38,902
2013	7.9	0.5	307	38,781
2012	8.7	0.5	338	38,837
2011	8.6	0.5	345	40,038
2010	9.2	0.5	370	40,240
2009	8.6	0.5	370	43,073

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	9.4	0.5	330	35,156
2020	8.1	0.5	288	35,473
2019	8.7	0.5	319	36,636
2018	8.4	0.5	311	37,000
2017	8.7	0.5	326	37,357
2016	8.7	0.5	329	37,928
2015	9.5	0.5	363	38,394
2014	8.2	0.5	317	38,736
2013	9.6	0.5	371	38,634
2012	8.9	0.5	344	38,669
2011	9.2	0.5	368	39,860
2010	9.6	0.5	385	40,036
2009	10.1	0.5	433	42,901

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	5.1	0.4	178	35,156
2020	4.8	0.4	172	35,473
2019	5.2	0.4	189	36,636
2018	5.3	0.4	195	37,000
2017	5.8	0.4	215	37,357
2016	5.4	0.4	204	37,928
2015	5.4	0.4	208	38,394
2014	5.1	0.4	199	38,736
2013	5.8	0.4	225	38,634
2012	5.5	0.4	214	38,669
2011	5.7	0.4	226	39,860
2010	5.5	0.4	220	40,036
2009	6.1	0.4	262	42,901

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.3	0.4	152	35,156
2020	3.3	0.3	116	35,473
2019	3.5	0.3	130	36,636
2018	3.1	0.3	116	37,000
2017	3.0	0.3	111	37,357
2016	3.3	0.3	125	37,928
2015	4.0	0.3	155	38,394
2014	3.0	0.3	118	38,736
2013	3.8	0.3	146	38,634
2012	3.4	0.3	130	38,669
2011	3.6	0.3	142	39,860
2010	4.1	0.3	165	40,036
2009	4.0	0.3	171	42,901

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	250.3	26.7	88	35,156
2020	242.4	26.2	86	35,473
2019	267.5	27.1	98	36,636
2018	281.1	27.6	104	37,000
2017	299.8	28.4	112	37,357
2016	263.7	26.4	100	37,928
2015	320.4	28.9	123	38,394
2014	250.4	25.5	97	38,736
2013	323.5	29.0	125	38,634
2012	289.6	27.4	112	38,669
2011	286.0	26.8	114	39,860
2010	279.7	26.5	112	40,036
2009	317.0	27.2	136	42,901

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	261.7	27.3	92	35,156
2020	214.2	24.6	76	35,473
2019	188.3	22.7	69	36,636
2018	205.4	23.6	76	37,000
2017	179.4	21.9	67	37,357
2016	152.9	20.1	58	37,928
2015	211.0	23.5	81	38,394
2014	131.7	18.5	51	38,736
2013	196.7	22.6	76	38,634
2012	142.2	19.2	55	38,669
2011	200.7	22.5	80	39,860
2010	222.3	23.6	89	40,036
2009	200.5	21.6	86	42,901

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.4 %	0.8 %	1,375	31,576
2020	4.5 %	0.9 %	1,475	32,522
2019	4.8 %	0.7 %	1,610	33,715
2018	5.6 %	0.8 %	1,887	33,550
2009	3.9 %	0.7 %	1,538	39,658
2008	4.8 %	0.7 %	1,978	41,339

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM DP - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	3.9	0.3	134	34,187
2020	3.2	0.3	112	34,559
2019	3.2	0.3	112	35,147
2018	2.9	0.3	104	35,571
2017	2.7	0.3	99	36,297
2016	3.0	0.3	104	35,106
2015	2.5	0.3	67	26,297
2014	1.9	0.2	67	35,365
2013	2.2	0.3	66	29,953
2011	1.4	0.2	37	27,180
2010	1.2	0.2	30	25,288

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL) (Newborn Screening Timely Follow-Up, Formerly NOM 12) - NBS

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

NOM NBS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

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

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	13.5 %	1.3 %	89,102	662,296
2020_2021	14.4 %	1.2 %	94,341	654,232
2019_2020	14.2 %	1.3 %	93,089	653,515
2018_2019	13.0 %	1.4 %	86,386	662,006
2017_2018	14.6 %	1.6 %	99,196	681,617
2016_2017	13.6 %	1.5 %	94,152	691,242

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	33.6	3.2	108	321,133
2021	33.9	3.2	111	327,820
2020	30.8	3.0	103	333,889
2019	31.4	3.1	106	337,337
2018	31.5	3.0	108	342,566
2017	29.9	2.9	104	348,132
2016	27.0	2.8	96	355,227
2015	28.5	2.8	103	361,291
2014	23.5	2.5	86	365,777
2013	31.7	2.9	117	369,629
2012	29.5	2.8	110	372,775
2011	31.8	2.9	119	374,324
2010	29.0	2.8	109	376,368
2009	36.2	3.1	136	375,948

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	58.0	3.8	234	403,623
2021	71.8	4.2	294	409,594
2020	58.9	3.8	237	402,683
2019	52.7	3.6	215	407,632
2018	51.3	3.5	212	412,860
2017	48.4	3.4	199	411,568
2016	50.3	3.5	207	411,536
2015	50.0	3.5	205	410,093
2014	51.9	3.6	214	412,063
2013	39.6	3.1	164	414,511
2012	41.1	3.1	173	420,571
2011	48.0	3.4	205	426,951
2010	45.5	3.2	197	432,867
2009	56.0	3.6	244	435,502

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	24.9	2.0	152	609,648
2019_2021	26.0	2.1	157	603,991
2018_2020	24.7	2.0	150	606,323
2017_2019	24.0	2.0	147	613,583
2016_2018	25.5	2.0	158	620,567
2015_2017	28.0	2.1	174	621,859
2014_2016	31.3	2.2	195	622,515
2013_2015	29.9	2.2	186	622,258
2012_2014	26.2	2.0	164	626,826
2011_2013	23.7	1.9	151	637,592
2010_2012	23.8	1.9	156	654,134
2009_2011	29.4	2.1	197	669,431
2008_2010	30.6	2.1	208	680,521
2007_2009	37.3	2.3	255	682,791

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	5.9	0.7	72	1,215,900
2019_2021	6.3	0.7	77	1,219,909
2018_2020	6.6	0.7	81	1,223,175
2017_2019	7.3	0.8	90	1,232,060
2016_2018	6.7	0.7	83	1,235,964
2015_2017	6.2	0.7	77	1,233,197
2014_2016	5.1	0.6	63	1,233,692
2013_2015	4.6	0.6	57	1,236,667
2012_2014	3.5	0.5	44	1,247,145
2011_2013	3.7	0.5	47	1,262,033
2010_2012	3.8	0.6	49	1,280,389
2009_2011	4.3	0.6	56	1,295,320

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17 (CSHCN, Formerly NOM 17.1) - CSHCN

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	22.9 %	1.4 %	158,168	690,471
2020_2021	22.6 %	1.3 %	156,628	693,446
2019_2020	21.4 %	1.4 %	149,648	698,363
2018_2019	22.1 %	1.5 %	155,927	706,548
2017_2018	24.4 %	1.8 %	175,104	716,402
2016_2017	24.8 %	1.8 %	179,239	722,780

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CSHCN - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	13.4 %	2.0 %	21,131	158,168
2020_2021	17.0 %	2.6 %	26,601	156,488
2019_2020	19.5 %	2.9 %	29,203	149,509
2018_2019	18.2 %	2.9 %	28,393	155,927
2017_2018	17.0 %	3.2 %	29,765	175,104
2016_2017	15.8 %	2.9 %	28,304	179,239

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder (Autism, Formerly NOM 17.3) - ASD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	3.3 %	0.6 %	19,052	578,323
2020_2021	2.6 %	0.5 %	14,744	573,712
2019_2020	2.3 %	0.5 %	13,279	579,730
2018_2019	2.9 %	0.7 %	17,319	599,071
2017_2018	3.1 %	0.9 %	19,313	617,029
2016_2017	2.3 %	0.8 %	14,623	624,409

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ASD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (ADD or ADHD, Formerly NOM 17.4) - ADHD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	14.0 %	1.2 %	80,951	578,068
2020_2021	13.9 %	1.2 %	80,211	575,974
2019_2020	14.9 %	1.3 %	85,467	573,644
2018_2019	13.1 %	1.3 %	76,956	589,645
2017_2018	14.7 %	1.8 %	89,895	612,086
2016_2017	15.8 %	1.8 %	98,085	621,213

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ADHD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	46.7 %	4.5 %	43,513	93,224
2020_2021	46.7 %	4.6 %	43,068	92,174
2019_2020	47.8 %	4.8 %	43,304	90,628
2018_2019	40.9 %	5.2 %	35,635	87,131
2017_2018	44.2 %	6.0 %	42,661	96,468
2016_2017	48.1 %	6.1 %	47,763	99,249

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM MHTX - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	83.7 %	1.4 %	576,707	689,069
2020_2021	85.7 %	1.3 %	592,497	691,105
2019_2020	87.3 %	1.2 %	607,938	696,761
2018_2019	85.8 %	1.4 %	605,280	705,851
2017_2018	87.5 %	1.4 %	626,413	715,706
2016_2017	87.7 %	1.3 %	633,617	722,403

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	14.4 %	0.3 %	2,839	19,685
2018	14.8 %	0.2 %	4,394	29,651
2016	14.4 %	0.2 %	4,110	28,493
2014	14.5 %	0.2 %	3,771	26,007
2012	14.8 %	0.2 %	5,082	34,417
2010	14.9 %	0.2 %	5,447	36,519
2008	15.8 %	0.2 %	4,793	30,421

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	23.2 %	1.4 %	27,282	117,485
2019	23.4 %	1.3 %	27,848	118,939
2015	18.9 %	1.0 %	24,264	128,216
2013	15.4 %	1.2 %	18,749	122,083
2011	15.8 %	1.1 %	21,018	133,254
2009	18.1 %	1.2 %	23,349	129,304
2007	17.7 %	1.1 %	21,871	123,634

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	26.1 %	2.0 %	114,345	437,471
2020_2021	25.0 %	1.8 %	107,261	428,260
2019_2020	23.2 %	1.8 %	101,120	436,342
2018_2019	23.6 %	1.9 %	104,078	440,840
2017_2018	24.8 %	2.3 %	111,667	449,836
2016_2017	25.1 %	2.4 %	108,414	432,700

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, without health insurance (Uninsured, Formerly NOM 21) - UI

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.3 %	0.4 %	35,524	675,536
2021	6.2 %	0.5 %	42,837	691,432
2019	5.5 %	0.4 %	38,258	698,345
2018	4.3 %	0.3 %	30,615	705,075
2017	4.8 %	0.5 %	34,507	715,140
2016	4.3 %	0.4 %	31,090	722,717
2015	4.1 %	0.4 %	29,501	729,123
2014	5.4 %	0.4 %	39,536	732,061
2013	7.4 %	0.6 %	54,774	736,122
2012	7.3 %	0.5 %	54,168	747,427
2011	7.5 %	0.5 %	56,059	751,780
2010	8.2 %	0.6 %	61,994	753,069
2009	10.1 %	0.5 %	77,482	764,467

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM UI - Notes:

None

Data Alerts: None

NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	67.4 %	4.0 %	24,000	36,000
2017	72.3 %	3.7 %	27,000	37,000
2016	71.1 %	3.7 %	27,000	38,000
2015	60.8 %	3.7 %	23,000	38,000
2014	69.9 %	3.9 %	27,000	38,000
2013	65.6 %	4.6 %	25,000	38,000
2012	72.0 %	4.2 %	28,000	39,000
2011	68.1 %	4.8 %	27,000	40,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM VAX-Child - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	42.1 %	2.2 %	277,763	659,770
2021_2022	39.4 %	1.6 %	258,785	656,518
2020_2021	42.9 %	2.1 %	280,665	654,231
2019_2020	51.9 %	1.7 %	343,196	661,264
2018_2019	48.8 %	1.6 %	326,955	670,127
2017_2018	51.2 %	1.7 %	345,491	674,344
2016_2017	50.5 %	1.7 %	342,387	677,725
2015_2016	52.3 %	2.1 %	357,011	682,490
2014_2015	50.4 %	2.0 %	348,619	691,156
2013_2014	44.5 %	2.1 %	312,599	702,674
2012_2013	45.9 %	2.4 %	325,392	709,465
2011_2012	42.6 %	2.6 %	303,945	713,942
2010_2011	44.3 %	6.0 %	319,563	721,361
2009_2010	37.7 %	3.0 %	266,593	707,144

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM VAX-Flu - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	61.0 %	4.1 %	128,435	210,562
2021	56.2 %	3.6 %	114,744	204,032
2020	55.2 %	3.5 %	112,440	203,865
2019	49.5 %	3.9 %	99,554	201,034
2018	51.7 %	3.5 %	104,130	201,248
2017	49.6 %	3.2 %	101,455	204,421
2016	45.6 %	3.3 %	93,479	204,829
2015	45.5 %	3.1 %	94,090	206,954

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-HPV - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	87.0 %	2.9 %	183,130	210,562
2021	89.1 %	2.4 %	181,754	204,032
2020	93.0 %	1.7 %	189,532	203,865
2019	90.4 %	2.5 %	181,652	201,034
2018	90.0 %	2.2 %	181,186	201,248
2017	92.4 %	1.6 %	188,870	204,421
2016	82.0 %	2.5 %	168,001	204,829
2015	74.7 %	2.7 %	154,578	206,954
2014	70.8 %	3.2 %	147,224	207,833
2013	60.2 %	3.4 %	125,534	208,669
2012	53.5 %	3.7 %	111,071	207,626
2011	36.9 %	3.5 %	77,727	210,830
2010	29.0 %	2.8 %	60,494	208,302
2009	22.6 %	2.3 %	48,507	214,998

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-TDAP - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	55.5 %	4.2 %	116,772	210,562
2021	60.2 %	3.5 %	122,883	204,032
2020	63.5 %	3.5 %	129,378	203,865
2019	60.3 %	3.8 %	121,169	201,034
2018	64.0 %	3.4 %	128,821	201,248
2017	63.0 %	3.0 %	128,848	204,421
2016	57.4 %	3.2 %	117,572	204,829
2015	55.3 %	3.1 %	114,460	206,954
2014	46.0 %	3.3 %	95,645	207,833
2013	50.1 %	3.5 %	104,491	208,669
2012	40.7 %	3.6 %	84,462	207,626
2011	34.2 %	3.5 %	72,072	210,830
2010	26.0 %	2.7 %	54,238	208,302
2009	19.3 %	2.1 %	41,410	214,998

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-MEN - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	26.4	0.5	2,683	101,499
2021	25.6	0.5	2,545	99,415
2020	27.9	0.5	2,711	97,321
2019	29.1	0.5	2,869	98,568
2018	27.8	0.5	2,808	100,890
2017	31.0	0.6	3,137	101,191
2016	32.6	0.6	3,326	102,043
2015	34.7	0.6	3,536	101,862
2014	37.8	0.6	3,853	101,916
2013	42.2	0.6	4,347	102,917
2012	46.1	0.7	4,781	103,755
2011	50.5	0.7	5,363	106,197
2010	55.4	0.7	6,077	109,667
2009	62.2	0.8	6,945	111,688

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	20.8 %	1.7 %	6,425	30,899
2020	21.7 %	1.7 %	7,024	32,338
2019	22.1 %	1.4 %	7,341	33,197
2018	23.5 %	1.5 %	7,860	33,398

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	4.0 %	0.7 %	27,148	684,966
2020_2021	3.6 %	0.6 %	24,548	689,005
2019_2020	3.1 %	0.6 %	21,351	691,398
2018_2019	2.9 %	0.7 %	20,108	698,910
2017_2018	3.4 %	0.8 %	23,907	711,949
2016_2017	3.3 %	0.8 %	23,362	715,068

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FHC - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Mississippi

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		78.5	79.7	80.9	82.1
Annual Indicator	74.2	75.4	77.5	74.7	77.3
Numerator	389,320	390,297	403,215	379,846	389,062
Denominator	524,486	517,720	520,497	508,347	503,084
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	82.9	84.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	71.9	74	76.2	78.5	80.9
Annual Indicator	63.4	70.0	68.0	69.4	74.2
Numerator	22,722	22,777	21,999	23,474	24,340
Denominator	35,813	32,539	32,351	33,806	32,793
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	80.9
Annual Indicator	69.8
Numerator	23,756
Denominator	34,054
Data Source	NVSS
Data Source Year	2022

Annual Objectives		
	2024	**2025**
Annual Objective	83.3	83.5

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	13.4	14.1	14.8	15.4	16.1
Annual Indicator	16.0	18.1	16.4	15.6	18.3
Numerator	5,507	5,651	5,200	5,053	5,746
Denominator	34,464	31,217	31,729	32,343	31,338
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2023
Annual Objective	16.1
Annual Indicator	23.0
Numerator	19,896
Denominator	86,365
Data Source	NSCH
Data Source Year	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	16.9	17.1

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	67.5	68.2	68.9	69.6	70.3
Annual Indicator	72.2	69.4	64.3	70.7	70.7
Numerator	23,861	22,384	20,451	21,727	21,727
Denominator	33,042	32,256	31,790	30,728	30,728
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	67.5	68.2	68.9	69.6	70.3
Annual Indicator	72.2				
Numerator	23,861				
Denominator	33,042				
Data Source	MS PRAMS				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives		
	2024	**2025**
Annual Objective	71.0	71.7

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	64.9	66.2	67.5	68.9	70.3
Annual Indicator	28.8	34.4	32.7	30.7	30.7
Numerator	9,167	10,964	10,154	9,166	9,166
Denominator	31,841	31,829	31,010	29,840	29,840
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	64.9	66.2	67.5	68.9	70.3
Annual Indicator	28.8				
Numerator	9,167				
Denominator	31,841				
Data Source	MS PRAMS				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives		
	2024	**2025**
Annual Objective	71.7	73.1

Field Level Notes for Form 10 NPMs:

None

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.6	47.9	50.3	52.8	55.4
Annual Indicator	42.3	41.3	42.4	41.9	41.9
Numerator	13,523	12,948	13,078	12,497	12,497
Denominator	31,973	31,323	30,870	29,808	29,808
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.6	47.9	50.3	52.8	55.4
Annual Indicator	42.3				
Numerator	13,523				
Denominator	31,973				
Data Source	MS PRAMS				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives		
	2024	**2025**
Annual Objective	58.2	61.2

Field Level Notes for Form 10 NPMs:

None

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

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

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	19.5	20.5	23.5	24.3	25.2
Annual Indicator	23.7	28.0	31.5	34.1	30.9
Numerator	16,993	19,663	25,115	28,605	25,435
Denominator	71,794	70,109	79,686	83,842	82,348
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	26.5	28.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent

Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2020	**2021**	**2022**	**2023**
Annual Objective			20.4	18.8
Annual Indicator	23.4	23.4	25.5	25.5
Numerator	29,043	29,043	31,054	31,054
Denominator	123,981	123,981	121,794	121,794
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2019	2019	2021	2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT				
	2020	**2021**	**2022**	**2023**
Annual Objective			20.4	18.8
Annual Indicator	16.7	20.6	20.5	14.0
Numerator	38,663	48,356	48,374	34,225
Denominator	231,717	234,684	235,476	243,942
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	17.2	16.2

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	79.4	80	80.6	81.2	82
Annual Indicator	77.0	66.2	65.1	60.5	61.6
Numerator	188,821	155,497	155,882	145,341	148,228
Denominator	245,226	234,939	239,310	240,226	240,436
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	82.8	83.6

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.5	47.1	48.7	50.3	51.9
Annual Indicator	46.9	51.4	46.2	43.2	40.8
Numerator	78,448	82,086	72,719	68,226	64,583
Denominator	167,120	159,664	157,506	157,885	158,168
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	53.5	55.1

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	42.7
Numerator	293,703
Denominator	687,740
Data Source	NSCH-All Children
Data Source Year	2021_2022

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	35.9	37.7	39.6	41.6	43.7
Annual Indicator	35.4	31.6	32.1	35.3	35.3
Numerator	12,028	10,696	10,493	11,307	11,307
Denominator	33,953	33,881	32,729	31,993	31,993
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	35.9	37.7	39.6	41.6	43.7
Annual Indicator	35.4	31.6	32.1	35.3	
Numerator	12,028	10,696	10,493	11,307	
Denominator	33,953	33,881	32,729	31,993	
Data Source	MS PRAMS	MS PRAMS	MS PRAMS	MS PRAMS	
Data Source Year	2018	2019	2020	2021	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives		
	2024	**2025**
Annual Objective	45.9	47.9

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	80.6	81.4	82.2	83	83.8
Annual Indicator	77.8	77.1	75.0	72.0	72.1
Numerator	525,080	500,754	484,100	468,061	474,563
Denominator	675,079	649,719	645,270	650,503	658,109
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	84.6	85.4

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	88.1
Numerator	27,351
Denominator	31,060
Data Source	PRAMS
Data Source Year	2021

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	73.6
Numerator	20,009
Denominator	27,196
Data Source	PRAMS
Data Source Year	2021

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Mississippi

SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age

Measure Status:	Active			
State Provided Data				
	2020	**2021**	**2022**	**2023**
Annual Objective			3.9	4
Annual Indicator		3.8	5	11.7
Numerator		5,554	7,297	16,977
Denominator		144,844	146,681	145,661
Data Source		Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program
Data Source Year		2021	2022	2023
Provisional or Final ?		Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	4.1	4.2

Field Level Notes for Form 10 SPMs:

None

SPM 10 - Percent of severe maternal morbidity events related to hypertension

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			2.2
Annual Indicator	3.5	3.4	3.9
Numerator	1,114	1,075	1,192
Denominator	32,010	31,331	30,637
Data Source	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	2.1	2.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This initiative ended in 2022. Data for 2020 were captured and reported in 2021; however, the 2021 data are not yet available.

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			11.2
Annual Indicator	11.7	7.1	18.4
Numerator	5,221	2,995	7,342
Denominator	44,528	42,144	39,888
Data Source	WIC Spirit database	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	10.7	10.2

Field Level Notes for Form 10 SPMs:

None

SPM 12 - Percent of women who are enrolled in WIC and initiate breastfeeding

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			51
Annual Indicator	49.3	54	55.9
Numerator		11,007	21,547
Denominator		20,401	38,512
Data Source	WIC Spirit database	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	51.5	52.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
These data come from the WIC Spirit database. 50.71% of infants were ever breastfed in CY2020 and 6% of infants were breastfed through 6 months of age in CY2020. Projections for 2021 are 49.31% and 5.8%, respectively.

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			67
Annual Indicator	46.9	40.4	40.8
Numerator	30	23	20
Denominator	64	57	49
Data Source	EPIC	EPIC	EPIC
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	77.0	87.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
During 2021, MSDH ended its use with a legacy system database for EHDI and began using MSDH's EPIC system to capture EHDI information. The EPIC system for EHDI went live in July 2021. Data for the first half of 2021 are in the process of entry. These data are preliminary.

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			341
Annual Indicator	310	272	291
Numerator			
Denominator			
Data Source	EPSDT Visits in EPIC	EPSDT Visits in EPIC	EPSDT Visits in EPIC
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	375.0	413.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: MSDH EPSDT encounter summary for children ages 9-30 months between 7/1/2020 and 6/30/2021	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Children between 9-35 months who received an EPDST visit between October 1, 2021 and September 30, 2022	

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			100
Annual Indicator	100	93.2	90
Numerator	60	2,722	72
Denominator	60	2,922	80
Data Source	Newborn Screening data	MS Newborn screening database and EPIC database	EPIC database
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	100.0	100.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data for this measure regarding timeliness are not yet available. However, we do have data on the number diagnosed, screened and referred.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data for this measure regarding timeliness of referral to a tertiary center are not yet available. However, we have data on timeliness of screening.	

SPM 16 - Nulliparous, term singleton, vertex (NTSV) cesarean rate

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			28.5
Annual Indicator	31.7	30.5	30.3
Numerator	3,304	3,300	3,367
Denominator	10,439	10,830	11,096
Data Source	Mississippi Hospital Discharge Data	NTSV from Vital Records	NTSV from Vital Records
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	25.7	23.1

Field Level Notes for Form 10 SPMs:

None

SPM 17 - Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			78.5
Annual Indicator	75.6	77.9	77.3
Numerator	67,008	56,332	73,729
Denominator	88,608	72,327	95,345
Data Source	MS BRFSS	MS BRFSS	MS BRFSS
Data Source Year	2021	2019 2021	2021 2022
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	79.0	79.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
At the time of the previous report, 2021 MS BRFSS data were not yet available, so the indicator was estimated using 2018-2019 data. The 2021 MS BRFSS data are now available for 2021, so the value has been updated.

The 2021 BRFSS variable for type of insurance was PRIMINSR, and the response options of interest were 5 (Medicaid) and 9 (State-sponsored health plan). The 2021 BRFSS variable for routine checkup was CHECKUP1, and the response option of interest was 1 (within past year, anytime less than 12 months ago).

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Mississippi BRFSS data are not yet available for 2022. The data reported are a 2-year prevalence estimate (2019 & 2021). Data on payer are not captured every year in BRFSS and are not available for the 2020 survey year.

The 2019 BRFSS variable for type of insurance was HLTHCVR1, and the response option of interest was 4 (Medicaid or other state program). The 2021 BRFSS variable for type of insurance was PRIMINSR, and the response options of interest were 5 (Medicaid) and 9 (State-sponsored health plan). CHECKUP1 was the variable used for routine checkup in both the 2019 and 2021 BRFSS. The response option of interest was 1 (within past year, anytime less than 12 months ago).

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
BRFSS data for 2023 will not be available until approximately September 2024. We used the 2021 and 2022 MS BRFSS data to estimate the prevalence for the specified time period.
The 2022 BRFSS variable for type of insurance was PRIMINSR, and the response options of interest were 5 (Medicaid) and 9 (State-sponsored health plan). State-sponsored health plan was included to allow for comparison of current estimates with previous estimates because, prior to 2021, Medicaid and state-sponsored health plan were combined as a single response option. The 2022 BRFSS variable for routine checkup was CHECKUP1, and the response option of interest was 1 (within past year, anytime less than 12 months ago).

SPM 18 - Percent of children with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			17.2
Annual Indicator	16.2	15.4	12.4
Numerator	8,954	9,208	8,155
Denominator	55,176	59,681	65,978
Data Source	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	18.2	19.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The main goal of this measure is to increase the percent of children with special health care needs who have received services necessary for transition to adult health care. Therefore, the numerator used is the percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The main goal of this measure is to increase the percent of children with special health care needs who have received services necessary for transition to adult health care. Therefore, the numerator used is the percent of	

SPM 19 - Adolescent suicide rate

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			11.3
Annual Indicator	11.6	10.8	8.7
Numerator			
Denominator			
Data Source	CDC WONDER Multiple Cause of Death Files	Office of Vital Records and Public Health Statisti	Office of Vital Records and Public Health Statisti
Data Source Year	2017-2019	2021	2022
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	11.0	10.6

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: CDC WONDER, Multiple Cause of Death Files, 2017-2019	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 10.8 per 100,000 ages 15-19 years	

SPM 20 - Number of MCH programs that have developed a written plan to address health equity

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			3
Annual Indicator	1	3	3
Numerator			
Denominator			
Data Source	MCH program data	MCH program data	MCH program data
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	6.0	9.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Other programs are working with partners to help develop their written plan to address health equity, however, they have not yet been formalized.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Other programs are working with partners to help develop their written plan to address health equity, however, they have not yet been formalized.	

SPM 21 - Percent of children with and without special healthcare needs who have a medical home

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			46.5
Annual Indicator	46.2	43.2	40.8
Numerator	72,719	68,226	64,583
Denominator	157,506	157,885	158,168
Data Source	National Survey of Childrens Health	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	46.7	47.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data come from the 2019-2020 National Survey of Children's Health.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The main goal of this measure is to assure that all children with special healthcare needs have a medical home. Therefore, the numerator used is the percent of children, 0-17 years with special health care needs who have a medical home.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The main goal of this measure is to assure that all children with special healthcare needs have a medical home. Therefore, the numerator used is the percent of children, 0-17 years with special health care needs who have a medical home.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Mississippi

ESM WWV.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			100
Annual Indicator	641	56	113
Numerator			
Denominator			
Data Source	MS Quitline provider and Baby and Me Tobacco Free	MS Quitline provider and Baby and Me Tobacco Free	MS Quitline provider and Baby and Me Tobacco Free
Data Source Year	2022	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	125.0	150.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Need to work with Quitline provider to ensure that data on sex / gender and pregnancy status are collected consistently on all callers as well as individuals who complete the intake process for treatment.

These are FY2021 data (7/1/2020 through 6/30/2021).

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The data represent the number of women assisted during pregnancy by the MS Quitline and Baby and Me Tobacco Free programs.

The program would need to work with Quitline provider to ensure that the data on the number of women of childbearing age (18-45) that were provided services by MS Quitline are collected.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
The data represent the number of women assisted during pregnancy by the MS Quitline and Baby and Me Tobacco Free programs.

The program would need to work with Quitline provider to ensure that the data on the number of women of childbearing age (18-45) that were provided services by MS Quitline are collected.

ESM BF.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	4	5	6	24	26
Annual Indicator	18	21	22	25	29
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	Baby Friendly USA	Baby Friendly USA
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	28.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The most current information is obtained from the Baby Friendly USA website.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
25 hospitals were considered Baby Friendly

The number of Baby Friendly Hospitals in Mississippi have increased and are on trend to continue to increase slightly in the following year.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
29 hospitals were considered Baby Friendly

It can be concluded that the number of Baby Friendly Hospitals in Mississippi have increased and are on trend to continue to increase slightly in the following year

ESM SS.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	20,200	20,450	20,700	21,000	21,250
Annual Indicator	10,000	14,880	9,560	11,863	13,950
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	21,500.0	21,500.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This is the count for the number of books distributed in one year to all birthing hospitals in MS. The books are given to families upon discharge from the hospital.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: This is the count for the number of books distributed in one year to all birthing hospitals in MS. The books are given to families upon discharge from the hospital. The COVID-19 pandemic continued to have an impact on the program's ability to produce and share resources in birthing hospitals.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: This is the count for the number of books distributed in one year to all birthing hospitals in MS. The books are given to families upon discharge from the hospital.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: This is the count of the number of books and resources distributed in one year to all birthing hospitals in MS. The books are given to families upon discharge from the hospital.	

ESM DS.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			20
Annual Indicator	0	1,162	2,928
Numerator			
Denominator			
Data Source	Early Intervention Child Find Log	Early Intervention Child Find Log	Early Intervention Child Find Log
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	30.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Activities not completed during the time period due to lack of in person training

ESM PA-Adolescent.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide

Measure Status:	Active			
State Provided Data				
	2020	**2021**	**2022**	**2023**
Annual Objective			22	23
Annual Indicator	20.6		20.5	14
Numerator	48,356		48,374	34,225
Denominator	234,684		235,476	243,941
Data Source	National Survey of Childrens Health		National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2019-2020		2020-2021	2021-2022
Provisional or Final ?	Final		Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	24.0	25.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: These data are from the 2019-2020 NSCH for Mississippi.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: No data available yet for the 2020-2021 period.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The data are from the 2020-2021 NSCH for Mississippi. Data for the numerator for this measure: ESM 8.2.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide were not available. Therefore, Numerator used for the current report was from NPM 8.2 - Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day, everyday.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The data are from the 2020-2021 NSCH for Mississippi. Data for the numerator for this measure: ESM 8.2.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide were not available. Therefore, Numerator used for the current report was from NPM 8.2 - Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day, everyday.	

ESM AWV.2 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years

Measure Status:	Active		
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			100
Annual Indicator	100	100	100
Numerator			
Denominator			
Data Source	MSDH County Health Department information	MSDH County Health Department information	MSDH County Health Department information
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: This measure may need to be refined to understand service differences in different locations and availability of the complete array of services for adolescents.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: This measure may need to be refined to understand service differences in different locations and availability of the complete array of services for adolescents.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: This measure may need to be refined to understand service differences in different locations and availability of the complete array of services for adolescents.	

ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	48	50	52	54	56
Annual Indicator	100	100	0	30	51
Numerator					
Denominator					
Data Source	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	58.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	600	650	700	750	800
Annual Indicator	409	347	0	1,000	1,000
Numerator					
Denominator					
Data Source	MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health - REDCAP	MSDH Office of Oral Health - REDCAP
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	850.0	1,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data captured from WIC program and Baby Cafes	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: We are currently using REDCAP as a tool to capture data from the activities of our Regional Oral Health Consultants. The number reflected includes women from WIC, community baby showers and similar events. The actual number is 1,186 but due to data ranges for this indicator, 1,000 was indicated for 2022.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: We are currently using REDCAP as a tool to capture data from the activities of our Regional Oral Health Consultants. The number reflected includes women from WIC, community baby showers and similar events. The actual number is 5,851 but due to data ranges for this indicator, 1,000 was indicated for 2023.	

ESM PDV-Child.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	1,000	2,000	3,000	4,000	100
Annual Indicator	0	903	0	29	38
Numerator					
Denominator					
Data Source	Office of Oral Health	Office of Oral Health	Office of Oral Health	EPIC	EPIC
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	150.0	200.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The MSDH Oral Health Program is working to obtain data from all clinics carried out the Cavity Free in MS program.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The MSDH Oral Health Program is working to obtain data from all clinics carried out the Cavity Free in MS program.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Of the 437 children seen by MSDH nurses so far, we have been able to speak with 90 parents/guardians. Twenty-nine children have been confirmed as having seen a dentist. We are working to assist those who have not seen the dentist with establishing a dental home. Some barriers encountered with these follow up calls include language, with need for an interpreter; inability to reach guardians; and the interface of Oral Health into EPIC has not been synchronized.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Total unduplicated encounters 0-3 = 354 All patient families called by dental team members; and reached 116; of this number 38 have seen a dentist; 53 had not seen the dentist; other calls-no ability to leave voicemail; those that could receive voicemails at their numbers- a voicemail was left.	

ESM PDV-Child.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	1,000	2,000	3,000	4,000	450
Annual Indicator	0	976	424	20	3
Numerator					
Denominator					
Data Source	EPIC	EPIC	EPIC	EPIC	EPIC
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	500.0	550.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Information was captured in EPIC EHR system based on EPDST wellness visits. There is an oral health evaluation component. We are working to customize reports to find out more regarding specifics of referrals.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The program is now aware of the check box for wellness visits active in the EPIC system and the ability to generate reports on dental referrals documented. Unfortunately, with the shortage and turnover of nurses with the agency, not all team members were using this tool and additional training is needed. The program is also unsure if this information is also documented in the patient's chart and they will need to manually review each entry to decide. The program is planning to work with the Chief Nurses to update training and protocols on this tool.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Based on reports from our EPIC system, only three referrals were entered using the prepopulated template. We have had new nurses to join the MSDH team who may be unaware or untrained on this template tool regarding oral assessments with EPDST wellness visits. During this grant period, we provided training to the nurse team lead and new nurses on this tool, and they are waiting for further training from our EPIC superusers.

ESM PDV-Child.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	60	65	70	75	20
Annual Indicator	10	2	8	14	6
Numerator					
Denominator					
Data Source	Office of Oral Health	Office of Oral Health	Office of Oral Health	MSDH Office of Oral Health REDCAP	MSDH Office of Oral Health REDCAP
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	25.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The log is being updated to capture data; however, the program is awaiting an official data collection tool to be implemented that will be used for all programs under MSDH Health Services. There was a decline in the number of trainings conducted during the reporting period due to the impact of COVID-19.

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The log is being updated to capture data; however, the program is awaiting an official data collection tool to be implemented that will be used for all programs under MSDH Health Services. There was a decline in the number of trainings conducted during the reporting period due to the impact of COVID-19.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
During this reporting period, fourteen (14) Cavity Free in Mississippi trainings were conducted where 54 non dental providers (medical doctors, nurse practitioners and physician assistants) were trained on the use of fluoride varnish in a primary care setting.

4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Our team experienced some attrition of staff with our ROHCS and thus we had a decrease in the number of team members who were able to provide this training.

During this reporting period, 14 six Cavity-Free in Mississippi training were conducted where 32 non-dental providers (medical doctors, nurse practitioners, and physician assistants) were trained on the use of fluoride varnish in a primary care setting.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Mississippi

SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of children on Medicaid aged 12 and 24 months that have a reported blood lead screening</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Mississippi children on Medicaid aged 12 and 24 months that have a reported blood lead screening is</td></tr>
<tr><td>Denominator:</td><td>Number of Mississippi children on Medicaid aged 12 and 24 months is</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Reduce blood lead levels in children aged 1 to 5 years — EH-04</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MSDH Lead Program data and Division of Medicaid data</td></tr>
<tr><td>Significance:</td><td>Lead is a potent and pervasive neurotoxicant. Elevated blood lead levels (EBBLs) can result in decreased IQ, academic failure, and behavioral problems in children. There are approximately half a million U.S. children ages 1-5 with blood lead levels above five micrograms per deciliter, the reference level at which CDC recommends public health actions be initiated. No safe blood lead level in children has been identified. Because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized. By school age, children with a history of lead exposure can exhibit poor attention and impulse control, with lower intelligence and academic performance. A blood lead test is the only reliable way to identify a lead-poisoned child. Medicaid has required testing of enrolled children since 1989. Many states do not enforce the Medicaid requirement for children to be tested for lead poisoning. Medicaid-enrolled children are three times more likely to have elevated blood lead levels (EBLLs) than those non-enrolled children, according to national studies.</td></tr>
</table>

SPM 10 - Percent of severe maternal morbidity events related to hypertension
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	By September 30, 2022, decrease the percentage of severe maternal morbidity events related to hypertension by 0.1% annually
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of severe hypertension events **Denominator:** Number of live births
Data Sources and Data Issues:	Mississippi Hospital Discharge Data Data issues are: Hospital Discharge data are typically delayed by 18-24 months.
Significance:	Mississippi has a high severe maternal morbidity rates and significant racial disparities.

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	By September 30, 2025, decrease the percentage of children, ages 2-5 years, who receive WIC services and have a BMI at or above the 85th percentile
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children, ages 2-5 yrs, receiving WIC services with a BMI at or above the 85th percentile **Denominator:** Number of children, ages 2-5 yrs who received WIC services during the reporting period
Data Sources and Data Issues:	WIC Spirit Database
Significance:	Participation in WIC is low in Mississippi and participating in WIC could improve child's nutrition and health.

SPM 12 - Percent of women who are enrolled in WIC and initiate breastfeeding
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the number of WIC mothers who initiate breastfeeding
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of WIC mothers who initiated breastfeeding **Denominator:** Number of mothers enrolled in WIC
Data Sources and Data Issues:	WIC Spirit Database
Significance:	Breastfeeding is low within the WIC population and breastfeeding can improve newborn health and reduce childhood obesity

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age
Population Domain(s) – Child Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the number of infants with confirmed hearing loss who received confirmation of hearing status by 3 months to 67%
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Infants with confirmed hearing loss who received confirmation of hearing status by 3 months **Denominator:** Infants with confirmed hearing loss
Healthy People 2030 Objective:	Increase the proportion of infants who didn't pass their hearing screening who get evaluated for hearing loss by age 3 months — HOSCD-02 (https://health.gov/healthypeople/objectives-and-data/browse-objectives/sensory-or-communication-disorders/increase-proportion-infants-who-didnt-pass-their-hearing-screening-who-get-evaluated-hearing-loss-age-3-months-hoscd-02)
Data Sources and Data Issues:	Program database and EPIC.
Significance:	According to NCHAM, approximately 95% of babies receive a hearing screen shortly after birth as part of universal newborn hearing screening; however, many infants who do not pass the hearing screening become lost to follow-up or documentation before an audiological evaluation can be completed or critical educational and medical intervention can be provided. Children with hearing loss who receive timely early intervention services are often able to develop language skills on par with their hearing peers. Timely access to early intervention is dependent upon timely confirmation of hearing status.

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit
Population Domain(s) – Child Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the number of children who receive developmental screening using a parent completed tool by 10% annually
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** All children at 9 months, 18 months and 30 months or when indicated **Denominator:**
Healthy People 2030 Objective:	Increase the proportion of children who receive a developmental screening — MICH-17 (https://health.gov/healthypeople/objectives-and-data/browse-objectives/children/increase-proportion-children-who-receive-developmental-screening-mich-17)
Data Sources and Data Issues:	Medicaid data; EPIC EPSDT visit data
Significance:	Developmental screening is early identification of children at risk for cognitive, motor, communication, or social-emotional delays. These are delays that may interfere with expected growth, learning, and development and may warrant further diagnosis, assessment, and evaluation.

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely
Population Domain(s) – Child Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	to increase timely screening and referral of newborns and infants diagnosed with a genetic or metabolic condition
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Infants born in the state diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel and who received screening within 24-48 hours of life and referral to a tertiary center for diagnosis within 24-48 hours of notification.</td></tr><tr><td>**Denominator:**</td><td>Infants born in Mississippi who are diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel</td></tr></table>
Data Sources and Data Issues:	Genetic Screening data from Perkin-Elmer and EPIC
Significance:	Genetic testing is an important medical tool for assessing various inheritable diseases, conditions, and cancers. The ability to diagnose patients before symptoms surface can help lessen the severity of symptoms and promote quality of life.

SPM 16 - Nulliparous, term singleton, vertex (NTSV) cesarean rate
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce the percent of cesarean deliveries among low-risk first births
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of cesarean deliveries among term (37+ weeks), singleton, vertex births to nulliparous women **Denominator:** Number of term (37+ weeks), singleton, vertex births to nulliparous women
Healthy People 2030 Objective:	Identical to Maternal, Infant, and Child Health (MICH) Objective 06: Reduce cesarean births among low-risk women with no prior births (Baseline: 25.9% of low-risk females with no prior births had a cesarean birth in 2018, Target: 23.6%)
Data Sources and Data Issues:	National Vital Statistics System (NVSS)
Significance:	Cesarean delivery can be a life-saving procedure for certain medical indications. However, for most low-risk pregnancies, cesarean delivery poses avoidable maternal risks of morbidity and mortality, including hemorrhage, infection, and blood clots—risks that compound with subsequent cesarean deliveries.1 Much of the temporal increase in cesarean delivery (over 50% in the past decade), and wide variation across states, hospitals, and practitioners, can be attributed to first-birth cesareans. Moreover, cesarean delivery in low-risk first births may be most amenable to intervention through quality improvement efforts. This low-risk cesarean measure, also known as nulliparous term singleton vertex (NTSV) cesarean, is endorsed by the National Quality Forum (#0471) and included within The Joint Commission's National Quality Measures for hospitals (PC-02), and the Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP. An Alliance for Innovation on Maternal Health (AIM) patient safety bundle for Safe Reduction of Primary Cesarean Births was released in 2018.

SPM 17 - Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the percent of women who have an annual preventive medical visit
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women on Medicaid ages 18 through 44, who report visiting a doctor for a routine checkup in the past year **Denominator:** Number of women on Medicaid, ages 18 through 44
Healthy People 2030 Objective:	Related to Access to Health Services (AHS) Objective 08: Increase the proportion of adults who receive appropriate evidence-based clinical preventive services. (Baseline: 8.0% in 2015, Target: 10.9%)
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System (BRFSS)
Significance:	An annual well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The Women's Preventive Services Initiative (WPSI) is a coalition of national health professional organizations and patient advocates led by the American College of Obstetricians and Gynecologists (ACOG) and works to develop, review, and update recommendations for women's healthcare preventive services. WPSI recommends an annual well-woman visit beginning in adolescence and continuing across the lifespan with any health care provider offering preventive well-woman care.

SPM 18 - Percent of children with and without special health care needs who received services necessary to make transitions to adult health care
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percent of children with special health care needs who have received services necessary for transition to adult health care
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children with special health care needs who have received services necessary for transition to adult health care (12-17 years) **Denominator:** Total number of children with special health care needs (12-17 years)
Data Sources and Data Issues:	NSCH 2020-2021 The main goal of this measure is to increase the percent of children with special health care needs who have received services necessary for transition to adult health care. Therefore, the numerator used is the percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.
Significance:	CYSHCN are children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. They also require health and related services of a type or amount beyond that required by children generally. According to our National Survey of Children's Health (NSCH) (PDF), in our country: (1) About 14 million children under 18 years old (19%) have a special healthcare need, (2) 25% of homes had one or more children with a special healthcare need, (3) CYSHCN are more likely to live in poverty, be non-Hispanic Black, and have public insurance than non-CYSHCN. Mississippi needs to work on a coordinated system of care to support transition.

SPM 19 - Adolescent suicide rate
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	to reduce the adolescent suicide rate among youth ages 15-19 years
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** number of adolescents aged 15-19 years who died by suicide **Denominator:** number of adolescents aged 15-19 years (per 100,000)
Data Sources and Data Issues:	2021 Office of Vital Records and Public Health Statistics
Significance:	Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. There are many factors that contribute to suicide. The goal of suicide prevention is to reduce factors that increase risk and increase factors that promote resilience. In 2020, an estimated 12.2 million adults seriously thought about suicide, 3.2 million made a plan, and 1.2 million attempted suicide. Suicide rates in 2020 were 30% higher than in 2000. Data for Mississippi indicate that the rate has increased from 5.9 deaths per 100,000 adolescents aged 15-19 years in 2012-2014 to 11.6 deaths per 100,000 adolescents aged 15-19 years in 2017-2019.

SPM 20 - Number of MCH programs that have developed a written plan to address health equity
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	to ensure all MCH programs implement plans to achieve health equity by addressing implicit bias, diversity, discrimination, and racism
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** number of written plans that address health equity **Denominator:**
Data Sources and Data Issues:	MCH program data
Significance:	Mississippi ranks last, or close to last, in almost every leading health outcome. In Mississippi and nationwide, these health disparities are significantly worse for those who have systematically faced obstacles to health due to their socio-economic status, race, ethnicity, religion, sexual orientation, geographic location, and other characteristics historically linked to discrimination or exclusion. The result is a disproportionate burden of disease and illness that is borne by racial and ethnic minority populations and the rural and urban poor. Health disparities not only affect the groups facing health inequities, but limit overall improvements in quality of care, the health status for the broader population, and results in unnecessary costs. The MSDH MCH programs believe that developing written plans on how each program will implement plans to achieve health equity by addressing implicit bias, diversity, discrimination, and racism

SPM 21 - Percent of children with and without special healthcare needs who have a medical home
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	to assure that all children with and without special healthcare have a medical home
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** children, 0-17 years, with and without special healthcare needs who have a medical home **Denominator:** all children, 0-17 years, in Mississippi with special healthcare needs
Data Sources and Data Issues:	NSCH 2019-2020
Significance:	A medical home is essential to overall mental, emotional and physical health of children. The American Academy of Pediatrics specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective care. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional who is familiar with the child and family and the child's health history. In Mississippi, the C/YSHCN program is working towards developing a comprehensive, coordinated and integrated system of services for children.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Mississippi

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Mississippi

ESM WWV.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy
NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Measure Status:	Active
Goal:	to assist women in quitting smoking during pregnancy
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of unduplicated individuals who have completed the intake process for Office of Tobacco Control-funded tobacco cessation treatment programs **Denominator:**
Data Sources and Data Issues:	Mississippi Quitline and Baby and Me Tobacco Free data Data issues: new Quitline provider needs to make a concerted effort to document sex / gender and pregnancy status of both callers AND persons up complete the intake process
Evidence-based/informed strategy:	This ESM measures the number of unduplicated individuals who have completed the intake process for OTC-funded tobacco cessation treatment programs and is associated with NPM 1. All providers should be asking their patients about the use of tobacco and nicotine-containing products and, if using tobacco or nicotine, having a discussion around use and making recommendations around quitting and staying quit. Data from the Mississippi Quitline provider and the Baby and Me Tobacco Free Program
Significance:	Data from the Mississippi Quitline provider and the Baby and Me Tobacco Free Program helps us understand how many individuals are accessing and initiating steps in quitting smoking. Along with other PRAMS data, it will allow MSDH to look at provider interactions with pregnant women and discussions / recommendations for quitting. United States. Tobacco use is the leading cause of preventable illness, disability, and death in the United States. About 34 million adults smoke cigarettes. More than 480,000 deaths each year are due to cigarette smoking, including 41,000 deaths from secondhand smoke. Cigarette smoking can negatively affect fertility, making it harder for women to become pregnant. Cigarette smoking during pregnancy has been linked to an increased risk of low birthweight, premature birth, birth defects, and sudden infant death syndrome (SIDS). Mississippi. There are a number of documented disparities related to smoking in Mississippi. Mississippi BRFSS Analytic Findings. Approximately 18% of women aged 18-44 years were

current smokers. The percentage of current smokers was significantly lower among Black women (11.3%) compared to white women (24.9%), and was significantly higher among women who have not completed a high school education (41.6%) compared to those with more than a high school education (13.2%).

Mississippi PRAMS Analytic Findings. Almost 22% of women aged 18-44 years reported smoking in the 3 months before pregnancy. In the last 3 months of pregnancy, about 1 in 10 women aged 18-44 years (10.6%) smoked. In the last 3 months of pregnancy and the postpartum period, smoking prevalence was significantly higher among non-Hispanic White women (15.4% [pregnancy] and 20.1% [postpartum]) compared to non-Hispanic Black women (5.9% [pregnancy] and 10.1% [postpartum]).

Continued monitoring and working with both providers and programs that aid smokers in quitting and staying quit can improve health outcomes for women, infants and children.

ESM BF.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals
NPM – A) Percent of infants who are ever breastfed B) Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Breastfeeding, Formerly NPM 4) - BF

Measure Status:	Active
Goal:	Increase the percent of births occurring in birthing hospitals designated as Baby Friendly
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of birthing hospitals in the state designated as Baby Friendly</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	MSDH Infant Health Program and Baby Friendly USA (https://www.babyfriendlyusa.org/for-parents/baby-friendly-facilities-by-state/)
Significance:	Research has shown that breastfeeding is recognized as the best source of nutrition for most infants. To help support breastfeeding mothers and increase breastfeeding rates in the United States, the U.S. Surgeon General released The Surgeon General's Call to Action to Support Breastfeeding in 2011. The Call to Action sets out clear action steps that communities, health care systems, health care providers, employers, public health professionals, and other organizations and individuals can take to support mothers and make breastfeeding easier. The Baby-Friendly Hospital Initiative (BFHI) supports and recognizes hospitals and birthing centers that offer an optimal level of care for infant feeding by following the BFHI's Ten Steps to Successful Breastfeeding. These steps are practices that hospitals can implement that have been shown to improve breastfeeding outcomes.

ESM SS.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals NPM – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep (Safe Sleep, Formerly NPM 5) - SS

Measure Status:	Active
Goal:	Increase safe sleep educational awareness to providers, MSDH staff and community partners by 1% in the next year.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of safe sleep educational books and resources distributed to families in all birthing hospitals. **Denominator:**
Data Sources and Data Issues:	MSDH Infant Health Program
Significance:	The number of U.S. sleep-related Sudden Unexpected Infant Death (SUID) cases, including Sudden Infant Death Syndrome (SIDS), is approximately 3,500 deaths per year. Since the Back to Sleep campaign launched in 1994, the overall U.S. SIDS rate declined by more than 60%; the proportion of infants placed on their backs to sleep increased from 27% in 1993 to 74% in 2011. Strategies to increase the percentage of infants usually placed to sleep on their backs include supporting the implementation of safe sleep practices through policies, accreditation, and legislation. .

ESM DS.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the awareness of health professionals and parents / families on the importance of developmental screening and monitoring using a parent-completed tool</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>Number of health professionals and parents / families who receive training on developmental screening and/or monitoring</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Early Intervention Child Find Log</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Professionals and families who understand the importance of developmental screening and monitoring and have the knowledge and skills to use quality measures are more likely to ensure timely developmental screenings and ongoing monitoring occurs.</td></tr>
<tr><td>Significance:</td><td>Professionals and families need awareness of developmental milestones and the importance of regular screenings and ongoing monitoring to ensure development is on track or to identify concerns early. Professionals and families also need skills in using parent-completed developmental monitoring and screening tools to use them successfully.</td></tr>
</table>

ESM PA-Adolescent.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide
NPM – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent

Measure Status:	Active
Goal:	Increase physical activity among adolescents, ages 12 through 17 years
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide **Denominator:** Number of junior high schools and high schools in Mississippi
Data Sources and Data Issues:	Completed School Health Index (SHI) Self-Assessment and Planning Guides
Evidence-based/informed strategy:	This ESM aims to identify the systems and structures that are barriers to adolescent physical activity. The School Health Index (SHI) Self-Assessment and Planning Guide is an online self-evaluation and planning tool for schools. The SHI is built on CDC's research-based guidelines for school health programs that identify the policies and practices most likely to be effective in reducing youth health risk behaviors. By working with schools that conduct the assessment, MSDH could collaborate with schools, particularly those with school-based health centers, on assisting in the development of policies and practices (such as 'exercise prescriptions') to increase time in schools for physical activity and laying a foundation for healthy behaviors.
Significance:	This ESM aims to identify the systems and structures that are barriers to adolescent physical activity. The School Health Index (SHI) Self-Assessment and Planning Guide is an online self-evaluation and planning tool for schools. The SHI is built on CDC's research-based guidelines for school health programs that identify the policies and practices most likely to be effective in reducing youth health risk behaviors. Given that approximately 1 in 5 youth are physically active at least 60 minutes per day, Mississippi needs to look towards systems, structures and policies that can be leveraged to facilitate physical activity among youth.

ESM AWV.2 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Measure Status:	Active
Goal:	to improve preventive medical visit coverage for Mississippi adolescents aged 12-17 years
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years **Denominator:**
Data Sources and Data Issues:	number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years
Evidence-based/informed strategy:	This ESM is a first attempt to better understand the array of services available to youth 12-17 years in each of the county health departments. This measure is designed to help show the gap filling nature for Mississippians who are uninsured, underinsured or without a medical home. While MSDH is not a medical home or the primary care provider for Mississippians, MSDH fills essential gaps in care and is the last payer of resort for many Mississippians.
Significance:	This measure is designed to help show the gap filling nature for Mississippians who are uninsured, underinsured or without a medical home. While MSDH is not a medical home or the primary care provider for Mississippians, MSDH fills essential gaps in care and is the last payer of resort for many Mississippians. MSDH also does its best to connect all patients to a primary care provider / medical home. MSDH county health departments provide an array of integrated health services, including family planning, HIV/STI services, cancer screening, sexual health counseling, immunizations, TB screening and treatment, and EPSDT (well child checks) to Mississippians across the life span, including adolescents, ages 12-17 years. However, not all services are provided at every location. MSDH served, in some capacity, about 30,000 children (not including WIC). As a gap filler, MSDH could assess locations and types of services offered to help improve family planning, HIV and STI prevention, and immunization coverage among Mississippi youth.

ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Measure Status:	Active
Goal:	Increase the number of providers receiving education or technical assistance about the need and importance of medical home/family-centered care by 5% in the next year.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care **Denominator:**
Data Sources and Data Issues:	MSDH Children's Medical Program
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. We are planning to work with two (2) community based clinics utilizing the medical home model as pilot sites for referring and providing care coordination to children and adolescents enrolled in CMP.

ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education NPM – Percent of women who had a preventive dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of pregnant and postpartum women who received oral health education by 10% in the next year in order to increase the awareness of women regarding the importance of oral health.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of expectant and postpartum women who received oral health education</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Office of Oral Health/PHRM/FQHC partners

We are currently using REDCAP as a tool to capture data from the activities of our Regional Oral Health
Consultants. The number reflected includes women from WIC, community baby showers and similar events. The
actual number is 5,851 but due to data ranges for this indicator, 1,000 was indicated for 2023.</td></tr>
<tr><td>Significance:</td><td>Oral Health promotion and oral disease prevention in parents and children; referral to dental home</td></tr>
</table>

ESM PDV-Child.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Measure Status:	Active
Goal:	Increase the collaborative partnership between MSDH nurses and Office of Oral Health in preventing oral disease and supporting children having a dental home by 1st year of life
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of children 0-3 years old who actually went to referred dentist **Denominator:**
Data Sources and Data Issues:	Office of Oral Health/MSDH Nurses-Epic system - While we are using our EPIC system to capture data on the number of EPSDT wellness visits where agency nurses provide oral health assessments and referrals to dentist, the process for this information to be given to our dental care coordinator was not synchronized during the time of this reporting. Four hundred thirty-seven (437) children, ages 0-3, were seen for EPSDT visits by MSDH nurses. Due to the lack of centralized reporting, we are uncertain of the actual number that saw a dentist, but we are working to follow up with these participants to share these data.
Significance:	Prevention of oral disease in children under 6 years old

ESM PDV-Child.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Measure Status:	Active
Goal:	Increase the collaborative partnership between MSDH nurses and Office of Oral Health in preventing oral disease and supporting children having a dental home by 1st year of life
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** # of referrals to dentists of children 0-3 by MSDH nurses **Denominator:**
Data Sources and Data Issues:	Office of Oral Health/MSDH Nurses-Epic system The program is now aware of the check box for wellness visits active in the EPIC system and the ability to generate reports on dental referrals documented. Unfortunately, with the shortage and turnover of nurses with the agency, not all team members were using this tool and additional training is needed. The program is also unsure if this information is also documented in the patient's chart and they will need to manually review each entry to decide. The program is planning to work with the Chief Nurses to update training and protocols on this tool.
Significance:	Prevention of oral disease in children under 6 years old

ESM PDV-Child.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Measure Status:	Active
Goal:	Increase the number of training completed by medical providers on use of fluoride varnish in primary care setting by 5% in the next year to eradicate oral disease in children through collaborative partnership between dentists and medical providers
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of training completed by medical providers on use of fluoride varnish in primary care setting **Denominator:**
Data Sources and Data Issues:	Office of Oral Health During this reporting period, fourteen (14) Cavity Free in Mississippi trainings were conducted where 54 non dental providers (medical doctors, nurse practitioners and physician assistants) were trained on the use of fluoride varnish in a primary care setting.
Significance:	Interdisciplinary care; oral disease prevention in children

Form 11
Other State Data

State: Mississippi

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Mississippi

Annual Report Year 2023

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	1		
2) Vital Records Death	Yes	Yes	Quarterly	1	No	
3) Medicaid	Yes	No	Quarterly	3	Yes	
4) WIC	Yes	Yes	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Less Often than Annually	18	No	
8) PRAMS or PRAMS-like	Yes	Yes	Less Often than Annually	18	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) BRFSS	Yes	Yes	Less Often than Annually	12	No	
10) YRBSS	Yes	Yes	Less Often than Annually	24	No	
11) NSCH	Yes	Yes	Daily	21	No	
12) EPIC	Yes	Yes	Daily	0	No	
13) HHLPSS	Yes	Yes	Daily	0	No	
14) CATALYST	Yes	Yes	Daily	0	No	
15) NVSS	Yes	Yes	Daily	0	No	
16) HPSA Find	Yes	Yes	More often than monthly	0	No	
17) Mississippi Infant & Toddler Intervention (MITI) Data System	Yes	Yes	Daily	0	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Mississippi

Annual Report Year 2023

Products and Publications information has not been provided by the State.