Maternal and Child Health Services Title V Block Grant

Mississippi

FY 2026 Application/ FY 2024 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

MISSISSIPPI STATE DEPARTMENT OF HEALTH

July 18, 2025

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 2026 Application and 2024 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 five 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 and five-year duration of this grant cycle 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 our interim grant coordinator, Danielle Seale at 601-576-7856 or by email at: Danielle.Seale@msdh.ms.gov.

Sincerely,

Daniel Edney, MD

Daniel Edney, MD, FACP, FASAM
State Health Officer
Mississippi Department of Health

Danielle Seale MSW LCSW

Danielle Seale, MSW, LCSW
Title V Project Director
Mississippi Department of Health

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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 *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

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. 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 women, infants, adolescents, children, and youth with and without special health care needs (CYSHCN), 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. 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 communications, health policy and planning, public health laboratory, health facilities, licensure/certification, and social services.

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, adolescents, children and CYSHCN across the state of Mississippi. Health Services oversees the provision of services and programs spanning the life course through various offices and programs: (a) Women's Health, including the Maternal & Infant Health Bureau, Healthy Moms/Healthy Babies, Healthy Start, Breast and Cervical Cancer Program, Time4Mom Postpartum Home Visiting Program, and Family Planning/Comprehensive Reproductive Health; (b) Child and Adolescent Health, including Genetics/Newborn Screening, Early Hearing Detection and Intervention, Early Periodic Screening, Diagnosis, and Treatment, Lead Poisoning Prevention and Healthy Homes, Maternal, Infant, and Early Childhood Home Visiting, Adolescent Health, and Children and Youth with Special Health Care Needs programs; (c) First Steps Early Intervention Program; (d) MCH Engagement and Coordination; and (e) Financial Management and Operations.

Health Services Division partners with the Office of Health Data and Research 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, adolescents, children and youth with and without special health care needs, and their families, such as the Office of Preventive Health, the Public Health Pharmacy, Oral Health, the Special Supplemental Nutrition Program for Women, Infants and Children's, 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 with Special Health Care Needs (CSHCN), 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: 2026 Five-Year Needs Assessment

In 2024-2025, MSDH conducted a comprehensive needs assessment for the 2026-2030 cycle using an independent contractor and internal staff. Key components of the needs assessment process involved: (a) qualitative and quantitative

data collection and analysis of surveys, focus groups, listening sessions, and town hall meetings; (b) a community and provider survey; (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. To ensure broad stakeholder engagement, MSDH collaborated with various internal and external partners in the needs assessment surveys. MSDH worked with internal stakeholders to bring together MSDH staff and community members to participate in the focus groups, listening sessions, and town hall meetings.

After collecting initial information, a stakeholder meeting was held with MSDH staff and partner organizations to examine each MCH domain to assist with selecting potential priorities and determining the importance, feasibility and workforce capacity. Recommendations were made to continue, improve, and/or adapt priorities based on the progress on performance measures made during the reporting periods. To support the selection of priorities, ensuring they align with the MSDH Mission and Vision, Health Service programs and capacity, Health Service team worked with the University of North Carolina, MCH Workforce Development Center to determine the 2025-2030 priorities, along with the NPMs, NOMs, and ESM for the 2025-2030 State Action Plan.

Identified Priorities and Performance Measures
As a results of the Five-Year Needs Assessment process, the MCH Programs and stakeholders, including community organizations, providers, supporters, 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).

Domain: Women / Maternal Health
Priority: *Improve Maternal Health Outcomes*

- *NPM: % of women using a most or moderately effective contraceptive following a live birth*
- *NPM: % of women who have a postpartum visit within 12 weeks after birth; % of women who attended a postpartum checkup and received recommended care components.*
- *NPM: % of women screened for depression or anxiety following a recent live birth*
- *NPM: % of women who had a preventive dental visit during pregnancy.*

Domain: Perinatal / Infant health
Priority: *Reduce Infant Mortality*

- *NPM: % of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)*
- *NPM: % of infants who are ever breastfed; % of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months*
- *NPM: % of infants placed to sleep on their backs; % of infants placed to sleep on separate approved sleep surface; % of infants placed to sleep without soft objects or loose bedding; % of infants room-sharing with an adult*

Domain: Child Health
Priority: Increase access to timely, health, developmental, behavioral health screenings

- *NPM: % of children with and without special health care needs, 0 through 17, who have a medical home.*
- *NPM: % of children, ages 1-17,who had a preventive dental visit in the past year.*
- *SPM: % of babies who meet 1-3-6 recommendations for screened (passed and not passed) before 6 months of age; % of babies who meet 1-3-6 recommendations for diagnosis with permanent hearing loss: before 3 months of age; % of babies who meet 1-3-6 recommendations babies referred to Part C EI: before 6 months of age.*
- *SPM: % of First Step Early Intervention Program referrals who get an Individualized Family Service Plan*
- *SPM: Percentage of individuals who have been identified as having sickle cell trait and/ or disease by the Genetic program who were referred to the Lead poisoning prevention program*
- *SPM: % of Mississippi newborns screened; % of Mississippi newborns who received a newborn screenings during 24-48 hours after birth; of Mississippi newborns who received a newborn screening during 24-48*

hours after birth with an abnormal result. (Newborn Screening program)

Domain: Adolescent Health
Priority: Improve Adolescent Health

- *NPM: % of adolescents, ages 12-17,with preventive medical visit in the past year*
- *NPM: % of adolescents, ages 12-17,who received needed mental health treatment and counseling*

Domain: Children and Youth with Special Health Care Needs
Priority: Ensure medial homes for CYSHCN

- *NPM: % of children with and without special health care needs, ages 0 through 17, who receive needed care coordination*
- *NPM: % of adolescents with and without special health care needs ages 12-17, who received services to prepare for the transition to adult health care.*
- *NPM: % of children with and without special health care needs, ages 0 through 17, who have a medical home*

Domain: Cross Cutting
Priority: Improve Access to and Utilization of MCH-serving programs and activities available through MSDH

- *SPM: # of social media messages focused on MCH-serving programs per year.*
- *SPM: # of community-based activities attended where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form.*
- *SPM: % of referrals by MSDH MCH-serving programs that are on the on-line Universal Referral Form.*

Priority: Maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations

- *SPM: % of MSDH MCH-serving programs that have administered a patient satisfaction survey in past year to engage community in program improvement.*

Priority: Increase access to timely, health, developmental, behavioral health screenings

- *SPM: Total number of referrals for social conditions affecting the health of patients being served by MSDH county health department clinics.*

Assuring Comprehensive, Coordinated, Family-Centered Services
The MCH Program assures comprehensive and coordinated services in several ways. MSDH core services (care coordination, community outreach, family planning, and health promotion) are offered in 85 county/local health departments. Title V funded MCH staff work at multiple levels: Central Office, four public health regions. (see Attachment: Regional, County, and Program Maps) to 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 for women, infants, adolescents, and CYSHCN, and their families as they seek information, 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. To further assure comprehensive care, MSDH has expanded its network of support services to assistance with applications for Marketplace Insurance and the Family Planning Medicaid Waiver, offering reduced-rate services, transportation support, and telehealth options.

Lived Experiences of Individuals, Communities, Families, and Caregivers
A strength of the Mississippi's MCH/Title V Program lies in its partnerships with individuals, communities, families, and caregivers. The MS 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 advance just and fair conditions in Mississippi. Examples of MSDH's MCH partners and partnering practices are described below in the Community Partner section.

Community Partners
Mississippi's MCH/Title V Program further expands its partnerships through grant-funded activities and partnerships

that align with state priorities, such as providing support and training for family leaders and creating guidance/training for delivering teen-friendly services.
Entities include, but are not limited to:

- Federally Qualified Health Centers and Community and School Health Centers
- Parent Advocacy Centers (*Families as Allies*, Family Voices, *MS Coalition for Citizens with Disabilities*, the IDEA Parent Training & Information Center)
- Community organizations (*Mom.ME.*, *Six Dimensions*, *MS Public Health Institute, Teen Health Mississippi, Institute for the Advancement of Minority Health)*
- Mississippi Perinatal Quality Collaborative
- Professional associations (*MS Public Health Association, MS Chapter of the American Academy of Pediatrics, MS Speech & Hearing Association, MS Hospital Association, a*nd *MS Head Start Association)*
- Professional Organizations (*St. Jude Research Hospital and Revvity Omics)*

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, Mississippi Department of Child Protection Services, Mississippi Division of Medicaid, and Mississippi Department of Education. 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 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. MCH Block Grant Leadership team assists with the planning, development and implementation of the State Action Plan, addressing integrated objectives, strategies, and activities. The 2026 application continues the implementation of broad objectives, strategies, and activities across multiple programs with a unified approach to improving health outcomes for MCH populations. Both are organized according to priorities and have been collectively developed by MCH program personnel and epidemiologists from the Office of Health Data and Research.

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, high poverty, aging infrastructure, and frequent natural disasters.

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 supported by Title V funds. Four public health (PH) regions are appropriated MCH Block Grant funding 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, perinatal, and maternal health across populations.

Aligning Title V funds within the Divisions of Health Services and Preventive Health 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. The Health Service Divisions has an active role via 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. Core public Health services are delivery through a network of county health departments (CHD) and staff, (clerical/administrative, social workers, nurses, nutritionists, and clinicians). Staff supported by state funding provide services to patients accessing programs supported or related to MCH, including clinical, perinatal/infant case management, EPSDT, childhood immunizations, and family planning. The programs are also supported by Title V funds for gap filling services.

In the ongoing effort to improve access to care, MSDH is actively transforming how services are delivered throughout CHDs. This transformation involves implementing a statewide, tiered Public Health Service Delivery System designed to provide effective and efficient care based on each clinic's size, available funding, staffing levels, and patient volume.

Major Investment in Promoting Mental Health

Throughout the 2023-2024 program years, 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, Genetic Services Bureau, Early Intervention Services, Healthy Moms/Healthy Babies, and Lead Poisoning Prevention and Healthy Homes, continued participation 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. To build capacity, four MCH staff members, including Early Intervention Service Coordinator Coaches and experienced Master Level 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.

Grant Enhanced Current Prenatal Vitamin Program

Prenatal vitamins are essential in supporting healthy pregnancies by supporting both the development of the baby and the well-being of the mother. Women, who want to become pregnant or are pregnant and receiving services within county health departments, are provided counseling and education on preconception health, including the importance of prenatal vitamins. Women are offered prenatal vitamins to bridge the gap between the pregnancy testing at the CHD and appointment with medical provider. Access to these supplements encourages women to engage with healthcare services early in their reproductive journey, facilitating informed decisions about family planning. This proactive approach supports healthier pregnancies and contributes to reducing maternal and infant mortality rates.

In June 2024, the Office of Women's Health was honored to receive the Vitamin Angels Grant, a public health nonprofit, to distribute prenatal vitamins to disadvantaged future and current expecting mothers. With the generous support of Vitamin Angels, we have been able to strengthen and expand our current efforts to support maternal and infant health within our communities and programs. These free bottles of prenatal vitamins support women who face financial and/or access issues related to obtaining vitamin supplements during pregnancy. One HM/HB participants shared she could not afford the over-the-counter prenatal vitamins. Through this program, she was provided a 6-month supply free and counseled on the importance of daily supplementation during pregnancy. For the reporting period, a total of 2,027 orders for prenatal vitamins were written for MSDH patients, most of them at the point of care pregnancy test.

III.B. Overview of the State

III.B.1. State Description

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 America 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 2025, Jackson, the state’s capitol and largest city, had a population of 141,449 and the next largest city is Gulfport, with a population estimate of 74,621.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 inadequately served medical areas, according to the Health Resources and Services Administration (HRSA).

Mississippi’s population is estimated to be 2,943,045 (1). Compared to the nation, a substantially larger percent of the Mississippi population is Black, 37.8% vs. 13.7% nationally, and substantially smaller percentages of the state population are Latinx, 3.9% vs 19.5% nationally, and the white population is 58.7% vs. 75.3% nationally. (2) 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 of homeownership. The tables below depict comparison rates between Mississippi and the United States, based on the July 1, 2024, Census Bureau population estimates, for demographics as well as some socioeconomic factors. (3)

	MS (%)	US (%)
White	58.7	75.3
Black	37.8	13.7
Two or more races	1.5	3.1
Asian	1.2	6.4
American Indian and Alaska Native	0.7	1.3
Native Hawaiian and Other Pacific Islander	0.1	0.3

Socioeconomic Factors	MS (%)	US (%)
High school graduate or higher	86.6	89.4
Unemployment rate (March 2025)	3.9 (4)	4.2 (4)
Homeownership rate	71.1	65.2
Children in poverty (<18 yrs)	23.2	16
Persons in poverty (all ages)	18	11.1
Persons without health insurance (<65 yrs)	12.4	9.5

Health Status of Mississippi's MCH Population

According to America's Health Rankings, Mississippi ranked 49th in overall health in 2024 (6). Traditionally, 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, teen births, and low birth weight. 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 (7).

State's Strengths and Challenges

Access to comprehensive, quality health care services is important for the quality of a healthy life for everyone. Health care access impacts overall physical, social, and emotional well-being status; prevention of disease and developmental delays / impairments; 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 developmental delays / impairments; 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 29 critical access hospitals (8), 73 rural hospitals with 49 beds or less, 238 Federally Qualified Community Health Center clinics, and 245 Rural Health Clinics.(9)

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 and morbidity, 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). *Note: The Breastfeeding Report Card has traditionally been released every two years. CDC will not publish a Breastfeeding Report Card in 2024. The next update will be in 2025. (10)*

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 total score for 2024 is 87 (compared to 82 nationally).

(11)

According to 2024 America's Health Rankings, tobacco use during pregnancy decreased 25%, from 6.8% to 5.1% between 2021 and 2022(12); of live births, teen births increased 3.1% from 25.6% to 26.4% of births between 2021 and 2022(13); meningococcal immunization among children ages 13-17 increased 13%, from 55.5% to 62.9% between 2022 and 2023(14); Tdap immunization among children ages 13-17 increased 5%, from 87.0% to 91.7% between 2022 and 2023(15); and physical inactivity among women ages 18-44 decreased 4.7% from 27.4% to 28.7% between 2021-2022(16). 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. The state maintained its historic gains in 4th grade reading and mathematics on the 2024 National Assessment of Educational Progress (NAEP). Based on information from the Mississippi Department of Education (MDE) statewide results from the 2024 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 47.8% in ELA, 63.4% in science, and 56.3% in mathematics. There was a slight decrease in U.S. History from 71.4% in 2022-2023 to 70.9% in 2023-2024. (17)

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 its highest-ever rate of students scoring proficient or advanced in all four NAEP tested grades and subjects. The percentage of grade 4 students scoring proficient or advanced in reading exceeds the national average. In grade 4 math, the percentage of students scoring proficient or advanced is statistically tied to the nation's average. Mississippi is one of only a few states with improved NAEP scores since 2013. In most states, NAEP scores have been falling over the past decade.

While Mississippi has more improvements to make, substantial progress has been made through the state's steady achievement in education.(18) 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 unequal income distribution, and 50th for healthy lives. (19) 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 rural characteristics, 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 2023, as part of the Behavioral Risk Factor Surveillance System (BRFSS), 14.1% of Mississippians(20) surveyed said they were unable to see a doctor at some point in the prior twelve months because of cost.

The state's challenges particularly impact the state's most unsupported residents, including CYSHCN and their families, Medicaid recipients, the working poor, and rural residents. Mississippi has a high percentage of CYSHCN, CYSHCN living in poverty, and more severe health care provider shortages than most states. In addition to those challenges are Medicaid changes to MCOs, closure of the Title V Children's Special Health Services clinic, and the decision not to expand Medicaid within the state of Mississippi. Also, Mississippi still faces challenges because of health care reform with the rising cost 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 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 2024, more than half of Mississippi counties (51.2% of counties)(21) are considered maternity care deserts. 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.

State Title V Program

The mission of MSDH is to “protect and advance the health, well-being and safety of everyone in Mississippi”. 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.

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 pertaining to women, infants, adolescents, children and children with special health care needs:

HB 188 - An act to create the "dignity and safety for incarcerated women act".
SB 2743 - To allow funds collected for certified copies of birth, death, and marriage records to be used for public health programs such as those pertaining to maternal, infant and child health.
HB 1308 - To establish the offense of grooming of a child.
HB 1189 - To increase the deposits paid into the "victims of human trafficking and commercial sexual exploitation fund".
HB 809 - To clarify the school enrollment choices of children or active-duty members of the United States armed forces.
HB 662 - To revise the criteria for presumptive eligibility for Medicaid for pregnant women to conform to federal law and regulations.
HB 1387 - To revise which relatives may receive reimbursement for the care of foster children.
HB 807 - An act to establish the division of autism services within the bureau of intellectual and developmental disabilities of the state department of mental health to develop and coordinate autism services.
SB 2771 - To revise the timeline for permanency hearings in youth court for children that have been adjudicated abused or neglected.

Postpartum Medicaid Extension: Mississippi Senate Bill 2212 was signed into law and took effect July 1, 2023, extending Medicaid coverage from 60 days to 12 months. This change eliminates the automatic enrollment of women ages 13 to 44, who are eligible for Medicaid maternity services and have reached the end of their 60-day postpartum period.

Medicaid Presumptive Eligibility for Pregnant Women: During the 2024 legislative session, a new “presumptive eligibility” law was passed and was to take effect July 1, 2024. This legislation was intended to allow for earlier Mississippi Medicaid coverage during pregnancy by offering presumptive eligibility for pregnant women (PEPW) to provide coverage for ambulatory prenatal care for up to 60 days. However, the original legislation required women to show proof of income upon application and monthly thereafter. It was found by the Centers of Medicare and Medicaid to conflict with federal law and therefore did not go into effect.

The revised law (HB 662) passed in the 2025 legislative session and revised the 60-day presumptive eligibility (PE) for pregnant women to however long it takes for her Medicaid application to be approved. However, that application must be made by the end of the second month of presumptive eligibility coverage. It also only requires the patient to attest to their income because Medicaid will be the agency to determine proof of income.

Pursuant to the legislation, the MSDH county health departments, along with FQHCs, are considered qualified providers and are approved and designated by the Division of Medicaid to conduct presumptive eligibility determinations for pregnant women. Other providers can apply to offer PE determinations. The Center for Public Health Transformation (CPHT) within MSDH was tasked with operationalizing presumptive eligibility across its statewide network of county health department clinics. The CPHT established key administrative foundation/infrastructure, submitted initial qualifying eligibility determination provider documents, and finalized an MOU with DOM during the reporting period. The Center also developed a model utilizing an existing workforce of clerks at each clinic and integrating presumptive eligibility determination into the existing new patient/established patient clinical workflow processes. The Center began operationalizing a plan for individualized training to increase the capacity for the clerical workforce to engage in presumptive eligibility determination. Training and final

operationalization is still in progress.

Newborn Screening Panel

In March 2022, the Mississippi Legislature unanimously passed House Bill 927, amending the comprehensive newborn screening program to align with the Recommended Uniform Screening Panel (RUSP). Under this new state law, the MSDH is required to update the newborn screening panel to include all conditions within three years of being on the RUSP and adopt any rules and regulations needed to accomplish the program or submit a report to the legislature on the status and reasons for the delay. As the Mississippi Panel was already largely compliant with the RUSP, this law will mainly ensure the panel remains current with the advances in science as new diagnostic tests and treatments for conditions are developed. Mississippi is the eighth state in the nation to adopt RUSP alignment legislation.

Maternal Mortality Review Committee

The Mississippi Legislature passed House Bill 494 in March 2017 authorizing MSDH to establish the Maternal Mortality Review Committee to review maternal deaths and establish strategies to prevent maternal deaths. The Mississippi Maternal Mortality Review Panel is a multidisciplinary committee whose geographically diverse members represent various specialties, facilities, and systems that interact with and impact maternal health. The panel consists of approximately 8-10 members who commit to serve a two-year term. The Maternal Mortality Review Panel will review and make decisions about each case based upon the case narrative and abstracted data. The purpose of the review is to determine the causes of maternal mortality in Mississippi and identify public health and clinical interventions to improve health systems of care. Maternal mortality includes deaths occurring during pregnancy and up to one year after pregnancy. Information is gathered from death certificates, birth certificates, medical records, autopsy reports, and other pertinent resources. Records are abstracted by a trained abstractor, and de-identified case narratives are reviewed by the Maternal Mortality Review Panel.

Child Death Review

The Mississippi Child Death Review Panel (CDRP) was established by House Bill 560 becoming in 2006. The legislation is intended to foster the reduction of infant and child mortality and morbidity in Mississippi and to improve the health status of infants and children. The review of these fatalities provide insight on factors that lead to the death, trends of behavior patterns, increases or decreases in the number of causes of death, and gaps in systems and policies that hinder the safety and wellbeing of Mississippi's children. Through the review process, the CDRP develops recommendations on how to most effectively direct state resources to decrease infant and child deaths in Mississippi. The CDRP reviews all child deaths from birth to under 18 years old due to unnatural causes.

1. U.S. Census Bureau QuickFacts: Mississippi; United States
2. U.S. Census Bureau QuickFacts: United States
3. U.S. Census Bureau QuickFacts: Mississippi; United States
4. BLS Data Viewer
5. Civilian unemployment rate
6. 2024 Annual Report | 2024 Annual Report
7. 2024 Health of Women And Children Report | 2024 Health Of Women And Children Report
8. Rural health for Mississippi Overview - Rural Health Information Hub
9. Data on Rural Hospitals – Saving Rural Hospitals
10. Breastfeeding Report Card | Breastfeeding Data | CDC
11. mPINC™ Regional Report | Breastfeeding Data | CDC
12. Explore Smoking During Pregnancy in the United States | AHR
13. Explore Teen Births in Mississippi | AHR
14. A User's Guide for the 2022 PUF
15. NIS-Teen: A User's Guide for the 2023 PUF
16. Explore Physical Inactivity in the United States | AHR
17. maap_2024_results_executive_summary_final_8.15.24.pdf
18. Mississippi's 2024 NAEP Results
19. U.S. Healthcare Rankings by State 2023 | Commonwealth Fund
20. Updated 2023 BRFSS data
21. Where you live matters: Maternity care access in Mississippi | PeriStats | March of Dimes

III.B.2. State Title V Program

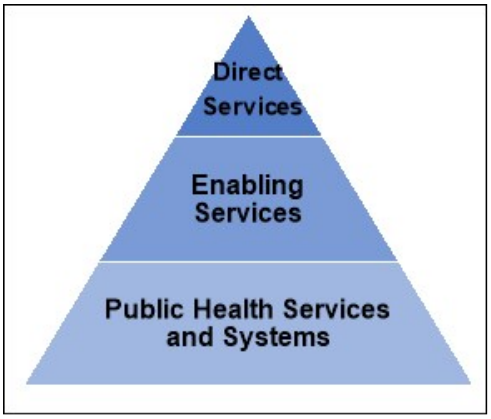
Purpose and Design

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 women, infants, adolescents, children with and without special health care needs, 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.

Public Health Services for MCH Populations:
The Title V MCH Services Block Grant

MCH Essential Services

1. Provide Access to Care
2. Investigate Health Problems
3. Inform and Educate the Public
4. Engage Community Partners
5. Promote/Implement Evidence-Based Practices
6. Assess and Monitor MCH Health Status
7. Maintain Public Health Work Force
8. Develop Public Policies and Plans
9. Enforce Public Health Laws
10. Ensure Quality Improvement



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 in-danger 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 in need of specialized medical care and treatment;
- Promote healthy behaviors in adolescents and successful transition to adult care; and
- Promote positive mental health and access to mental health care services to assure quality of life and wellbeing across MCH populations.

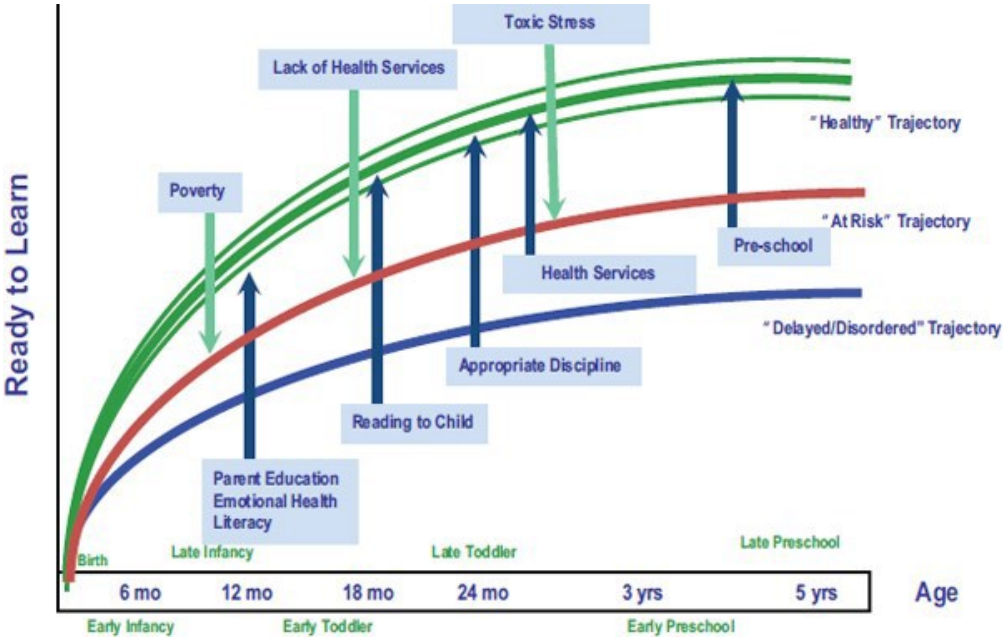
Conceptual Frameworks

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 differences. 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 "in-danger" 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 of 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, community/state/regional organizations, research institutions, and media), and policy (such as local/state/national legislatures, federal government agencies, and national/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 the obstacles and identifies interventions which point towards 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.

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 ten years of implementation and monitoring progress toward the original four priorities, a second round of assessment was conducted in 2019 and an updated plan was developed in 2022.

With analysis complete, the SHAIC considered the following prioritization criteria to identify a list of strategic issues:

- Cross Cutting issues emerging from multiple assessments
- Differences related to issue (disproportionately affected sub-populations)
- Cost and/or return on investment
- Availability of solutions/best practices
- Availability of resources (staff, time, money, equipment, potential grants) to address issues
- Urgency of addressing issues
- Size of issues (e.g., # of individuals affected)
- Feasibility (likelihood of being able to make an impact working together)

After reviewing these key findings from the prioritization criteria, the SHAIC identified the 2022-2026 priorities as: 1) Battle weight related issues to prevent and manage chronic disease; and 2) Addressing social conditions impacting health. 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 supported by active and committed citizens and organizations*."[1]
For more information about the SHIP, link to the UProot Mississippi website at https://uprootms.org/.

Partnership/Leadership in Accomplishing the 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, and with other advisory capacities.

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 to accomplish the mission and vision of the MCH Block Grant. The MCH Leadership Team also aids in the identification of additional partnerships and resources at the state and local level.

Key Personnel

New key personnel have assumed MSDH/MCH leadership due to personnel leaving the agency or retiring. Below is the list of current MSDH/MCH leadership, those who have left the agency, along with vacancies:

Daniel Edney, MD, FACP, FASAM, is the 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.

Shelia Anthony, Ed.D., serves as the Director for the Office of Child and Adolescent Health, which includes 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.

Krista Guynes, MSW, LCSW, serves as 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, NE MS Healthy Start, Family Planning/Comprehensive Reproductive Health (FP/CRH) Program, the Maternal and Infant Health Bureau (MIHB) and Time4Mom (T4M). She previously led the BCCP and Perinatal High-Risk Management (PHRM) Programs.

Valecia Davis, MS, serves as the CYSHCN Director. She previously served in Early Intervention and Health Services Operations and interim Adolescent Health Director.

Ms. Danielle Seale, MSW, LCSW, serves as the MCH Engagement and Coordination Office Director and interim MCH Block Grant/Title V Director, bringing more than a decade of public health experience. The Office was assigned a cadre of Public Health Social Workers to provide supplemental social services to Health Service programs.

Johnny Singleton serves as the Office of Financial Management and Operations from the MSDH F&A Office. The Office supports MCH programs in budgeting and tracking expenditures.

Melissa Cox serves as the interim Part C Coordinator for the First Steps Early Intervention Program, organized directly under Health Services.

Ellen Agho, DrPH, MPH, CHP serves as the Director of the Office of Health Data & Research.

Staff who have left the agency since the last reporting period include: Dr. Beryl Polk, the former Title V Director, retired after 24 years of service; Dr. AnnaLyn Whitt; Praise Tangbe; and Stacy Callender.

Currently, several key MCH leadership positions remain vacant, including: The Adolescent Health Director position,

the Health Service Bureau Director, and the MCH Block Grant / Title V Director, currently filled by Danielle Seale. 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 colleagues 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.

The Mississippi State Department of Health (MSDH) delivers core public health functions across the state through a network of county health departments. These services are provided through a comprehensive network of clinical, programmatic, case management, and home and community-based services. These services are available in some capacity at every county health department. Among the most critical offerings are Maternal and Child Health Services, which are integrated into the broader continuum of care provided by multidisciplinary teams that include physicians, nurse practitioners, registered nurses, case managers, and other health professionals.

In the ongoing effort to improve access to care, MSDH is actively transforming how services are delivered throughout Mississippi's county health departments. This transformation involves implementing a statewide, tiered Public Health Service Delivery System designed to provide effective and efficient care based on each clinic's size, available funding, staffing levels, and patient volume.

Under this model, county health departments are classified into four levels:

- **Level I Clinics** are located primarily in smaller, rural counties. Although they do not provide nursing services, they serve as vital access points by offering WIC nutrition and education, fingerprinting, and records requests. Level I clinics also serve as essential access points by assisting clients with scheduling appointments and arranging transportation to higher-level facilities.
- **Level II Clinics** offer the full range of public health services, including nursing care, on a part-time or full-time basis, depending on local needs.
- **Level II/III Clinics** offer part-time clinician coverage tailored to patient demand and census data.
- **Level III Clinics** operate as full-service centers, typically located in larger counties, and serve as regional hubs for comprehensive public health services.

To further expand access to care, MSDH has expanded its network of support services to eliminate common challenges to obtaining to care. These include assistance with applications for Marketplace Insurance and the Family Planning Medicaid Waiver, offering reduced-rate services, transportation support, and telehealth options. MSDH is also seeking opportunities to collaborate with community-based organizations and Federally Qualified Health Clinics to expand and create a larger and more comprehensive network of care.

Recognizing the unique health disparities in the Mississippi Delta, MSDH has designated a special Delta Public Health Region, comprising the 13 core Delta counties. This region faces distinct challenges that contribute to poorer health outcomes. The Delta Region initiative aims to address these issues by prioritizing Maternal and Child Health, Chronic Disease prevention and management, and Health Literacy.

MSDH remains dedicated to understanding and addressing the many factors that influence health outcomes across Mississippi. Through continued innovation and transformation of health service delivery, the agency strives to ensure that all Mississippians have access to the quality care they need—regardless of where they live.

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, the EHDI program's Advisory Committee, and the Genetics Advisory Committee.

- The CYSHCN Care 2 Team (FQHCs) consists of care coordinators, primary care and specialty providers,

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 (FQHCs) initiative promotes team-based care, population-based services, transitioning to adult healthcare providers, and family engagement.

- The Early Intervention State Interagency Coordinating Council (SICC) is comprised of 29 members (providers of early intervention services, representatives of various state agencies and community organizations and parents of children with developmental delays (21% of the council membership)), who provide guidance to the program on addressing the needs of children with developmental impairments and delays.
- The EHDI 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's 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 plans and helped establish the family support program. The EHDI 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.
- 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 MS Newborn Screening (NBS) Panel. The committee meets twice annually and is comprised of 13 volunteer members, including national experts, clinicians, consumers, parents, supporters, and partner agency representatives. In 2022, HB 927 was passed requiring the MS NBS 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 MS NBS Panel, identifying and sharing testing and treatment options, providing guidance on public awareness and prevention efforts, and recommendations on NBS fees.

III.B.2.b. Organizational Structure

Organizational Structure

Divided into divisions and programs, MSDH provides leadership and support for state, regional and local county PH services. MCH/Title V falls within Community Health and Clinical Services, Division of Health Services which houses the following programs which work together to perform the different PH functions.

Health Services:

First Steps Early Intervention Program (FSEIP)(*Individuals with Disabilities Act Part C program*) is responsible for coordinating a statewide comprehensive interagency system of EIS for children under 3 years of age with a developmental delay/condition likely to lead to a delay and their families. FSEIP coordinates with healthcare, early care & education providers, and families to ensure infants and toddlers with identified impairments/developmental delays are identified, evaluated and receive timely, comprehensive, family-centered services. FSEIP state office provides training, guidance and oversight to 9 local early intervention programs. FSEIP uses Child Find for public awareness campaigns and outreach, promotion of developmental screening/monitoring by families, healthcare & education providers. FSEIP provides service coordination from intake to transition for school/community-based services and refers to 422 participating EIS providers (*physical, occupational, speech and behavioral therapists, nurses, special instructors and audiologists*), who educate and support families in understanding their child's special needs and support their child's grow, develop and learning.

MCH Engagement and Coordination Office supports Health Service/MCH program personnel through training and capacity building. The Office provides professional development for internal/external MCH personnel and

partners on topics of public health, Title V/MCH, and leadership. Using results from a staff survey, professional development opportunities are created to meet the unique needs of staff, including self-paced modules, in-person, or virtual offerings with continuing education (CE) credit, recorded webinars & leadership book clubs and to support internal and external social workers with free CE hours. March 2023, an integrated public health social work program provides short-term follow-up and social service supports to multiple MCH-servicing programs. This integrated approach is rooted in *no wrong door* philosophy and enables referrals to programs depending on individual situations and needs across MCH programs.

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

Office of Women's Health:

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

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 differences in rates of infant death and adverse perinatal outcomes. The program provides clinical and enabling services (*screening, referrals, case management, care coordination, health & parenting education, and linkage to clinical care*) for women/men of childbearing ages, expectant women, new fathers, infants, and toddlers up to age 18 months in 6 counties. The program convened a Maternal Health Symposium to advise and inform activities, the workgroups developed and implemented action plans to address 5 maternal health areas: Preconception Health; 4th Trimester/Post-Partum Care; Maternal Patient Safety/IPV; Maternal Mental Health/Substance Abuse; & Social Conditions Impacting Health.

Healthy Moms/Healthy Babies (HM/HB) is a maternal and infant health support program for expectant and postpartum women, infants up to 12 months, and their families who have identified health risks working to ensure a safe birthing experiences and healthy infant development. Offering client centered, integrative & evidence-based approaches to case management and care coordination services, the goal is to decrease preterm birth rates and infant mortality, improve maternal health and support infant physical/mental development. HM/HB partners with the MS Division of Medicaid, medical homes, and communities to provide services that are compassionate, non-judgmental and services including assessment, education, support and linkages to other services.

Breast and Cervical Cancer Program (BCCP) promotes early detection of breast and cervical cancer in high-risk women, more likely to have advanced disease when symptoms appear, including those who are uninsured, medically underserved, minority, and age 40 & older. BCCP provides education and promotes access to free breast and cervical cancer screenings, in partnership with screening providers. June 2023, BCCP had a network of 144 contracted providers at over 313 sites statewide (FQHCs, health department clinics, private family physicians, other primary care providers, hospitals, ambulatory surgery centers, surgeons, radiologists, medical oncologists, & laboratories). Using a fee-for-service reimbursement model and with 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. For women diagnosed with cancer, the BCCP clinical staff expedite coverage for treatment through a referral to Medicaid.

BCCP and Office of Preventive Health, and Heart Disease/Stroke Prevention Programs operate the **MS WISEWOMAN** program to extend additional preventive health services to women enrolled in the BCCP, including screenings for cardiovascular disease, stroke risk, and diabetes and referrals for healthy behavior supports. 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, funded by the National Institute of Health's Centers of Excellence in Maternal Health program, MSDH has implemented the **Time4Mom** program in 5 counties. This initiative reduces maternal morbidity and mortality in the MS Delta region and enhances maternal health outcomes by facilitating postpartum home visits provided by nurses and community health workers, linking women with local health resources, referrals for mental health and lactation support, and providing educational support on postpartum health.

Family Planning/Comprehensive Reproductive Health (FP/CRH) program, administered through the MSDH clinics under the direction of Field Services and administratively supported by the Office of Women's Health, 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. FP/CRH provides voluntary, affordable services (*pregnancy testing, counseling, preconception health services, screening and prevention*) through the Medicaid Family Planning Waiver for those ages 13-44, with family income at or below 194% of the Federal Poverty Level, who are not currently expecting and who have not had a vasectomy, tubal ligation, or hysterectomy. Under the FPW, the FP/CRH provides physical and clinical breast exams, counseling on birth control methods, contraceptive supplies, testing for Pap, pregnancy and STD/STI/HIV, and pre-conception counseling. Clients who require services not provided at PH clinics, lack health insurance coverage, or minors who desire confidential services that do not require parental consent, are provided resources to community providers (FQHCs and Title X clinics) and assisted with making appointment.

Office of Child and Adolescent Health:

Genetic Services Bureau houses the MS Newborn Screening (NBS), Chronic Congenital Heart Defects, Early Hearing Detection and Intervention (EHDI) programs and the Birth Defects and Sickle Disease Registry. Genetic Service programs aim to reduce infant mortality/morbidity of newborns with birth conditions through early detection and treatment, follow-up screening, referrals and education for professionals and families using a family-centered approach. State law requires newborns to be screened per the National Recommended Uniform Screening Panel, including 63 core and secondary conditions. NBS programs partners with Revvity, the state lab, to collect and report results. NBS programs provide short-term follow-up for identified newborns, ensuring repeat screens are conducted as needed. Families are referred to specialists for confirmatory testing, long-term follow-up, care/service coordination, and early intervention. These programs partner with birthing hospitals, tertiary clinics, and pediatric facilities statewide and MCH-serving programs. EHDI program works with health care, primary care, and early intervention providers, birthing hospitals, midwives, audiologists and otolaryngologists to ensure that all infants born receive a hearing screening by 1 month of age, infants are referred for hearing diagnosis by 3 months of age when screening indicates, infants with confirmed hearing loss receive early intervention services by 6 months of age, and infants who are susceptible for late onset or progressive hearing loss receive ongoing follow-up to identify any hearing loss that may develop. 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.

Using the well-child screenings per the Bright Futures Periodicity Schedule, MSDH clinics provide **Early Periodic Screening, Diagnosis, and Treatment** (EPSDT) services as a gap filling service in areas with limited primary care providers. Screenings indicating needs are referred to a general practitioner/specialty provider for diagnosis/treatment and to a local primary care provider/community health center for continuity of care (wellness and sick care) in a medical home, and long-term follow-up as appropriate. Children identified through EPSDT screening are referred to internal MCH-serving programs.

Lead Poisoning Prevention and Healthy Homes Program (LPPHHP) ensures Medicaid-enrolled children are screened for elevated blood lead levels through EPSDT. All laboratories and medical facilities in the state are required to report all blood lead levels (BLL) to MSDH. Data are analyzed to determine the status of lead poisoning

and healthy homes issues and to identify high-risk areas to target education, outreach, and policy interventions. LPPHHP identifies lead and other environmental home health hazards & provides practical prevention measures for families of children up to 72 months of age with a confirmed venous BLL ≥3.5 micrograms per deciliter through care coordination services *(telephone counseling, home visits, environmental assessments, education on lead poisoning, healthy homes, and safe sleep, recommendations for decreasing hazards, nutritional counseling, and referrals for supports/services)*. The goal of 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 & their families in partnership with community organizations.

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program works to improve maternal/child health outcomes by providing evidence-based home visiting with families of children prenatal to kindergarten in 16 high-risk counties. MIECHV 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 is to ensure children are healthy, safe, and ready to learn by: increasing parent knowledge of early childhood development, positive parenting practices, and early detection of health and developmental issues and connection to services; improving parent, child, and family health and well-being; and strengthening community capacity and connectedness.

Adolescent Health program seeks to improve connection and promote access 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 differences that affect young people and advances leadership practices for MCH at the national, state and local levels for those ages 10-21.

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, coordinated, multi-disciplinary, system of care by the health department system and primary care practices, including personal contacts, counseling, education, referrals for a medical home, and supporting the development and implementation of a shared plan of care.

The Health Services Division partners with the following offices: Office of Preventive Health, Public Health Pharmacy, Office of Oral Health, Special Supplemental Nutrition Program For Women, Infants, and Children, Center for Health Transformation, and Office of Vital Records & PH Statistics. Office of Health Data and Research assists the MCH Programs in data management, surveillance, data analysis, reporting, and program evaluation on MCH populations.

III.B.3. Health Care Delivery System

III.B.3.a. System of Care for Mothers, Children, and Families

Health Care Delivery System

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 MCH 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 29 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-seven acute care, eleven psychiatric, one rehabilitation, and seven long-term acute care facilities. 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.

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

Systems of Care for Mothers, Children and Families

There are a combination of systems which come together to meet the holistic care for women, infants, adolescents, children with and without special medical needs, and their families. These systems include the statewide Public Health system, Child Protection Services, Educational System, Hospital Systems, Mental Health Systems, Alcohol/Drug Treatment System, Vocational Rehabilitation Systems, Federally Qualified Health Center, and Rural Health Systems. See Health Care Delivery System section for more details. Summer 2025, MSDH is spearheading the effort to create a new Obstetrics System of Care. MSDH brought together stakeholders (doctors, nurses, emergency medicine, emergency management systems, Division of Medicaid, managed care organizations, and others), to discuss the proposed OB System of Care, the increased prenatal care opportunities, perinatal regionalization, maternal and neonatal levels of care designation, facilities and expedited transfers to appropriate levels of care and the opportunities to incorporate MSDH Alliance for Innovation on Maternal Health (AIM) safety initiative work.

There are gaps in the systems such as the distance some residents must drive to arrive at a hospital because of health care shortages and financial strains closing hospitals. Limited substance abuse/mental health beds for expecting women to receive services.

There are many gaps in the system of care for children and adolescents including lack of collaboration amongst internal stakeholders and external agencies to support continuity of care. Another impediment involves families having limited access to resources that are needed to access the system of care such as income, transportation, technology, or interpreters for non-English speakers, and the deaf/hearing impaired populations. Early detection and identification are also challenges to the systems of care that results in late, or few intervention services being provided. While collaborative efforts have been limited due to personnel shortages, they have been effective in increasing community involvement, family-centered, and data-driven decision-making to support comprehensive and coordinated care efforts state-wide.

III.B.3.b. System of Services for CSHCN

System of Services that Support CSHCN

The system of services that support CSHCN in MS varied, as it is more robust in the more populated areas, as it relates to access and availability of supports, but much sparser in the more rural areas of the state. This is why the partnerships that have been created by MCH funding have been so critical to ensuring that CSHCN and their families have access to care. The CSHCN program is comprised of Care Coordinators and a state Family Leader at the state office level to aid families in navigating the critical support systems that are critical to meeting their needs. The CSHCN office also partners internally with the Health Services Public Health Social Workers to provide Care Coordination, as staffing has been stalled. External partnerships include partnerships with three FQHCs across

the state in which CSHCN supports funding for Care Coordination and a Parent Consultant, as well as Care Coordination support at six tertiary clinics at the level 5 trauma hospital to increase population of focus and spread of those with special health care needs. Examples of supports within the systems of care include, but are not limited to, the Division of Medicaid and Managed Care groups, to assist with funding access to care, as well as transportation, Department of Rehabilitative Services to assist with SSI/Disability, networking with the EI systems, SEA and LEAs to support navigation of Part C & Part B (IFSP/IEP/504/and Health and safety plans) systems. Partnerships with local health departments, local AAP and Head Starts for developmental screenings and Genetics Bureau for early identification of health concerns and well as a comprehensive referral system which allows anyone with knowledge of a child with special health care needs to make a referral to the CSHCN Program. Not only do Care Coordinators assist with navigating the systems of support, they work with the CSHCN and their families to develop a shared plan of care identifying all critical partners and begin transition planning at no later than age 13 with a plan in place by age 16 which not only addresses medical transition from pediatric to adult healthcare, but also post-secondary transition to addresses community/educational/vocation needs and financial planning for both the CSHCN and their family/care giver. Title V also supports Respite Care by partnering with a bonded provider to CSHCN care givers, ensuring that they also can remain healthy in the care that they provide the CSHCN and the State Family Leader allows for monthly family/care giver virtual meetings to discuss topics of their choice or information that is useful to the family.

III.B.3.c. Relationship with Medicaid

Relationship With Medicaid

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, MississippiCAN. Over 24% of Mississippians identified as low-income (below the federal poverty level) are enrolled in Medicaid. Of the 657,814 Medicaid enrollees, 65.6% of enrollees were contracted through managed care organizations (MCO) and Primary Care Case Management (PCCM), with the remaining 34.4% of enrollees receiving services through the traditional fee-for-service (FFS) structure.

While the percentage of Mississippi adults who report being uninsured has dropped since 2019, cost is still the greatest challenge 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.

Within Mississippi, the Title V program works with the MS Division of Medicaid (DOM) to improve the overall health of the MCH population including CYSHCN. Programs that assist clients to access Medicaid 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. The BCCP Program assists clients 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 is diagnosed with breast or cervical cancer.

Quarterly meetings are held between Health Service / MCH programs and DOM to discuss program strengths and gaps. Since Medicaid funds are used for reimbursement of services, DOM provides monitoring and quality of care recommendations for the following programs: HM/HB, FSEIP, and Family Planning Waiver. See attachments for Interagency Agreements.

Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The MSDH and DOM have entered into Interagency Agreements (IAA) for the provision of nursing and social work Fee-For-Service and targeted case management by MSDH nurses for expecting, postpartum women and 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 impairments/developmental

delays 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 treatment services as well family planning services under Medicaid.

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 encouraging 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., African American 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.B.4. MCH Emergency Planning and Preparedness

MCH Emergency Planning and Preparedness

Disasters impact all Mississippians and are particularly difficult for our most unprotected 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. In recent years, Mississippi has been severely impacted by tornados and high winds, damaging houses and small towns and communities. Mississippi's public health preparedness is an excellent model of public-private-volunteer cooperation.

During March 2025, Mississippi was struck by severe storms. Governor Tate Reeves issued a state of emergency for all 21 counties impacted. Using mobile units, MSDH provided free Tdap (tetanus, diphtheria, and pertussis) vaccinations and birth certificates to residents impacted by the tornadoes in Walthall and Jefferson Davis counties.

In Mississippi, MSDH is the coordinating agency for ESF-8 - Public Health and Medical Services. MSDH partners with the University of Mississippi Medical Center (UMMC) to fulfill all ESF-8 responsibilities. Mississippi has a written Comprehensive Emergency Management Plan (CEMP), which is reviewed every two years. The MSDH Division of Strategic Planning and Response (SPR) in coordination with the Mississippi ESF-8 Healthcare Coalition (MEHC) works with organizations and agencies that represent these unprotected 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 Public Health Senior Advisory Committee meets at least once a year to review state plans to ensure that the needs of medically susceptible groups are considered and addressed.

The MSDH Division of Strategic Planning and Response (SPR) is responsible for operating state and regional shelters for the medically fragile. MSDH has trained teams, which are MSDH employees *(county Nurses and Social*

Workers paid from Title V funds), 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 impairments including those that require the assistance of service animals; and people with other impairments who cannot be sheltered at a general population shelter. While not specifically listing medically susceptible women, infants, and children, the SMNS sites can and do accommodate medically susceptible women, infants, and children and their families.

Example of how the programs address emergency preparedness – the HM/HB integrates emergency preparedness into the care plans through a Birth Preparedness and Readiness Plan. This plan is a structured questionnaire completed by nurses with each client to ensure mothers are equipped with essential knowledge and resources in case of an emergency or unexpected delivery. It includes guidance on transportation options, identification of emergency contacts, awareness of nearby delivery hospitals, and emergency disaster preparedness. After completing the Birth Preparedness and Readiness Plan, the client receives a copy of the plan to keep for personal reference and use in emergency situations.

An update on the Jackson Water Crisis. There was a change from a “motion to intervene” in the Environmental Protection Agency’s case against the city of Jackson. For the first time in decades, there will be Jackson residents sitting at the table and having a voice in the improvements of the Jackson water infrastructure.

III.C. Needs Assessment

III.C.1. Five-Year Needs Assessment Summary and Annual Updates

III.C.1.a. Process Description

Introduction

The Title V Maternal and Child Health (MCH) Block Grant program is a federal-state partnership that is a key source of support for advancing and improving the health and well-being of the nation's women, adolescents, infants, and children with and without special health care needs. Authorized under Title V of the 1935 federal Social Security Act, Title V was converted to a Block Grant Program in 1981. State funding allocations are determined by a formula that takes into consideration the proportion of the number of low-income children in a state compared to the total number of low-income children in the United States.

The Title V MCH Block Grant Program requires that every $4 of federal Title V MCH Block Grant money be matched by at least $3 of state and/or local money. The program also requires that a minimum of 30% of federal Title V MCH Block Grant funds be used to support services for Children and Youth with Special Health Care Needs (CYSHCN) and 30% of federal funds be used to provide preventive and primary care services for children. In addition to annual performance reporting, states must conduct a comprehensive needs assessment every five years to identify priority issues of the MCH population.

Every five years, the Title V programs are required to conduct a state-level, comprehensive needs assessment of the health standing of women, adolescents, infants, and children with and without special health care needs to identify the priority health needs that guide the public health MCH-serving programs funded by Title V. The Title V MCH Block Grant 5-Year Needs Assessment is a systematic process to collect information about the state's public health system and service provision to women, adolescents, infants, and children with and without special health care needs. The information collected through the needs assessment process is used to identify seven to ten statewide priorities, drive strategic planning, and allocate funds which can be impacted by strategic public health over the next five years. The goal of the statewide needs assessment is to improve MCH outcomes by aligning evidence-based strategies with the identified needs of the MCH population.

2025-2030 Needs Assessment Process

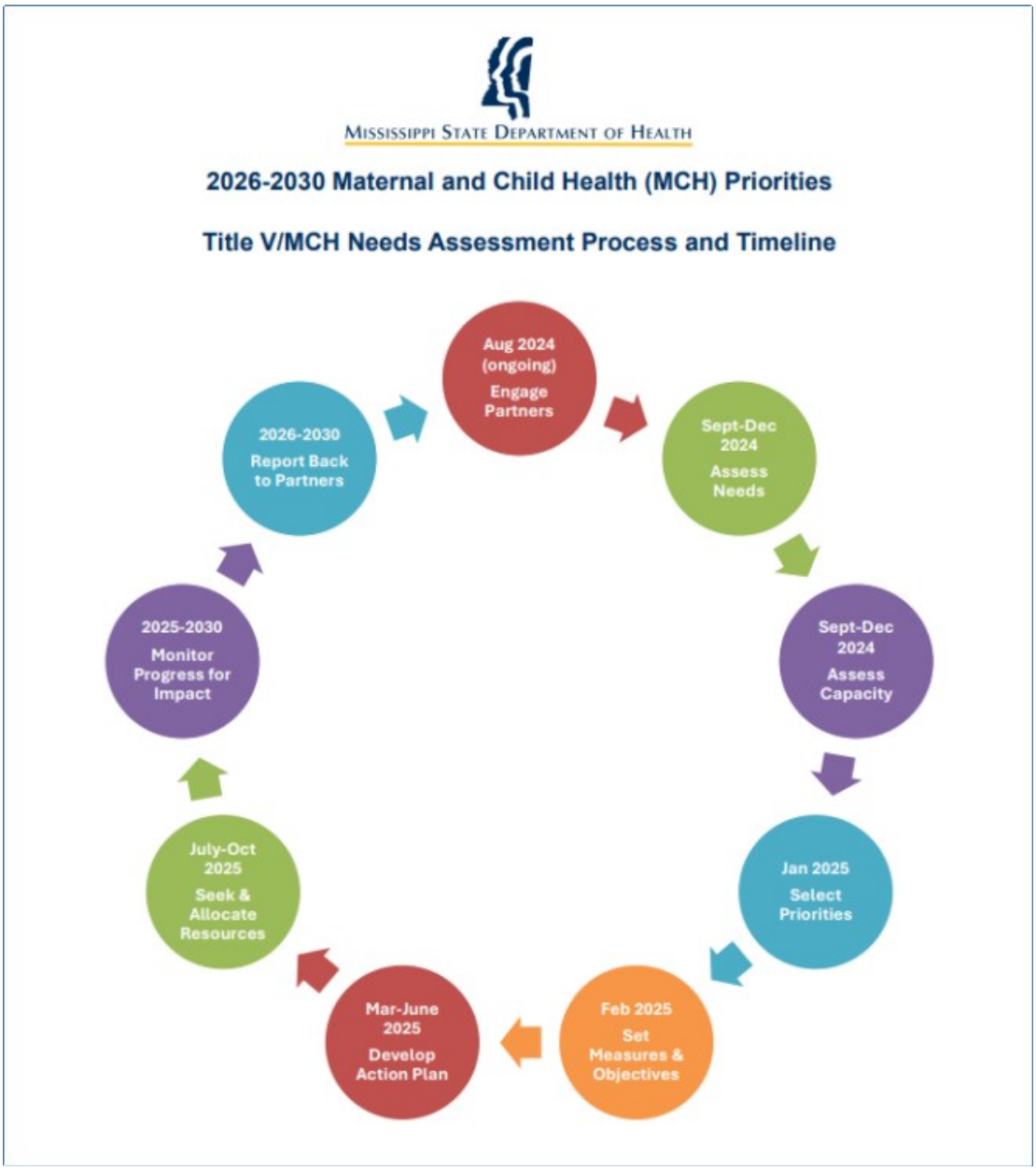
The Mississippi State Department of Health (MSDH) administers the Title V Block Grant in Mississippi and oversees programs for all five MCH population domains. These are the Women/Maternal, Perinatal/Infant, Child, Adolescent, and CYSHCN Domains.

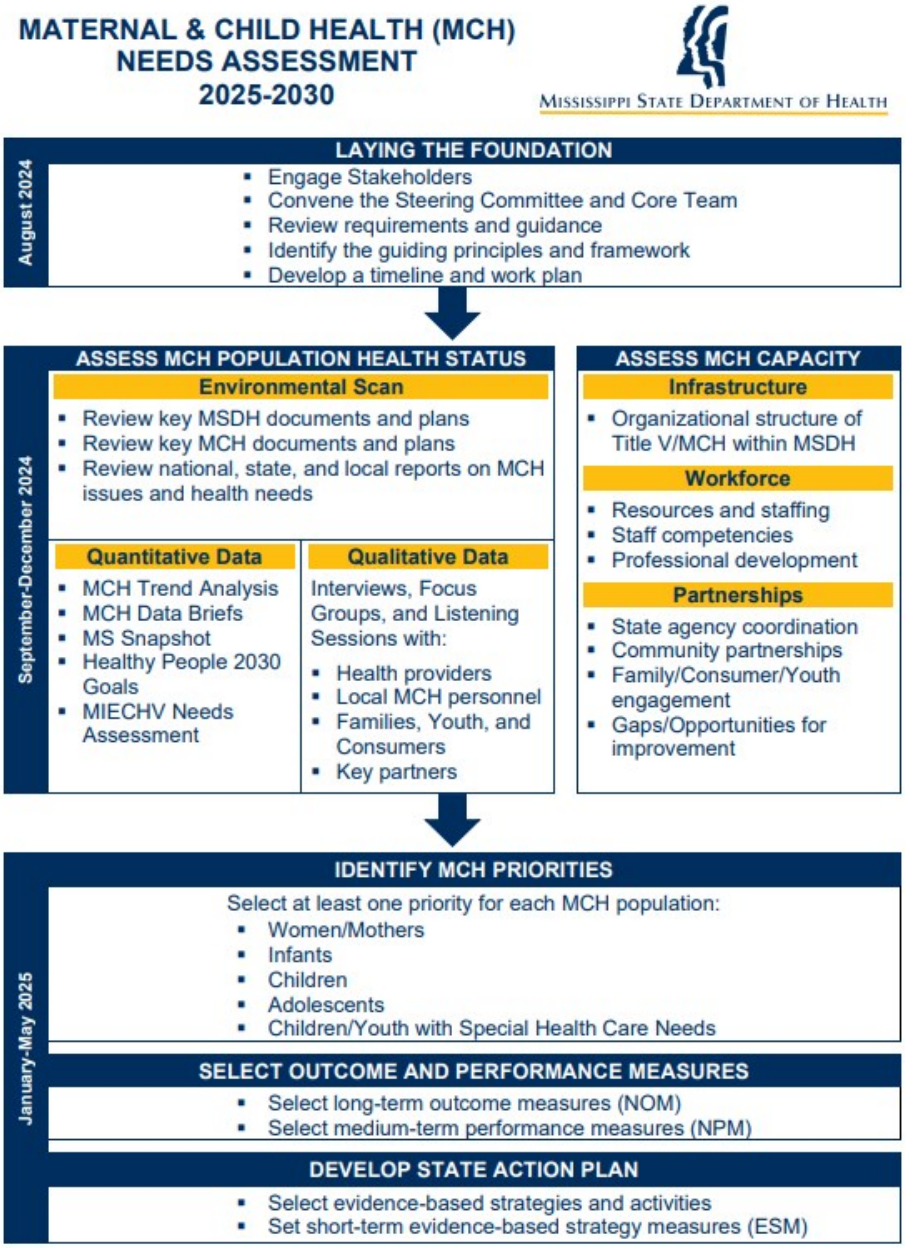
The MCH Needs Assessment involved a multi-step process. The Needs Assessment began with a review of national, state, and local reports and plans surrounding issues impacting MCH populations. This also included internal partnerships and activities where data was collected which would contribute to discussions for the MCH priorities. The Needs Assessment collected and analyzed quantitative and qualitative data, including vital statistics, key indicators of population health, focus groups, listening sessions, interviews, and surveys. The Needs Assessment also assessed the MCH-serving public health infrastructure, workforce, and partnerships to determine the Title V program's capacity to address identified needs of the MCH population.

The Title V MCH Needs Assessment included strategies to assure opportunities for participation so that broad stakeholder voices could be heard. These included:

- Mobile online surveys for residents and stakeholders
- Paper surveys for residents
- Using translation and interpreter services (surveys and focus groups)
- Collaborating with partner MSDH programs and external partners for dissemination of survey and awareness efforts
- Facilitating listening sessions, town hall meetings, and focus groups

The needs assessment data collection and prioritization process for each domain is described below. The multi-step process is outlined below:





Process

As part of the 2025-2030 Title V MCH Comprehensive Needs Assessment, the MSDH entered into an agreement with an individual contractor, to develop, analyze, and report on data collected from Mississippi families, practitioners, and other stakeholders. The methods used and results obtained are summarized below. All data collection instruments were designed through a joint effort between the independent contractor and MSDH. The MSDH was responsible for efforts related to marketing the needs assessment, recruitment of survey participants, identification of key informants and populations for focus groups, listening sessions, and town hall meetings, and provided final approval for all activities. The MSDH and independent contractor facilitated the focus groups, listening sessions, and town hall meetings. The MSDH shared the survey with partners. The MSDH Health Service partnered

with Office of Preventive Health for opportunities to distribute the survey. The MSDH collected the data and performed all analyses and developed final reports.

Needs Assessment Data Sources and Methods of Collection

Overview

The intent of the data collection for this report was to collect the experiences and perceptions of stakeholders such as health care consumers, families, and providers across the state to increase the MSDH's knowledge and assist in identifying MCH strengths and needs. Reports and information from national surveys, national report cards, census data, vital statistics, Mississippi Infant Mortality reports, Mississippi Maternal Mortality reports, and other assessment were considered by MSDH.

Federally Available Data

The MSDH Office of Health Data & Research used the Federally Available Data (FAD) provided by the Health Resources and Services Administration (HRSA)/Maternal and Child Health Bureau (MCHB) through the Title V Information System. It catalogues the National Performance Measures (NPMs) and National Outcome Measures (NOMs) for each Title V state and jurisdiction. FAD are designed to clarify indicators and aid states in making comparisons between national and state data. See Mississippi Title V MCH New National Outcome Measures at the end of this document.

Surveys

Statewide Resident Survey – The MSDH conducted a Statewide Resident Survey of Mississippi residents to obtain information regarding Mississippi's capacity and the strengths and needs/deficits in the state's health care delivery system. The survey was designed by the independent contractor and limited MCH staff and disseminated online through REDCap. Public access to the survey was housed on the MSDH MCH Block Grant Website. A distribution of QR Code brought the respondents to the MSDH MCH Block Grant Website where they needed to navigate the webpage to find the electronic survey. The survey was disseminated online in both English and Spanish. The survey QR code was marketed by MSDH staff to Mississippi residents through flyers, social media postings, email, partnerships with other agencies and health care providers. MSDH staff promoted the QR Code at the Mississippi Public Health Association Conference. At the initial closing date of the survey, there were a total of 76 survey respondents.

A second push of the Statewide Resident Survey occurred with multiple changes in the distribution and access. The survey QR code brought the participant directly to the electronic survey without having to navigate the through the MSDH MCH Block Grant webpage. The survey was disseminated online in English, only. Surveys were marketed by MSDH staff to Mississippi residents through flyers, social media postings, email, and partnerships with other agencies and health care providers. In addition, paper surveys were distributed by the Health Service Public Health Social Workers to community and church groups, at the Healthy MS conference, and the 2nd Annual State Employee Wellness Expo. Through this effort, there were 374 Statewide Resident Surveys completed. In all there were 450 Statewide Resident Surveys collected.

Provider Survey – The MSDH also conducted a survey of primary health care providers who care for women of childbearing age, children, and youth regarding Mississippi's service capacity. The survey was designed by the independent contractor and limited MCH staff and disseminated online through REDCap. Surveys were marketed by MSDH staff to Mississippi providers through flyers, social media, email, and partnerships with other agencies and health care providers.

A second push of the Provider Survey occurred with changes to the access. The QR Code brought the provider directly to the electronic survey without having to navigate the through the MSDH MCH Block Grant webpage. The survey was disseminated online in English. Surveys were marketed by MSDH staff to other providers through flyers, social media postings, email, and partnerships with other agencies and health care providers.

In all, there were a total of 71 provider surveys completed. There were another 85 respondents who started the survey but did not complete it.

Focus Groups, Town Hall Meetings and Listening Sessions

Qualitative data collection included semi-structured focus groups, listening sessions and town hall meetings. The sessions included local residents, individuals identified by MSDH staff as having expert knowledge in one or more MCH populations, or those with work within MSDH MCH. There were 194 individuals representing local community and professional members who consented to participate in the focus groups, listening sessions or town hall meetings. There were sixteen listening sessions, with at least one listening session in each of the nine Public Health Districts; five town hall meetings; and seven focus groups spread across the state, with one for Deaf and Hard of Hearing population and one in Spanish. Focus groups, listening sessions, and town hall meetings were conducted in-person and by zoom.

The independent contractor and limited MCH staff facilitated the focus groups, listening sessions or town hall meetings. They designed a template for a consistent notetaking process during the focus groups, listening sessions and town hall meetings.

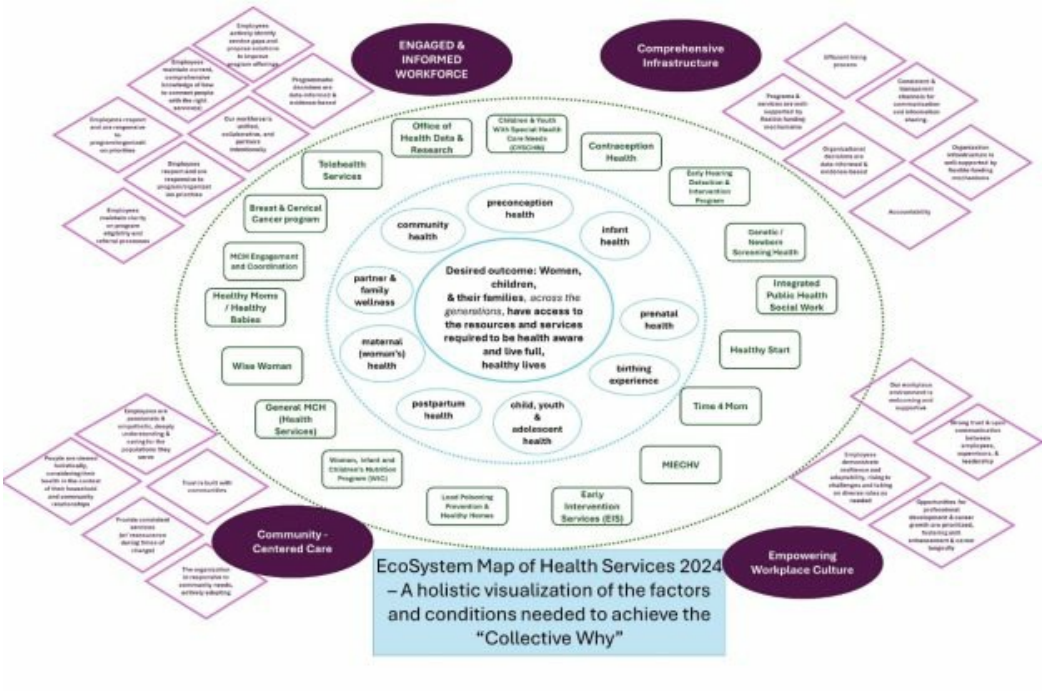
- 20 Focus group participants were comprised of general public, MSDH professionals and MCH-serving professionals.
- 20 Town hall meeting participants comprised of general public and professional mix.
- 154 Listening session participants comprised of a mix of MSDH staff and MCH-serving program staff (MIECHV, First Steps Early Intervention Services, Health Service Public Health Social Workers and Nurses, Family Consultant, and Community Health Workers.)

Other Activities

In the summer of 2024, the MCH Engagement and Coordination Office conducted a needs assessment survey to determine the professional needs and wishes of the MSDH Health Service team members throughout the agency. The survey received 117 responses, a 44% staff response rate. Using the “employee location” information provided, it appears that information may be generalized for the whole Health Service Team across regions, districts and counties. Identifying the current and future transitions within MCH, the survey results highlighted that 54.7 % of the current employees have five or less than years’ experience at MSDH; 11.1% have 21 or more years at MSDH and in the next four years, 24.7% of the MCH Health Service workforce are eligible to retire.

MSDH engaged with the National MCH Workforce Development Center’s 2024 Learning Journey. The primary goal was to support MCH programs in improving the current referral process by designing a systematic tool using the concept “no wrong door”. During the Learning Journey’s On-Site Consultation time, the MCH-serving programs participated in a two-day event. While the team learned about multiple tools, two end products addressed the need of the MCH Block Grant Needs Assessment. The first was the system support mapping, a visual framework which assisted the team in connecting individual roles, responsibilities and needs with the broader system. Through this structured process, the team was able to identify the strengths of the MCH-serving programs and identify gaps. The second product focused on identifying how the MCH-serving programs interconnect to meet the needs of the MCH population. Because many of the MCH-serving programs have staff with less than five years’ experience in public health, this On-Site Consultation supported them in identifying, communicating, and understanding the complex intersection of MCH-serving programs. At the end of this process, the team was able to conceptualize the need for an electronic universal referral system to meet the needs of the MCH population and ensure a “no wrong door” entry into public health services. See the pictorial of the System Support Map and the visualization of interconnected programs.

Pictorial of the System Support Map and the visualization of interconnected programs:



How the MCH-serving programs interconnect to meet the needs of the MCH population.

MSDH Child and Adolescent Health Program partnered with Teen Health Mississippi for focus groups to discuss with women ages 15-44, recently pregnant (between 2020 and 2024), about their experiences accessing the health care setting before, during and after pregnancy. Twelve focus groups across the state were held via zoom, with a total of 107 participants. Participants were recruited by word-of-mouth, social media, and partnering organizations. Key and emerging topics included:

- Experiences of not receiving the care they expected, *from their perspective*.
- Experience of healthcare providers talking "at" them instead of "with" them.
- For youth, they shared experiences of healthcare providers insisting on parents participating in the healthcare visits.
- For youth, feeling as if they were left out of the decision-making process because healthcare providers talked to their parents instead of them.

The Northeast Mississippi (NE MS) Healthy Start Consortium was tasked with completing a needs assessment of the targeted communities (Clay, Chickasaw, Lowndes, Lee, Monroe, and Prentiss counties). Through the community needs assessment, it was determined that maternal and infant health awareness and support systems are needed.

Based on data from the NE MS Healthy Start needs assessment, it was determined that access to care, whether it be medical care, dental care, or specialty care, was a prominent theme in the data. Transportation access and shortages contribute to the difficulties many people encounter in obtaining care. Northeast Mississippi lacks an urban transit system thus, residents who need transportation must rely on rural transit systems operated by a variety of community agencies. In addition, support systems for maternal and infant health were an identified issue.

Assets were identified by participants completing the NE MS Healthy Start needs assessment. The medical community was identified as an asset because there are prominent practitioners that work toward bridging the gaps in services. However, even in areas where the medical community is strong, there is still a severe shortage in pediatric and obstetric providers who care for indigent patients or who accept Medicaid. With medical costs continuing to rise, it is not plausible to assume that a few can carry the load of many.

Key findings of the NE MS Healthy Start needs assessment include:

- Several prominent themes were concluded from the overall needs assessment results. Social conditions impacting health such as poverty, healthcare accessibility, and family support programs were among the highest ranked concerns.
- Education ranked the highest as having the biggest impact on maternal and infant health outcomes.
- The majority of participants (70%) affirmed that community education programs were needed.
- The majority of participants (73%) also suggested that there is not enough support in the community for new mothers.
- The programs that respondents believed to be most impactful in supporting pregnant women and new mothers / father were WIC and childcare assistance programs.
- Many parents and caretakers in the community believe that income level and access to health care are major factors affecting maternal and infant health.
- Parents and caretakers expressed a need for more educational, nutritional and mental health support programs to improve outcomes.

III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing

MCH Population Health and Wellbeing

Data Analysis

The Mississippi State Department of Health (MSDH) launched its statewide 5-Year Needs Assessment for the Title V Maternal and Child Health (MCH) Program. This assessment was a vital step in identifying strengths, gaps, and opportunities to improve the health and well-being of Mississippi's women, infants, children, adolescents, and children and youth with special health care needs (CYSHCN). MSDH Office of Health Data & Research reviewed the surveys, focus groups, listening sessions and town hall meetings for emerging themes, and subsequent thematic summaries were determined based on data included in the emerging themes.

Findings

Information below incorporates both quantitative and qualitative findings. This section begins with an overview of the information from the town hall meetings, listening sessions focus group, and surveys, along with the FAD from the HRSA/MCHB Title V Information System. Data presented include NPMs and NOMs reported for MS.

Focus group, listening sessions, and town hall meetings were analyzed to identify common themes. Responses to specific questions from the focus groups, listening sessions and town hall meetings include the following:

Question 1: ***Most important RESOURCES that support the health of women, infants, children, and adolescents, including those with special health care needs in community***

Resources Present

Communities supporting the health of women, infants, children, and adolescents including those with special health care needs benefit from a range of available resources. Respondents indicated the following as valuable resources:

- Hospitals
- Infant care programs
- Churches, nonprofit centers
- Recreational activities
- Healthcare services
- State programs provide essential support.

Resources NEEDED

Key areas for improvement include:

- Access to interpreters
- Increased funding
- Housing assistance
- Improved neighborhood spaces like parks
- Expand health education and foster more community groups focused on educational outreach
- Transportation issues persist
- Lack of awareness about existing resources
- Strengthening collaboration with government agencies and ensuring access to affordable childcare are also key priorities to better meet the various needs of families.

Question 2: ***Greatest RESOURCES to assist success as an MCH nurse/professional***

Resources present:

Success as a MCH nurse/professional in the field of MCH is greatly supported by several key resources already in place, including:

- Training on device use
- Team and personnel support
- Access to computers and the internet

- Professional development through workshops and courses
- There was also an emphasis on providing resources such as referral systems and encouraging health and wellness.

Resources NEEDED

MSDH District Level

MSDH district level, professionals stated there is a need for:

- Greater access to providers
- More staffing
- Better pay
- Financial support
- Improved communication
- Transportation solutions for rural areas
- 24/7 service availability
- Lower caseloads

State Level

MSDH state level, professionals stated there is a need for:

- Support from leadership
- More visits to fields
- More funding
- Flexibility
- Software training
- Incentives for patients
- Consistent supplies are essential

Additional priorities included resilience, training, opportunities to learn from MCH coordinators in other states, ongoing staff education, and stronger community involvement in program development. Open communication and recognition of staff efforts remained key to maintaining motivation.

Question 3: ***Summary of locations or sources where individuals access healthcare services***

Healthcare is accessed through various sources reflecting different care options across populations. Respondents indicated the following:

- Private clinics (Medicaid, Medicare, waivers etc.)
- Public health services (MSDH for prenatal care, family medical for OB, etc.)
- Medical centers (Magnolia women's center, Le Bonheur Hospital)
- Early intervention (Knit together, home healthcare) and therapy services
- Insurance-based providers

Question 4: ***Summary of MSDH service utilization and reasons for non-use among individuals and households.***

Used Services

Household members who accessed MSDH services reported using a variety of programs such as: Immunizations, WIC, First Steps Early Intervention Services, Family planning and reproductive health, Pediatric and child health services

Did not use Services

Common reasons for those who did not use MSDH services included:

- Having access to affordable or free care elsewhere
- Lack of awareness about available services
- Being referred directly to specialists
- Concerns about privacy when seeking care

Question 5: ***Feedback on experiences with MSDH services among current or past users***

Feedback on MSDH services revealed a range of experiences. Many individuals reported:

- A positive service experience
- Highlighting satisfaction with care

However, some noted mixed quality of care, indicating inconsistency in service delivery. Others faced financial constraints that limited access, while a few shared negative personal experiences.

Question 6: Additional comments or thoughts about MCH or the MSDH

Participants emphasized the need for better promotion of programs, improved awareness of available resources, clearer communication to the public, around healthcare access, MCH services and prenatal care. Gaps in health education and literacy were noted, along with the importance of improving context-awareness and linguistic accessibility. Suggestions included effective resource allocation and stronger community.

Responses focused on understanding MCH highlighted key areas, emphasizing importance of comprehensive care for mothers, pregnant women, infants and children, including access to prenatal and postnatal healthcare services. Many noted the value of social support programs in improving MCH outcomes, pointing out the need for stronger family and community involvement and identified ongoing foundational issues, indicating the need for broader improvements in the healthcare system.

Summary of Focus Groups, Listening Sessions and Town Hall Meetings by Domain

Below are the results from the discussions with participants, by public health domains, indicating the strengths/resources and needs/deficits. It is a summary of the most significant health-related needs.

Woman / Maternal Health

Strengths/Resources

Responses highlight key strengths within the Woman / Maternal Health domain. Strengths and resources included:

- MSDH programs like MIECHV, WIC, HM/HB, FSEIP, STD/HIV and BCCP that provide comprehensive support.
- Women benefit from access to regular screenings, mobile health clinics, and resource centers offering information and assistance.
- Community outreach, health events, and social groups promote engagement and education.
- Strong support systems from families, churches, and the community further enhance connections and well-being.

Summary of the Most Significant Health-Related Needs

Women in MS communities face significant health challenges, particularly in accessing comprehensive care and support services. Key needs included:

- Access to care – Limited availability of OB-GYN, maternal, primary, and dental care services
- Education and awareness – A lack of information about available programs and nutrition resources
- Behavioral Health – Increasing concerns around mental health issues and substance misuse.

- While access to wellness screenings and consistent primary care remains limited, many preventive services, postnatal support and breastfeeding assistance, are often unavailable.
- Financial constraints, high childcare costs, and low awareness of resources further limit access to care.
- Unsafe living conditions and lack of support services also negatively impact women's health outcomes.

Needs

The discussions revealed six key needs affecting healthcare access.

- Knowledge gaps around available services and health education reduce effective use of resources.
- Service access issues, such as limited transportation, and lack of providers / specialty care, make it difficult to receive timely support.
- Financial challenges, including unaffordable insurance and food insecurity, limit access to necessary care.
- Poor implementation of programs like Medicaid and lack of paid leave create employment constraint.
- Cultural and social deficit, including language differences, impact care quality and access.
- Lack of supportive infrastructure, such as childcare and respite services, adds further difficulty for families trying to manage their health needs.

Perinatal / Infants Health

Strengths/Resources

Responses highlight the following strengths for infants:

- Support from MSDH programs like car seat distribution, HM/HB & WIC, providing essential resources.
- Community baby showers and lactation education promote early health.
- Medicaid & CHIP ensure healthcare coverage.
- Baby-friendly hospitals and newborn screenings improve care access.
- Increased availability of primary care providers supports timely & consistent infant care.

Summary of the Most Significant Health-Related Needs

Infants in MS communities have significant health-related needs, especially in accessing:

- Preventive care
- Immunizations
- Medications
- Baby equipment
- Screenings like EPSDT and genetic testing

Many parents lack knowledge about infant care, feeding, development, and safe sleep, along with prenatal complications and limited postnatal education affect infant health. Parent mental health challenges and a lack of healthcare providers added to these concerns. Support programs like WIC and home visits help, but the home visiting programs have limited reach throughout the state. High childcare costs and inconsistent access to well visits remain as major problems. Expanding healthcare services and parenting education is essential to support healthy infant development and well-being.

Needs

The discussions revealed needs affecting the perinatal/infant domain which fell into five main areas.

- Access to care is limited by a lack of providers, including specialists (audiologists), and difficulty reaching programs like WIC and Safe Sleep initiatives.
- Financial constraints include lack of insurance, high childcare costs, and limited access to basic supplies.
- Knowledge gaps around childcare and available services.
- Time and transportation issues due to work, school, or lack of transit make it harder for families to seek care.
- Language and cultural issues such as citizenship and limited English proficiency

Child Health

Strengths/Resources

Responses highlight key strengths within Child Health domain. Strengths & resources included:

- Children receive vital support through MSDH programs such as MIECHV, LEAD, FSEIP, EPSDT, and vaccination initiatives provide essential preventive care.
- Access to school-based services, including nurses, dental and vision screenings, & after-school or summer programs, enhances both health and learning.
- Recreation, sports, churches, and civic organizations further contribute to social and emotional well-being for children.

Summary of the Most Significant Health-Related Needs

Respondents indicated that children in MS communities need:

- Access to routine exams, vaccinations, dental and vision care, & important screenings like EPSDT & developmental evaluations.
- Health education on nutrition, hygiene, exercise, sex education, and life skills to support their well-being.
- Proper nutrition, & opportunities for recreation & socialization are key community needs.
- Parent education programs are important to promote healthy development and daily care.
- Addressing adverse childhood experiences is essential for their emotional and physical health.
- Access to after-school care & support for healthy growth also helps children thrive.

Needs

Children face several key deficits affecting their health and development. The discussions revealed these needs impacting Child Health:

- Access to care is limited by provider shortages, lack of wellness visits, and inadequate school-based services.
- Transportation & difficulties reaching clinics due to job constraints impact children.
- Knowledge gaps and language deficits reduce effective communication and care.
- Socioeconomic factors, such as poverty, housing instability, food insecurity, and lack of clothing, further impact their well-being.
- Poor school quality, limited after-school supervision (latchkey kids) and unmet mental health needs.

Adolescent Health

Strengths/Resources

Responses highlight the following key strengths within Adolescent Health domain:

- Adolescents are supported through schools, school nurses, & targeted programs that address both academic and personal needs.
- Civic organizations, summer programs, special clubs, and recreation/sports offer positive engagement opportunities.
- STD, HPV, & mental health screenings ensure essential health support.
- Access to career training and education for teen parents promote long-term success.
- Outreach, mentoring, fraternities, & sororities provide additional guidance and peer connection.

Summary of the Most Significant Health-Related Needs

Adolescents in MS communities have key health-related needs focused on mental health support and preventive education. Critical topics essential for their physical and emotional well-being include:

- Sexual health
- Pregnancy prevention
- STD awareness
- Substance use and vaping
- Suicide prevention
- Access to wellness checks such as eye, dental care, & immunizations
- Proper nutrition

Adolescents benefit from opportunities for recreation, community engagement, and education on self-care and life skills. Supporting emotional stability, leadership development, & organizational skills also helps them prepare for a healthy future.

Needs

Adolescents face multiple needs that impact their health and well-being. The identified needs/deficits per respondents included:

- Limited access to care, because of transportation, insurance gaps, and lack of general & mental health providers.
- Educational gaps, such as lack of sex education and resources to address vaping.
- Social and emotional challenges, including bullying, stress at home, isolation, & homelessness, are common.
- Financial constraints/limitations.
- Reduced physical activity.

CYSHCN

Strengths/Resources

Responses highlight the following key strengths within the CYSHCN domain:

- CYSHCN receive specialized support through child development centers, special schools, &programs, like PPECS & Special Olympics, providing opportunities for education, communication and physical activity.
- Social events, parent educators, & community organizations provide valuable connections and resources.
- MSDH programs such as MIECHV, Healthy Start, & First Steps Early Intervention offer essential services that promote growth and development for CYSHCN.

Summary of the Most Significant Health-Related Needs

CYSHCN faces significant challenges in accessing specialized therapies like speech therapy & applied behavior analysis, as well as home healthcare and durable medical equipment.

Additional comments made by the respondents included:

- Many families struggle due to a shortage of qualified providers and limited respite care to support daily caregiving.
- There is a strong need for better information, resource guidance, support groups, &community programs to assist these families.
- Improved coordination of early intervention services is essential for timely & comprehensive care.
- Access to special education programs, personalized planning and evaluation (PPEC), & thorough assessments are critical to providing effective support.

Needs

Complexity of CYSHCN care requires coordinated education and support to improve outcomes. CYSHCN faces multiple challenges impacting this care. The identified needs/deficits per respondents included:

- Access to services is hindered by a lack of specialized providers and centers, delays in screening and

neuropsychological evaluations, and long waiting times.

- Transportation difficulties.
- Financial needs - lack of insurance coverage.
- Significant gap in knowledge among both parents & providers regarding available resources and equipment.
- Language issues and low literacy levels make communication & completing forms difficult.

Figure 1: Core Health-Related Needs Among All Population Groups.

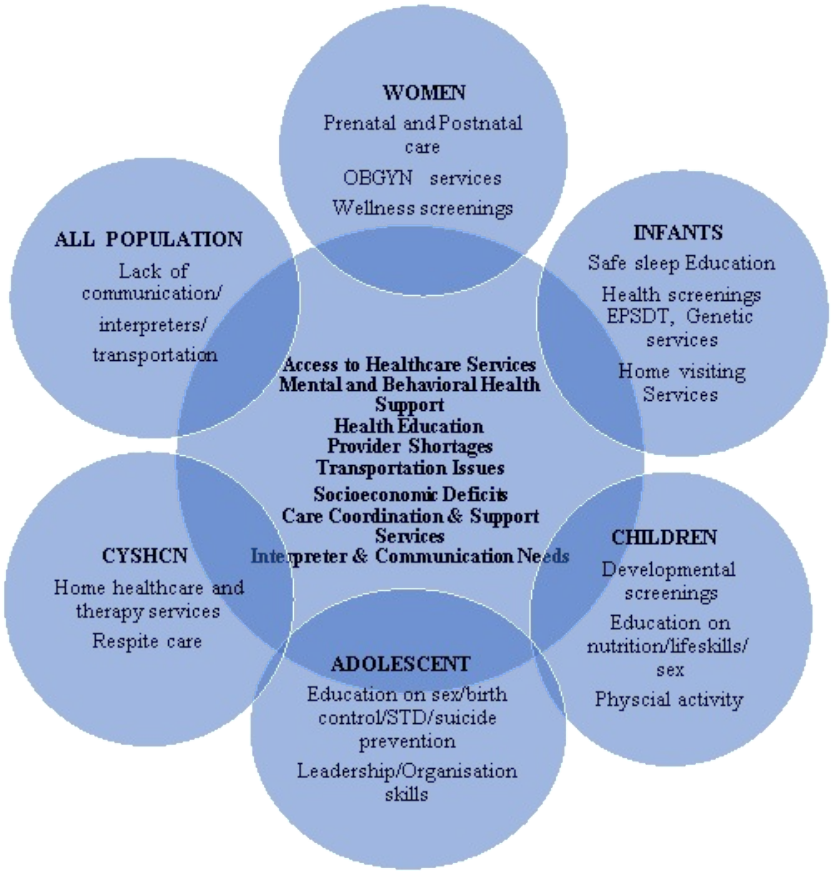


Figure 2: Key strengths in the populations served

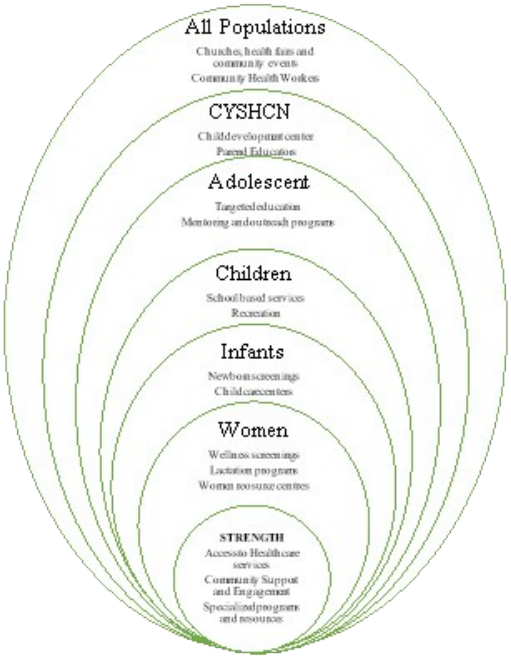
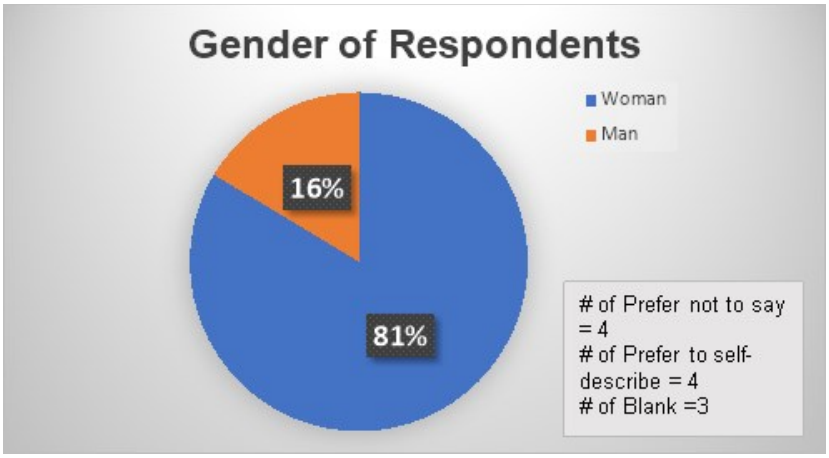
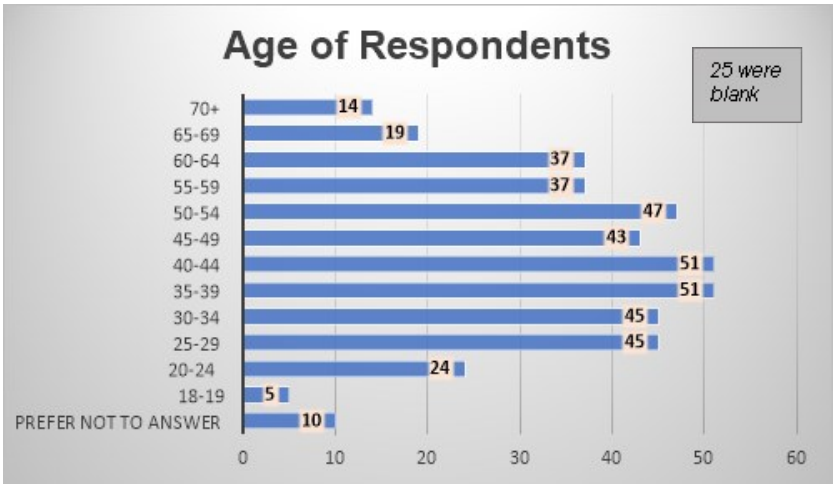


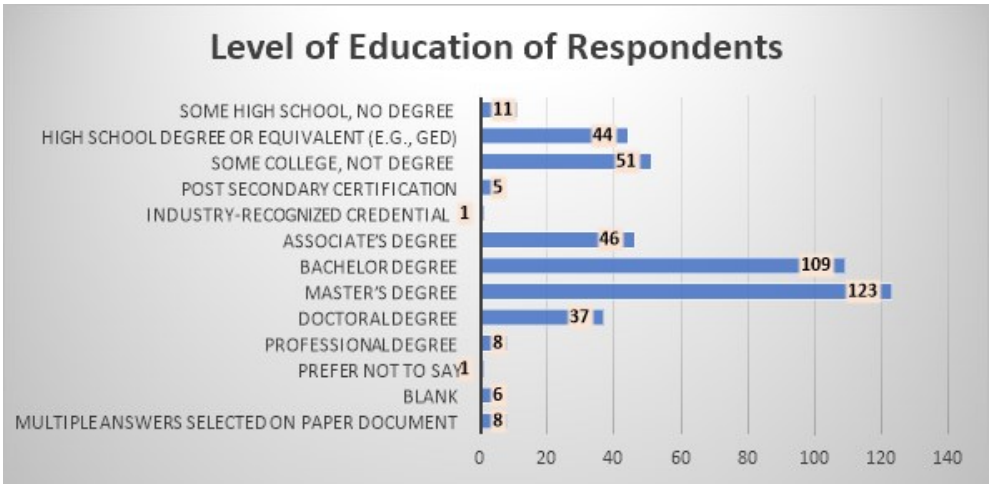
Figure 3: Key needs/deficits limiting access to necessary health services

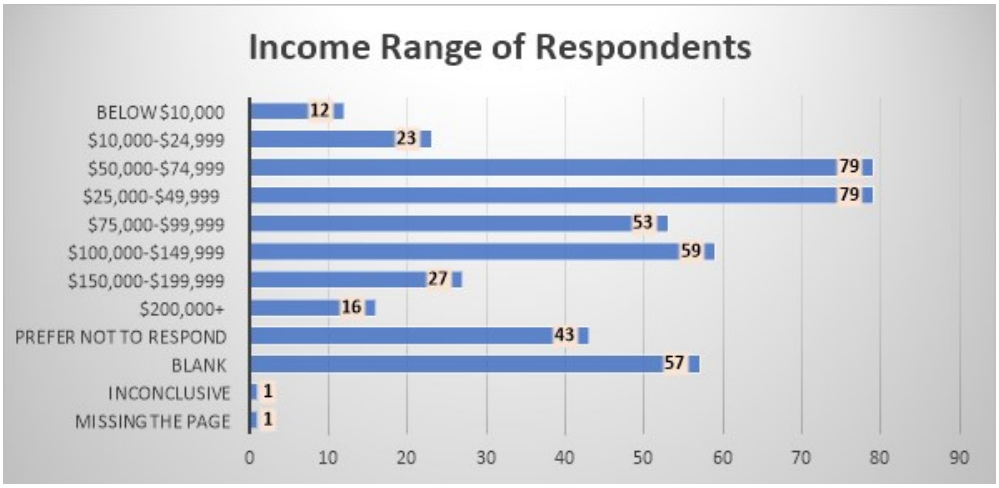
Summary of the Statewide Resident Survey

In the Winter of 2024 and Spring of 2025, the MSDH Title V MCH Block Grant 5-Year Needs Assessment was conducted to identify information regarding MS's capacity and the strengths and needs/deficits in the state's health care delivery system. Results were obtained from 73% of the MS 82 counties, with 450 respondents. The statewide resident survey did generate enough surveys to meet the +/- 5% margin of error. There were only 450 statewide surveys collected. There needed to be 384 completed surveys for a +/-5% margin of error; 1,048 surveys completed for a +/- 3% margin of error. (n=450)


Gender of Respondents
Woman
Man
16%
81%
# of Prefer not to say = 4
# of Prefer to self-describe = 4
# of Blank =3


Age of Respondents
25 were blank
70+ 14
65-69 19
60-64 37
55-59 37
50-54 47
45-49 43
40-44 51
35-39 51
30-34 45
25-29 45
20-24 24
18-19 5
PREFER NOT TO ANSWER 10
0 10 20 30 40 50 60


Level of Education of Respondents
SOME HIGH SCHOOL, NO DEGREE 11
HIGH SCHOOL DEGREE OR EQUIVALENT (E.G., GED) 44
SOME COLLEGE, NOT DEGREE 51
POST SECONDARY CERTIFICATION 5
INDUSTRY-RECOGNIZED CREDENTIAL 1
ASSOCIATE'S DEGREE 46
BACHELOR DEGREE 109
MASTER'S DEGREE 123
DOCTORAL DEGREE 37
PROFESSIONAL DEGREE 8
PREFER NOT TO SAY 1
BLANK 6
MULTIPLE ANSWERS SELECTED ON PAPER DOCUMENT 8
0 20 40 60 80 100 120 140



Responses to the following questions included:

1. Do you or does anyone in your household have special health needs? (This may include physical, developmental, or mental health conditions such as asthma, diabetes, high blood pressure, heart disease, sickle cell disease, epilepsy, anxiety or depression, autism, vision or hearing impairments, or learning disorders.)

   Yes = 230
   No = 208
   Blank = 12

2. Which area(s) of health would you like to improve or maintain for yourself? Select up to 5 areas that are most important for you.

	# of respondents who selected item
Alcohol, drug, or nicotine/tobacco dependence	53
Behavioral/Mental health	190
Breastfeeding	18
Dental/Oral health	175
Vision/Eye health	144
Hearing/Ear health	40
Nutrition/Healthy eating	274
Physical activity	270
Physical/Medical conditions (e.g., asthma, diabetes, sickle cell disease, cancer, high blood pressure)	199
Physical injury (e.g., car accident, school, or workplace accident)	30
Pregnancy and/or postpartum care)	34
Preventive care (e.g., well visits, annual check-ups)	88
Sexual health (e.g., fertility, sexually transmitted infections)	19
Sleep	97
Trauma/Violence (e.g., domestic violence, bullying, cyberbullying)	31
I do not have any areas of health I would like to focus on for myself)	33

3. Which healthcare or health insurance resources do you NEED that would be most helpful for you? Please select up to 5 that are most important.

	# of respondents who selected item
Breastfeeding resources and supports	11
Dental services	117
Healthcare providers who listen to my needs and provide referrals when I need them	90
Good coordination among my healthcare providers	65
Simple healthcare process (e.g., simple paperwork, healthcare system that is easy to understand	67
Telehealth	52

Provider Survey - Below are the top themes stated across the 71 respondents, regarding the question, "What is the greatest health-related need for the population(s) you serve?" *narrative answers provided. (quotes from surveys)*

Maternal Services

- Maternity
- Prenatal & post-partum care
- Syphilis in pregnancy
- Maternal and infant mortality rate
- Maternal morbidity and mortality, hypertension in pregnancy and postpartum
- Prenatal care
- Getting to needed appointments for maternal and infant appointments
- Follow up maternal care after hospital discharge
- Access to urgent gynecological care.

Mental Health Services

- Primary & prevention health
- Mental health conditions / care
- Mental Health / physical health
- Mental health services including therapy & psychiatric care
- Easy access to resources for pregnancy and postpartum for mental health resources

Nutrition Services

- Poor nutrition
- Food and nutrition education
- Breastfeeding education, assistance
- Lactation support for Medicaid moms
- Education about disease process & diet related to those diagnoses
- Education about nutrition, healthy eating and healthy lifestyle choices. Education that doesn't shame the patient.
- Shop for nutritious foods; meal prep is an important skill for good nutrition as well.

Social Services

- Assistance with health-related social needs, especially transportation.
- Awareness of resources available
- Education and financial assistance
- Transportation to and from appointments
- Financial stability, transportation, affordable housing, dental services statewide, vision services & insurance to cover needed services.

Other

- Access to resources, care, providers, to quality healthcare, higher education to improve economic standing, safe & affordable housing.
- Insurance needs, funding for medication, Medicaid for dental services.
- Access & education to primary or preventive health care.
- Care through substance use, care for drugs, alcohol, and homeless populations.
- Sexual health education (prevention of pregnancy NOT just abstinence), sexually transmitted infection prevention, healthy relationships, contraceptive access.

Description of Prioritization Process

Final selection of MCH priority needs per domain was conducted in a three-phase process. It was a priority of the MSDH to include broad stakeholder input prior to making any decisions. This was accomplished through a one-day stakeholder meeting where data was presented prior to stakeholder discussions around the priority needs of the MCH population. The group reviewed data from national & state reports, from focus groups, listening sessions, and virtual town halls held during Fall 2024. Working in small groups, the stakeholders generated a lengthy list of health needs for MCH populations. This list was comprised of health outcomes where MS has significantly worse outcomes from the national average or where trends indicated worsening health outcomes. Using a collective voting process, the stakeholders then identified the current top ten needs for MCH populations.

Following stakeholder input, MSDH MCH Leadership held virtual internal meetings to discuss stakeholder opinions while incorporating their knowledge of agency capacity and other feasibility considerations in order to determine potential MCH Priorities. In February 2025, the MSDH MCH leadership team reviewed and refined this list, consolidating some overlapping priorities, to generate a potential list of seven key priorities.

After the development of the potential MCH priorities, there was a change in MSDH MCH leadership. The remaining MCH Leadership were relatively new to the Title V/MCH Block Grant. MSDH outreached to University of North Carolina, Maternal Child Health Workforce Development Center for a one-day retreat regarding Title V/MCH Block Grant 101 and support in finalizing the identification of the 2025-2030 priorities, along with the NPMs, NOMs, & ESM for the 2025-2030 State Action Plan. During this retreat, discussions included: the proposed seven priorities, input from the stakeholder meeting, FAD and state data, agency capacity, and projections surround unstable funding. Education was provided to the group regarding how the National Outcome Measures (NOMs) and National Performance Measures (NPMs) are provided, strategies for selection, & support in identifying Evidenced-Based Strategies (ESMs). Through these discussions the current MCH Leadership determined the 2025-2030 priorities, along with the NPMs, NOMs, and ESM for the 2025-2030 State Action Plan.

Final Priorities by Domain

As a results of the Five-Year Needs Assessment process, the MCH Programs and stakeholders, including community organizations, providers, supporters, 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).

Women / Maternal Health

Priority: *Improve Maternal Health Outcomes*

- *NPM: % of women using a most or moderately effective contraceptive following a live birth*
- *NPM: % of women who have a postpartum visit within 12 weeks after birth; % of women who attended a postpartum checkup and received recommended care components.*
- *NPM: % of women screened for depression or anxiety following a recent live birth*
- *NPM: % of women who had a preventive dental visit during pregnancy.*

Perinatal / Infant health

Priority: *Reduce Infant Mortality*

- *NPM: % of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care*

Unit (NICU)

- *NPM: % of infants who are ever breastfed; % of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months*
- *NPM: % of infants placed to sleep on their backs; % of infants placed to sleep on separate approved sleep surface; % of infants placed to sleep without soft objects or loose bedding; % of infants room-sharing with an adult*

Child Health

Priority: Increase access to timely, health, developmental, behavioral health screenings

- *NPM: % of children with and without special health care needs, 0 through 17, who have a medical home.*
- *NPM: % of children, ages 1 through 17, who had a preventive dental visit in the past year.*
- *SPM: % of babies who meet 1-3-6 recommendations for screened (passed and not passed) before 6 months of age; % of babies who meet 1-3-6 recommendations for diagnosis with permanent hearing loss: before 3 months of age; % of babies who meet 1-3-6 recommendations babies referred to Part C EI: before 6 months of age.*
- *SPM: % of First Step Early Intervention Program referrals who get an Individualized Family Service Plan*
- *SPM: Percentage of individuals who have been identified as having sickle cell trait and/ or disease by the Genetic program who were referred to the Lead poisoning prevention program*
- *SPM: % of Mississippi newborns screened. (Newborn Screening program)*
- *SPM: % of Mississippi newborns who received a newborn screenings during 24-48 hours after birth. (Newborn Screening program)*
- *SPM: % of Mississippi newborns who received a newborn screening during 24-48 hours after birth with an abnormal result. (Newborn Screening program)*

Adolescent Health

Priority: Improve Adolescent Health

- *NPM: % of adolescents, ages 12-17,with preventive medical visit in the past year*
- *NPM: % of adolescents, ages 12-17,who received needed mental health treatment and counseling*

Children and Youth with Special Health Care Needs

Priority: Ensure a medial homes for CYSHCN

- *NPM: % of children with and without special health care needs, ages 0 through 17, who receive needed care coordination*
- *NPM: % of adolescents with and without special health care needs ages 12-17, who received services to prepare for the transition to adult health care.*
- *NPM: % of children with and without special health care needs, ages 0 through 17, who have a medical home*

Cross Cutting

Priority: Improve Access to and Utilization of MCH-serving programs and activities available through MSDH

- *SPM: # of social media messages focused on MCH-serving programs per year.*
- *SPM: # of community-based activities attended where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form.*
- *SPM: % of referrals by MSDH MCH-serving programs that are on the on-line Universal Referral Form.*

Priority: Maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations

- *SPM: % of MSDH MCH-serving programs that have administered a patient satisfaction survey in the past year to engage the community in program improvement.*

Priority: Increase access to timely, health, developmental, behavioral health screenings

- *SPM: Total number of referrals for social conditions affecting the health of patients being served by MSDH county health department clinics.*

Limitations to MCH 5-Year Needs Assessment

Due to turnover within MSDH, the original staff who initiated the MCH Needs Assessment left the agency prior to the completion of the MCH Needs Assessment. The determination of what was the best practice in instrument development and/or the recruitment decisions on how to obtain participants for the listening sessions, town hall meetings and focus group is unknown. This information was not written down or disclosed prior to their departure.

The creation of the survey was done with limited MSDH MCH Leadership input. The length of the survey was a deterrent for many to fully complete. After clicking on the QR code, the need to scroll down the MSDH MCH Block Grant Webpage to find a link to access the survey was a deterrent for many. The paper survey had limitations. People were able to skip questions without a response, answer questions which would not have pulled down on the computer version, unless the response met the need for explanation, and respond with multiple answers when only one response was allowed. This led to additional information which conflicted with the original response.

Review of the database for the statewide survey in Spanish shows that there were no respondents. Because the distribution of the QR Code for the provider survey was addressed by the staff who left, there is no information indicating the attempted outreach and/or use of this survey.

Within the database for the provider survey results, there were too few completed surveys to analyze for relevant generalization across the state. Comments from providers were added to this summary. Because the distribution of the QR Code for the provider survey was addressed by the staff who left, there is no information indicating the initial outreach and/or distribution process follow-up for this survey. While the survey was pushed out electronically during the second wave, review of the database indicates only 20 surveys were completed during this time.

Lesson learned is that the decisions made toward future needs assessments should be determined by all MCH Leadership and records kept in meeting minutes. The survey needs to be shortened and distribution efforts organized prior to initiation of the survey.

III.C.1.b.ii. Title V Program Capacity

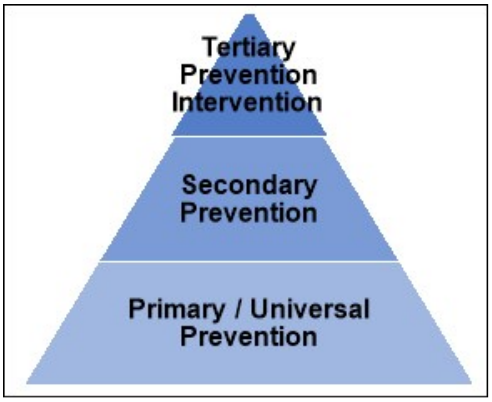
III.C.1.b.ii.a. Impact of Organizational Structure

Impact of 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 Health Care Needs (CYSCHN) program, and the Office of MCH Engagement and Coordination. Additional Health Service 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 grant development. Over the past 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 changes.

The MCH Programs have continued to expand their ability to serve various populations through the establishment of new grant-funded programs, including the Maternal Infant and Early Childhood Home Visiting (MIECHV) under the Office of Child & Adolescent Health, and the Wisewoman, Time4Mom, and Healthy Start Programs under the Office of 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 First Steps Early Intervention Services for children with

impairments/developmental delays or CYSHCN services for those with special health care needs. The MSDH and Mississippi in general have fewer secondary prevention programs for selected populations of children and families to prevent rather than treat poor health and wellbeing. Under the Prevention Health Pyramid model, these expanded programs provide Tier II: Secondary Prevention services, expanding the capacity of MSDH to reach beyond its existing Tier 1: Primary/Universal Prevention and Tier III: Tertiary Prevention and Intervention programs.



Recognizing the power of prevention in improving the health and well-being across the life course, health Services and the MCH programs have expanded its collaboration with the Office of Preventive Health and Office of Public Health Transformation / Field Services to address the social conditions impacting the health of MCH populations and all Mississippians. Programs in the Office of Preventive Health and Office of Public Health Transformation / Field Services assist MCH-related strategies around issues such as maternal and infant mortality, developmental screenings, well visits among infants, children, and adolescents, and cross-cutting issues such as mental health. 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 all its MCH population.

Over the past five years, MSDH has undergone reorganization of regions, divisions, offices, programs, and personnel. Reorganization includes:

- Public Health Pharmacy and the Special Supplemental Nutrition Program for Women, Infants and Children's (WIC) were moved out of Health Services into their own Divisions.
- Tobacco Program and Office of Oral Health were moved under the Office of Preventive Health.
- The Early Hearing Detection and Intervention Program was integrated with the Newborn Screening Program.
- The First Steps Early Intervention Program was moved out from the Office of Child and Adolescent Health into its own Bureau.
- Health Services established the Office of Financial Management and Operations for overseeing the supporting programs for budgeting and expending MCH funds.
- The MCH Engagement and Coordination Office was created to address the professional developmental needs of the MCH-serving programs. It expanded the breadth of programming by adding an integrated Public Health Social Worker team spread across MCH-serving programs.

There was a statewide transformation and reorganization. It created the tiered Public Health Service Delivery System designed to provide effective and efficient care based on each clinic's size, available funding, staffing levels, and patient volume.

Under this model, county health departments are classified into four levels:

- **Level I Clinics** are located primarily in smaller, rural counties. Although they do not provide nursing services, they serve as vital access points by offering WIC nutrition and education, fingerprinting, and records requests. Level I clinics also serve as essential access points by assisting clients with scheduling appointments and arranging transportation to higher-level facilities.
- **Level II Clinics** offer the full range of public health services, including nursing care, on a part-time or full-time

basis, depending on local needs.

- **Level II/III Clinics** offer part-time clinician coverage tailored to patient demand and census data.
- **Level III Clinics** operate as full-service centers, typically located in larger counties, and serve as regional hubs for comprehensive public health services.

To further expand access to care, MSDH has expanded its network of support services to eliminate common challenges to care. These include assistance with applications for Marketplace Insurance and the Family Planning Medicaid Waiver, offering reduced-rate services, transportation support, and telehealth options. MSDH is also seeking opportunities to collaborate with community-based organizations and Federally Qualified Health Clinics to expand and create a larger and more comprehensive network of care.

Recognizing the unique health disparities in the Mississippi Delta, MSDH has designated a special Delta Public Health Region**,** comprising the 13 core Delta counties. This region faces distinct challenges that contribute to poorer health outcomes. The Delta Region initiative aims to address these issues by prioritizing Maternal and Child Health, Chronic Disease prevention and management, and Health Literacy.

Over the past three years, MSDH has experienced challenges with the aging and exiting of skilled public health professionals. 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 five years.

III.C.1.b.ii.b. Impact of Agency Capacity

Impact of Agency Capacity

During the past five years, MSDH has experienced numerous events which have had a serious impact on staff and services. These include, staffing shortages, statewide reassessment and realignment of job classifications, lower salaries than the private sector, and a limited skilled public health professionals, resulting in difficulty with recruiting and maintaining skilled public health professionals.

While MSDH has made some progress with recruitment, the MSDH also needs to improve retention. Previous workforce surveys found that MSDH was viewed as lacking innovation and under resourced.

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 health manager program through the Mississippi Personnel Board. To support the social work professionals within MSDH, and with external partners, free social work continuing education hours are offered monthly, allowing social workers to renew their license with limited financial obstacles.

Within the past two years, MSDH instituted a monthly “Grand Rounds” with the specific purpose of growing the skills of MSDH staff. Through this collaborative effort by different disciplines and MSDH-serving programs, Grand Rounds are used as a teaching methodology to build the existing staff’s capacity. Data and case presentations are show cased providing educational learning opportunities for staff regarding various MSDH programs, data and best practice innovations.

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.

The MCH Engagement and Coordination Office participated in the 2024 Title V MCH Workforce Development Learning Journey from the UNC National MCH Workforce Development Office. While the learning journey project

focused on development of the Health Service Universal Referral form, UNC National MCH Workforce Development team provided the MSDH Health Services program staff a two-day on-site consultation, “Building Stronger Linkages for Better Outcomes” to build program staff capacity. The outputs from this included:Training on the “Collective Why”, Ecosystem Mapping, Whole System Mapping, Mutual Learning Teams, and Conversational Capacity.

Per the follow-up survey, the make-up of the group included 9 Title V/CYSHCN participants, 11 State non-Title V participants, 3 county health department participants, and 4 “other”.

Survey results indicated staff reported:

- “The on-site consultation was a good use of my time” (96% stated strongly agree or agree)
- “The on-site consultation will help me engage meaningfully/lead health transformation in my state”. (92% stated strongly agree or agree)

Because of the positive response regarding the on-site consultation, it will be recommended that MSDH outreach to UNC National MCH Workforce Development team for further support and professional development. Recognizing the challenge of a rather new MCH / Title V staff, technical assistance to build the knowledge base and capacity is needed.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

Title V Workforce Capacity and Workforce Development

Developing a knowledgeable and motivated public health workforce to serve communities is essential to improving MS’s health and well-being. Due to retirements and reorganizations, the MSDH has undergone significant personnel changes requiring transformation and 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.

During 2024, in the ongoing effort to improve access to care, MSDH actively transformed how services were delivered throughout county health departments to meet the needs of the staff and the residents of MS. This transformation involved implementing a statewide, tiered Public Health Service Delivery System designed to provide effective and efficient care based on each clinic’s size, available funding, staffing levels, and patient volume.

Under this model, county health departments are classified into four levels:

- **Level I Clinics** are located primarily in smaller, rural counties. Although they do not provide nursing services, they serve as vital access points by offering WIC nutrition and education, fingerprinting, and records requests. Level I clinics also serve as essential access points by assisting clients with scheduling appointments and arranging transportation to higher-level facilities.
- **Level II Clinics** offer the full range of public health services, including nursing care, on a part-time or full-time basis, depending on local needs.
- **Level II/III Clinics** offer part-time clinician coverage tailored to client demand and census data.
- **Level III Clinics** operate as full-service centers, typically located in larger counties, and serve as regional hubs for comprehensive public health services.

During 2024, the MCH Engagement and Coordination Office assessed the current MCH / Title V staff (N=265) to determine their demographics and professional development needs. The survey had a 44% response rate. Of the respondents, 53.8% were African American; 38.5% were white. According to the survey, 54.7% of respondents have 5 or less years employment at MSDH and 11.1% have 21 years or more experience at MSDH. 24.7% stated they could currently retire in 4years or less. The implied concern from the information is that a little over 1/4 of those who responded have the potential of retiring from MSDH in five years or less; leaving a relatively new workforce with under 10 years’ experience at MSDH.

Additional demographics were as follows:

Employment Status	
Full-time employees	76.9%
Full-time contractors	6.8%
Part-time contractors	12%
Ages	
25-34	16.5%
35-44	25.2%
45-55	37.4%
55-64	11%
65-70	2.2%

Gender	
Female	88.9%
Male	7.69%
Preferred not to answer	3.41%
Education Level	
High school diploma/GED	0.9%
Associate/2-yr degree	17.9%
4-year college degree	35.9%
Master's degree	36.8%
PhD or higher	6.8%
Preferred not to answer	1.7%

Desired training topics were: Conflict Resolution, Critical Thinking, Professional & Effective Communication, Team Building Activities within my Department, Time Management & Productivity, and Adaptive Leadership Skills. 84.6% of respondents stated they would like a quarterly newsletter with information surrounding supervision, management, public health and MCH topics.

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, public meeting dates, self-care topics, and other professional development opportunities. The current distribution list includes 600+ MSDH staff members and external partners.

Workforce Development

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, public meeting dates, self-care topics, and other professional development opportunities. The current distribution list includes 600+ MSDH staff members and external partners.

Agency Support for Professional Development

The MSDH provides employees with professional development opportunities to build their capacity. MSDH Workforce program provides a new employee orientation and offers a supervisor skill development orientation. 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, AMCHP, 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.

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 26 sessions events for a total of 31.5 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.

Mississippi's Health Professional Shortage Areas

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 unprotected 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 includes 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 128 hospitals of which there are ninety-five acute care, four psychiatric, one rehabilitation, one OBGYN and ten long- term acute care facilities. 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, 2 specialized programs for adolescents and 11 regional centers with county governing authorities.

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

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-nine counties are designated as dental HPSAs, and all but four counties are designated as mental health HPSAs. All 82 counties are designated as either whole or partial-county Medically Underserved Areas (MUAs).

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

In 2022, MS had a total of 657,814 Medicaid enrollees providing coverage to 27.7% 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 MS Medical Center

Distribution of Primary Care Physicians, Dentists, and Psychiatrists in MS		
Health Profession Category	**% Serving Rural**	**% Serving Urban (MSAs)**
Primary Care Physicians	41.9% 887 physicians serve 64 rural counties *1 rural county have no primary care physicians*	58.1% 1230 physicians serve 17 urban counties *all urban counties have primary care physicians*
Dentists	40.2% 520 dentists serve 62 rural counties *3 rural counties has no dentists*	59.78% 773 dentists serve 15 urban counties *2 urban counties have no dentists*
Mental Health (Psychiatric Only)	20.57% 36 psychiatrists serve 14 rural counties *51 rural counties have no psychiatric mental health providers*	79.43% 139 psychiatrists serve 9 urban counties *8 urban counties have no psychiatric mental health providers*

While the percentage of MS adults who report being uninsured has dropped since 2013, cost is still the greatest impediment 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.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

Performance Narrative
Overall Accomplishments and Challenges

This Mississippi State Systems Development Initiative (MS SSDI) Progress Report outlines changes to the Mississippi State Department of Health (MSDH) during the 2024 - 2025 reporting period. MS SSDI has been used to support the work of the Title V Maternal and Child Health Block Grant (MCHBG), MCH-related analyses, and the Pregnancy Risk Assessment Monitoring System (PRAMS). In Mississippi, the Title V MCHBG supports several

programs, including Child and Adolescent Health, Children and Youth with Special Health Care Needs (CYSHCN), Early Hearing Detection and Intervention (EHDI), Newborn Screening (NBS), Early Intervention (EI), Reproductive Health, and Women's Health. and aligns with the work of the Healthy Moms Healthy Babies of MS program (formerly the Perinatal High-Risk Management/Infant Services System), Breast and Cervical Cancer Prevention Program (BCCP), WIC program, Maternal Infant and Early Childhood Home Visiting program, and the Lead Poisoning Prevention and Healthy Homes program. This report was collaboratively authored by MSDH team members from the Office of Health Data and Research (OHDR), the Office of Women's Health (OWH), and the Office of Child and Adolescent Health (OCAH), the Offices of Health Data, Operations, and Research (HDOR), including the Office of Data Governance (ODG), and the Office of Vital Records and Public Health Statistics (VRHS).

MSDH has maintained a collaborative approach between the OHDR team, the HDOR teams, the Title V Director, MCH program staff, County Health Department clinical personnel, and SSDI staff. The agency has expanded and maintained a productive partnership focused on supporting MCH programs. The ODG set up procedures and an online site to facilitate data exchange and requests. An ongoing partnership with VRHS has facilitated the timely exchange of critical data for numerous MCH programs. VRHS staff have also provided epidemiological support for data linkages between birth and NBS. The electronic health record (EHR), EPIC, replaced many of the outdated data systems and this transition has allowed MSDH to have a unified and longitudinal EHR for individuals served across the agency. The addition of a Clinical Informatics team of epidemiologists in the Epic Department improved the ability to extract data for surveillance and program reports. The Revenue Cycle and EPIC teams continue to strengthen the relationship with the MS Division of Medicaid (DOM) by providing analytical reports and medical records through, EPIC. The clinical informaticists also provide ambulatory operations reports, stakeholder and advisory group reports for many of the MCH programs. The Epic Office team introduced centralized scheduling, patient self-registration, electronic patient questionnaires, and a telehealth platform, which are used by many MCH programs to enhance access to public health services and clinical care.

OHDR utilizes SSDI funding to provide software, hardware and professional development opportunities for OHDR staff to advance data capacity. MSDH remains committed to modernization, data accessibility, and collaborative, evidence-based approaches to strengthen the ability to acquire and utilize essential MCH health data in MS.

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 OHDR staff accesses, collects, analyzes, and uses reliable data from various internal MSDH offices and external state agencies, such as DOM, the University of MS Medical Center, Department of Education, and Department of Human Services to develop indicators not directly available to the MS SSDI Programs. MS SSDI supports improving existing systems instead of creating new ones and encourages data exchange within agency data systems. Also, SSDI supports the growth of MS MCH data capacity to support Title V program efforts and helps clinical and public health programs make data-driven decisions. This includes support for the needs assessment and Title V MCHBG data, identifying structural and process measures for Title V and programs, and assisting MCH programs to develop State and National Performance Measures (SPMs and NPMs) to address priority needs. To meet this goal, the agency focused on the following activities:

- Provide technology modernization and data support to MCH programs
- Provide data support for the Title V MCHBG application and reporting including developing and reviewing structural/process measures
- Assist with statewide Needs Assessment for the Title V MCHBG; and setting performance objectives for all measures
- Provide coordinated data and technical support for timely and accurate Title V MCHBG submission.

The objectives and activities for this five-year goal include providing data and support to MCH programs agency-wide, particularly the Title V MCHBG application, reporting processes, and statewide needs assessment.

Throughout the term, SSDI staff have consistently offered data and technical support for timely and accurate submissions of Title V MCHBG and needs assessment. The support of SSDI funds has significantly increased the OHDR's MCH data capacity. The ability to purchase software licensure and support epidemiologists and statisticians in MCH data analysis is critical to achieve the goals outlined in this application. Additionally, with an emphasis on MCH data, OHDR offers data analysis and reporting support to other Health Services offices, including the OWH, OCAH, and Oral Health. The epidemiology and research biostatistician personnel also respond to data requests from other state agencies, the MS Legislature, and the public.

Objective 1.1 By 11/30/2024, conduct an MCH Title V Block Grant Data Needs Assessment for the five years

Activities	Details
Identify MCH Title V MCHBG Data Needs Assessment activities. Administration of Redcap™ online surveys to MSDH and community stakeholders to perform quantitative analyses. Application of qualitative methods, i.e.: community structured interviews, town hall meetings, and focus groups, to collect data for qualitative analyses. Translate data and provide analytical support to the MCH Title V MCHBG Team through the data collected in the data needs assessment activities. Summarize data findings in a meaningful format for presentation to the MCH Title V MCHBG Data Needs Assessment Stakeholder Group. All activities above completed Staff receive training related to MCH Title V MCHBG Data Needs Assessments activities.	The MCH team, HDR leadership and epidemiologists developed a plan to assess data needs and create a statewide MCH data analysis plan that includes quantitative analyses and comparisons of both state and national data. The plan also involves developing questions for community-structured interviews, town hall meetings, and focus groups, to collect data for qualitative analyses. MSDH collaborated with an independent contractor to carry out the 2024 Needs Assessment. Data collection tools were jointly developed by the contractor and the MSDH Title V/SSDI team, and survey questions were distributed via REDCap to MSDH staff and community stakeholders. Community interviews, town hall meetings and focus group meetings were conducted. The SSDI leadership and epidemiologist analyzed the collected data both quantitatively and qualitatively and completed the reports. The report summary was presented to Title V MCHBG data needs assessment stakeholder group. By utilizing both quantitative and qualitative data, the MSDH Title V/SSDI team and stakeholders identified priority needs related to unfair and preventable differences in health outcomes. They adjusted and realigned measures to address shifting population and resource needs.

Objective 1.2: Review the State MCH Block Grant Action Plan to select appropriate NPMs and outcomes. Development of corresponding SPM measures

Activities	Details
Support the leadership team in selecting national performance measures based on identified priority needs. Completed Advise team on developing state performance measures based on identified priority needs. Completed	HDR SSDI leadership and epidemiologists worked with the MCH team to analyze NPM data, comparing MS data with overall US to identify priority needs and correlate them to accessible data sets. This analysis guided the MCH/SSDI team in developing SPMs. Using the state priority MCH Needs Assessment results, the Title V/SSDI workgroup and partners identified gaps in the existing Title V NPMs. The MSDH Title V MCH/SSDI team developed a list of NPMs and SPMs based on the assessment findings.

Objective 1.3: Develop at least one ESM for each NPM selected. Evaluation: Number of ESMs to address the NPMs/SPMs selected by MS's Title V programs

Activities	Details
Perform a review of the literature and a meta-analysis, where applicable, to support the choice of ESMs. Consult with content experts to validate the measures selected. Finalize structural and process measures for linkage to selected NPMs. All Activities above completed	The Title V/SSDI workgroup reviewed and revised existing ESMs, retiring some and proposing new ones based on the 2025 Needs Assessment, through several meetings. The chosen ESMs were linked to NPMs aligned with selected priorities and staff capacity.

Objective 1.4: Establish performance objectives for all measures. Evaluation: (1) Review the trend for measures (2) Number of recommended performance objectives to the State Title V Director based on trends and Healthy People 2030 objectives

Activities	Details
Perform and disseminate trend data analyses for the measures selected. Completed Recommend 2030 objectives performance objectives to the State Title V Director based on State Health Plan, Trend Analyses, and Healthy People 2030 objectives. Completed	HDR SSDI leadership and epidemiologist team identified relevant Healthy People 2030 objectives for new performance measures and created a trend analysis document for Performance and Outcome Measures The Title V/SSDI workgroup provided epidemiological support for the MCH programs to establish SMART performance objectives for MCHBG by reviewing recent MS trend data and comparing it to Healthy People 2030 objectives, or applying a 1.0% annual relative growth compared to the previous year if no target existed. The finalized objectives were recommended to the State Title V Director for the MCHBG.

Objective 1.5: Provide and update data to MCH Block Grant Application/Report Evaluation: Number of NPMs/SPMs, NOMs/SOMs, and ESMs continued, revised or retired by April 30 annually

Activities	Details
Request updated data for Title V indicators. Compile data on assigned indicators. Support other MCH or MSDH staff in gathering/analyzing data for MCH Title V MCHBG. Review data with State Title V Director. Prepare and present to MCH program staff and management recent trends in selected Title V indicators. Review current NPMs, SPMs, and ESMs to identify any changes that may be needed in conjunction with the Title V team. All Activities above, completed	HDR SSDI Epidemiologist requested and compiled data on assigned Title V MCH indicators. HDR SSDI leadership and Epidemiologist analyzed all the Title V MCHBG data and reviewed findings with the Title V Director Title V/SSDI team reviewed MS NPMs, SPMs, and ESMs, selected new ones, and ensured alignment with program needs and activities

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 improved through SSDI funding over the past grant cycles. MS SSDI conducted sub-state-level analyses to support data-driven decision making. MSDH leadership enhanced data linkage, enabling stakeholders to collaborate and access data more efficiently. The ODG is advancing data modernization by creating a data catalog and updated request system, which is accessible to the public. These systems enhance capacity for state agencies, stakeholders, and policymakers to design policies and fund interventions that improve health outcomes. Linked data systems enable early identification of vulnerability, monitor Health outcomes variations, and detect manifestations of adverse effects over time across different health domains and diverse subpopulations defined by geography, ethnicity, or other characteristics. In past grant cycles, MSDH focused on expanding the use of core data sets to build a robust data structure supporting State MCH efforts. In previous grant cycles, MSDH renewed existing memoranda of understanding with the DOM, expanded partnerships with VRHS to link birth records and program data such as lead poisoning prevention, NBS, and maternal mortality, and PRAMS, providing essential data about women before, during and just after pregnancy. Health Services continues to strengthen collaboration with internal and external partners. The goals are to identify data gaps to meet the Minimum or Core Datasets (M/CDS), establish necessary MOUs to close the gaps, implement new linkages between birth, death, hospital discharge and Medicaid eligibility data, and improve the availability, timeliness and use of linked MCH data reporting. Traditionally, SSDI epidemiologists secured access to M/CDS through various sources using many indicators for Title V Needs Assessment and reporting. An assessment of MS’s capacity to report on M/CDS Indicators was conducted. Much of the data came from VRHS and the DOM, two MCH stakeholders. No MOU was required to expand SSDI partnerships with VRHS.

For the coming year, SSDI epidemiologists continue to analyze both unlinked and linked data sets to support MCH programs. MSDH will maintain data-sharing agreements with the DOM and increase collaboration with partners to assess data gaps. MCH and SSDI epidemiologists worked with VRHS and DOM to ensure the timely linkage of birth certificates and DOM beneficiary data. MSDH SSDI Program has maintained the data-sharing agreement with DOM and strengthened partnership to assess data gaps. The MS SSDI team also maintained internal partnerships with VRHS and PRAMS. MSDH MCH team and SSDI epidemiologists conducted a data needs assessment and created a statewide MCH data analysis plan emphasizing key data linkages and the need for integrated state-level data. This plan integrates existing agencies and program strategic plans for a comprehensive maternal and child health agenda aligned with state health improvement goals. It includes input from MSDH Epic team and ODG to improve the data collection, storage, and dissemination for MCH surveillance and programs.

SSDI epidemiologists in HDR are collaborating with the Office of Oral Health to identify oral health professional shortage areas using GIS data visualization. They are developing a plan for 3rd-grade oral health basic screening

surveillance. The Title V/SSDI team created a plan for additional data needs assessments, conducted by epidemiology staff in OHDR and across MCH programs

Objective 2.1: Advance the existing MCH data linkages

Activities	Details
Partner with Medicaid to receive MCH Medicaid claims data and implement data linkages. Partner with VRHS to access accurate records of state births, deaths, and other vital events, such as children's immunization records. OHDR began linking PRAMS data to Newborn Screening data to gather more reliable mothers' contact information and increase PRAMS response rates. Work with DOM to identify the indicators necessary for the M/CDS. Assist in the analysis of linked data. Assist in the translation and dissemination of the analyses using linked data. All Activities above completed Epic training and certification for the SSDI epidemiologist	MSDH SSDI Program has maintained the data-sharing agreement with DOM and increased collaboration with partners to assess data gaps. SSDI Epidemiologist linked DOM data to MCH data to identify service gaps and guide decision-making SSDI/MCH leadership and epidemiologists have worked with VRHS and DOM to ensure timely linkage of birth and Medicaid data and it has also maintained internal partnerships with VRHS and PRAMS. SSDI/MCH Epidemiologist analyzed linked data from DOM with Lead, and data from VRHS data with NBS to inform programming SSDI epidemiologist plans to attend EPIC training and earn certification in analysis and reporting.

Objective 2.2: Identify and obtain data sources for data elements

Activities	Details
Work with internal and external partners to identify the existing data gaps to meet the M/CDS. Completed Work with internal and external partners to initiate all necessary MOUs and DUAs to close the data gaps. Completed	To meet M/CDS, HDR assessed MS's reporting capacity on the M/CDS indicators using data from VRHS EHR from EPIC, and DOM, key MCH stakeholders and SSDI/MCH team expanded partnerships accordingly. No MOU was required for VRHS/EPIC, but to capture data from DOM MOU was renewed. In the current grant cycle, Health Services focused on improving partnerships and identifying existing data gaps to meet M/CDS Goals, including initiating MOUs linking birth, death records, and hospital discharge data or Medicaid data, and improving the availability and use of linked MCH data.

Objective 2.3: Support the development of data products in collaboration with partners and community stakeholders to meet the Minimum and Core Data Sets (M/CDS) and facilitate utilization of the M/CDS

Activities	Details
Develop a framework for the creation and reporting of data elements in the M/CDS. Disseminate linked data reports that use M/CDS with internal and external stakeholders. Provide technical assistance to internal and external stakeholders to facilitate the interpretation and use of reports. All Activities above completed	High-quality integrated data systems enhance decision making for states, communities, and policymakers, impacting maternal and child health. The SSDI team developed a data dashboard with MCH indicators from multiple sources which has been shared with Title V program and stakeholders. MSDH Title V MCH/ SSDI leadership will maintain the data sharing agreement with DOM and increase collaboration with partners to assess data gaps. It has also expanded internal partnerships with EHR from EPIC, VRHS and PRAMS.

Goal 3: Enhance the development, integration, and tracking of Fair opportunities to achieve health, dignity, and well-being, and conditions and policies affecting health, to inform Title V programming

MSDH SSDI program recognizes the need to integrate and track opportunities to achieve health, dignity, and well-being, and the conditions and policies affecting health, aiming to develop tools that support planning and evaluation of MCH programs to inform Title V efforts. Through these performance measurement efforts, Title V/SSDI epidemiologists can collect valuable contextual data to enhance MCH service delivery and results. Title V MCH and SSDI team will track, monitor, and evaluate program activities and effectiveness. MCH and SSDI will continue engaging with the MSDH multi-office initiative to develop fair opportunities for health, dignity, and well-being. This data project will guide the use of small numbers and best practices for aggregating/disaggregating data by race and ethnicity. To protect privacy, all reports are reviewed by ODG to ensure compliance with small numbers and reidentification policies.

Objective 3.1: Build capacity for integrating and tracking high-quality, coordinated, and accessible data on conditions and policies affecting health, to inform State MCH Title V Block Grant programming

Activities	Details
Develop a systematic method to collect high-quality, coordinated, and accessible data on conditions and policies affecting health. Identify valuable contextual high-quality, coordinated, and accessible data on conditions and policies affecting health that can help improve the MCH Title V MCHBG program's service delivery and results. Identify any needed surveys or other data collection instruments that help collect high-quality, coordinated, and accessible data on conditions and policies affecting health. Meet quarterly to review the status of each activity pertaining to collecting high-quality, coordinated, and accessible MCH Title V MCHBG data on conditions and policies affecting health. All Activities above, completed Develop a plan to incorporate State MCH Title V MCHBG high-quality, coordinated, and accessible data needs assessment for conditions and policies affecting health. Coordinate the implementation of continuing training for MCH staff on the importance of adequately collecting high-quality, coordinated, and accessible data on conditions and policies affecting health.	SSDI leadership, the epidemiologist and State Title V Director have worked to develop and implement data collection methods to effectively monitor and evaluate data on MCH program activities and their impact on health-related conditions and policies. Programs submitted quarterly reports along with detailed program activities. Data from sources like EPIC, Vital Records, PRAMS, REDCap, and other programmatic databases were downloaded and analyzed to assess program impact. The Title V/SSDI workgroup tracks, monitors, and evaluates activities related to NPMs to support the evidence base for the Title V MCHBG needs assessment. Title V/SSDI leadership and epidemiologists conducted ongoing assessments as well as provided an understanding to evaluate progress, identify new and emerging issues, and assess MCH programs' capacity. Title V/SSDI team will continue to meet with MCH staff to track and monitor activities related to health conditions and policies.

Objective 3.2: Maintain capacity for integrating and tracking high-quality, coordinated, and accessible data on conditions and policies affecting health to inform State MCH Title V Block Grant programming

Activities	Details
Continue to meet quarterly to review the status of high-quality, coordinated, and accessible data collection on conditions and policies affecting health. Completed	HDR leadership and epidemiologists meet quarterly with the MCH team to review coordinated, high-quality, and accessible data collection on the health conditions and policies.

Objective 3.3: Improve capacity for integrating and tracking high-quality, coordinated, and accessible data on conditions and policies affecting health, to inform State MCH Title V Block Grant programming

Activities	Details
Review the results of the program evaluation and adjust data procedures for improvements. Completed Develop factsheets and reports to demonstrate the use of high-quality, coordinated, and accessible data on conditions and policies affecting health, to inform decision-making for improved MCH Title V MCHBG outcomes. Completed	The MCH/SSDI leadership and epidemiologists developed a systematic approach to collect high-quality, coordinated, and accessible data on conditions and policies affecting health. This contextual data has improved Title V MCHBG program's service delivery and results. Surveys and focus group questionnaires were developed and used in the State Title V MCHBG needs assessment. Regular meetings were held to review progress on collecting high-quality, coordinated, Title V MCHBG data. The MSDH SSDI team also worked to improve capacity for integrating and tracking this data to inform State programming

Goal 4: Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats

The Reorganization and transformation of HDOR and along with institutionalization of data governance procedures and processes significantly enhanced the office's role in the agency's data modernization and transparency efforts. HDR played a key role in leading the collection, analysis, reporting, and visualization of MCH data on the agency's website, becoming the point of reference for access for community stakeholders seeking general information. For this new SSDI funding, SSDI and MCH epidemiologists will continue to review and update the MCH/CDS assessment, analyze linked data sets and support data visualization for program needs. The Program will also maintain data-sharing agreements and increase collaboration with partners to assess data gaps.

Objective 4.1: Develop Capacity to Inform Rapid State Program and Policy Action Related to Emergencies and Emerging Issues/Threats

Activities	Details
Develop a systematic method to inform rapid state program and policy action. Identify key indicators for a Rapid State Program and policy action. Coordinate protocols for urgent notification to leadership about the Rapid State Program and policy action.	

Significant Changes

Durga Susmitha Vaddi, BDS, MPH, transitioned to her new role on 6/1/2024. She now leads complex analytical epidemiologic activities related to research, surveillance, detection and prevention of diseases/injuries within the MCH programs. As part of clinical informatics, Ms. Vaddi will become Epic-certified in analytics and report writing, enabling direct access to MCH longitudinal data and to provide dedicated support to MCH programs.

Plans for the Upcoming Budget Year

MSDH SSDI will continue to provide data and technical support outlined in this report and will request or submit proposals for technical assistance and staff development as needed. Key objectives/activities for the upcoming budget period include:

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

MCH/SSDI leadership and epidemiologists will facilitate tracking and visualization of all MCH measures to help MCH personnel and stakeholders monitor progress across priorities. MCH/SSDI leadership and epidemiologists

will develop a measurement plan to monitor progress. They will also help MCH programs set SMART performance goals for all MCHBG indicators by offering epidemiologic and statistical support. Needs Assessment results will be used to guide future program activities, documents, factsheets, and training.

Ongoing Needs Assessment activities will continue across MCH programs alongside the five-year statewide MCHBG Needs Assessment. This enables ongoing monitoring of the needs of the MCH population and the system's ability to address those needs. Every five years, at the start of a new grant cycle, MS MCH conducts a full Needs Assessment and offers an ongoing Needs Assessment update as an annual follow-up. MCH/SSDI epidemiologists are assisting MCH programs with technical matters and working on the data for the Title V MCHBG submission. MCH/SSDI leadership and epidemiologists are offering technical support to MCH programs that include Epic use in their program activities.

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
High quality integrated data systems enhance knowledge for states, communities, and policymakers to develop policies and fund maternal and child health interventions. In the coming year, SSDI/MCH leadership and epidemiologists will continue analyzing linked data to support programs as needed and work with internal and external partners to identify and close the existing data gaps to meet the M/CDS

MSDH MCH/SSDI Program will maintain the data-sharing agreement with DOM and increase collaboration with internal and external partners to assess data gaps. MS SSDI team will maintain internal partnerships with VRHS and PRAMS. MCH/SSDI epidemiologists have ensured timely completion of program reports, fulfillment of data requests and analyses that support data-driven decision making.

G**oal 3: Enhance the development, integration, and tracking of metrics on Fair opportunities to achieve health, dignity and well-being and Conditions and policies affecting Health. to inform Title V programming**
Building capacity to integrate and track high-quality, coordinated, and accessible care data on conditions and policies affecting health is a priority for the MCH/SSDI leadership and epidemiologists to inform Title V MCHBG programming. The MSDH SSDI Program will continue to develop a systematic method to collect high-quality, coordinated, and accessible data on health conditions and policies, and identify valuable contextual data to enhance MCH Title V MCHBG program's service delivery and results. Additionally, necessary surveys or other data collection instruments will be identified, along with a plan to incorporate the State MCH Title V MCHBG needs assessment for high-quality, coordinated, and accessible care data on Conditions and policies affecting Health. Regular meetings will be held to review progress of activities pertaining to collecting MCH Title V MCHBG data on High-quality, coordinated, and accessible care on Conditions and policies affecting Health. The MSDH SSDI Program will work to improve capacity for integrating and tracking data to inform State MCH Title V MCHBG programming.

Goal 4: Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats
MSDH SSDI Program will continue to develop the capacity to inform Rapid State Program and policy action related to emergencies and emerging issues/threats by developing systematic methods and identifying key indicators for a Rapid State Program and policy action. Efforts will focus on coordinating protocols for urgent notification to leadership about the Rapid State Program and policy action.

III.C.1.b.ii.e. Other Data Capacity

Other Data Capacity

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's 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 (Revvity 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 clearinghouse.

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.

The MSDH formally initiated a Data Modernization Initiative (DMI) in 2024 to enhance its technology infrastructure and workforce capacities. The charter established a Project Steering Committee (PSC) as the primary authoritative body responsible for guiding and overseeing the strategic activities of the DMI with the Modernization Advisory Committee (MAC) operating under its purview. The PSC and MAC collaborate to ensure effective modernization efforts across MSDH.

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.

MCH Epidemiology Workforce

The Office of Health Data and Research (OHDR) currently has four full-time Epidemiologists and one full-time Research Data Analyst and one part-time Research Data Analyst dedicated to health information management, epidemiology, and data infrastructure for the MCH programs at the MSDH. The office provides support to MCH programs through direct grant funding. The OHDR collaborates with the Offices of Health Data Operations and Research (OHDOR), comprising seven offices and approximately 180 personnel, also dedicated to health information management, epidemiology, and data infrastructure for the MSDH. Several of the offices, such as the

Offices of Data Governance, Data Modernizations, Epic and Clinical Informatics, Strategic Procurement, Revenue Cycle, and Vital Records and Public Health Statistics, provide support to MCH programs through indirect, fee or revenue funding.

The Office of Health Data and Research provides non-communicable epidemiological and biostatistical support, including surveillance, data analysis, reporting, and program evaluation. The office director, Ellen Agho, DrPH, MPH, supervises the epidemiological and biostatistical staff. She has a doctorate in Public Health with an emphasis in Epidemiology and has worked in the areas of MCH for about 13 years. Presently, the dedicated MCH epidemiology workforce is composed of four full-time MCH epidemiologists, one full-time research data analyst, and one part-time research data analyst. In addition to these state staff, OHDR hosts Master's and DrPH-level Epidemiology Interns. The MSDH epidemiological workforce in the Office of Health Data and Research is located at the MSDH Central Office in Jackson, MS. The MSDH Epidemiologist team is composed of professional staff who hold advanced degrees (MPH, MS, DrPH, PhD) 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, Civil Rights, and human subjects training. MSDH also supports and encourages additional training and skills-building opportunities for analytic skills. The MCH epidemiologists and research biostatisticians participated in AMCHP, HRSA/MCHB, CityMatch conference, National Lead and Healthy Housing conference, and MSDH Epidemiology and Research Biostatistics Day peer learning opportunities. The team is also actively involved in the MSDH Grand Rounds and presented several projects and analyses during the grant year. They collaborated with their counterparts in the Office of Preventive Health to align goals, share resources, and coordinate workflows to improve health outcomes for the maternal and child health population.

The Office of Vital Records and Public Health Statistics enhanced its partnership with the MSDH MCH program by providing direct epidemiological support outside of its 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, NIH CEAL, 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, Fetal Infant Mortality Review Committee, Infant Mortality Review Committee and Child Death Review data analysis and reporting, and multiple program required vital records mortality review and birth data support. They also provide the MS BRFSS and PRAMS estimates for the Title V MCH block grant report. During this past year, the BRFSS and PRAMS team oversaw the production and publishing on the MSDH website of MS PRAMS reports (all related to MCH and useful to MCH programs).

The Office of Data Governance, through the Information Security Management Council, oversaw the revision and development of data management policies and procedures for the Maternal Mortality Review Committee, Fetal Infant Mortality Review Committee, and Child Death Review Panel. They provide oversight and approval of any request submitted for data or public records from any MSDH program funded by the MCH block grant. The clinical informaticist team provided all the raw data from the EPIC system for the MCH programs. Epidemiologists in the OHDOR worked with the MCH program monthly and quarterly reporting to the Division of Medicaid and assisted in the training of new Epidemiologists and in creating the MCH program risk map and journal project.

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Title V Program Partnerships, Collaborations and Coordination

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 (UMMC)
HM/HB and University of Mississippi Medical Center 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
HM/HB and MS Department of Child Protection Services have a MOU to refer mothers and infants to HM/HB who have tested positive for substance use during pregnancy or at delivery.

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) (FAA)
The EHDI 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 (IAMH)
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 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.

Mississippi Breastfeeding Coalition (MBC)
The MS WIC Program partnered with the MBC to develop breastfeeding initiatives to address differences in health and access to 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 (MSHI)
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 over weight data to evaluate the impact and effectiveness of the program.

Mother's Milk Bank of Mississippi
WIC collaborates with the Mother's Milk Bank of Mississippi by encouraging moms to donate breast milk to support 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.

Rising Together, Operation Shoestring
The MIHB partnered with Operation Shoestring to address impediments to optimal maternal health outcomes for traditionally disadvantaged 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.

The CARE Project
The EHDI 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.

III.C.1.b.iv. Family and Community Partnerships

Family and Community Partnerships

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". 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

The MSDH Title V/MCH Program adopted the following levels of engagement:

- **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 linguistically appropriate manner for the target audiences. Communication channels are varied, using consistent messaging, evidence informed 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.

- **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 availability of services, clarity of message, courtesy/helpfulness/professionalism of personnel, timeliness of services, (general or program-specific) knowledge, and overall satisfaction.

- **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 improving 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.

- **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.

- **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.

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. They are informed about programs and activities” through social media.[5]

Between October 2023 to September 2024, MSDH Office of Communications posted on Facebook and Instagram a variety of MCH social media announcements. The focus included women, infant and child health. Through social media, mental health concerns and supports for women and child are also posted. The Office of Communications tracked measures regarding each posting:

Facebook: 123 messages with 444,677 reaches.
Instagram: 62 messages with 38,048 reaches.

Examples of the postings include, but not limited to:

Be vigilant, Mississippi parents! recognize the signs of lead poisoning in CHILDREN developmental delays; learning difficulties; irritability or mood swings; loss of appetite; abdominal pain. if you suspect exposure, seek medical attention promptly. early detection saves lives! #leadpoisoningawareness #healthyms #healthcantwait
maternal mental health matters! postpartum depression is real, affecting many new MOMs. if you're feeling overwhelmed, know that help is available. reach out, talk to someone, and seek support. you are not alone, and there is strength in seeking help. #ppdawareness #youarenotalone #healthyms #healthcantwait
it's never too early to start good #oralhealth! when KIDS learn good habits, they last for life. how you brush, when you floss, and what you eat all make a difference. learn about brushing right and eating right at healthyms.com/cavityfree #dentalhygienemonth #healthyKIDS #healthyms
when you keep your teeth and gums healthy, you keep infectious germs out of your body. that means better health overall, especially heart health. good #oralhealth is linked to a lower risk of heart disease, stroke, and even premature BIRTH. make brushing and flossing twice daily your health habit. learn more about the connection between oral health and whole-body health at healthyms.com/brush #dentalhygienemonth #healthymouthhealthybody #healthyms
healthcare workers and PREGNANCY professionals: coming February 5 is a free webinar on stillBIRTH prevention and the new count the kicks app from MSDH. the count the kicks app lets expectant MOTHERs easily monitor fetal movements and detect problems early. find out more and register at no cost at
stillBIRTHs remain a major public health problem in Mississippi. the count the kicks program is a simple method of tracking the health of a developing CHILD that MOTHERs can easily use in their third trimester without visiting a doctor. we want all healthcare providers and those who work with WOMEN in the community to understand this new program and encourage its use. together, we can #makeadifference in INFANT mortality! register for the November 10 webinar at https://bit.ly/3f7sfc8 #healthyBABIES #healthyms #publichealthmatters
a clear sleep space for your INFANT means keeps out items that can interfere with their breathing. that means a lower risk of sleep-related death. it's one of the simple steps you can take for #safesleep for your BABY. learn more at healthyms.com/safesleep
#BREASTCANCER is the second most common cancer for u.s. WOMEN. learn about your risk and ways to keep it low at healthyms.com/pinkribbon. worried about the costs of cancer screening? you may qualify for help. check out healthyms.com/bcc. #healthyWOMEN #healthyms
happy WOMEN's health Wednesday! today, we're shining a spotlight on the health and well-being of WOMEN across Mississippi. from reproductive health to mental wellness, it's vital for WOMEN to prioritize their health at every stage of life. on this WOMEN's health Wednesday, let's empower each other to make informed choices, seek regular check-ups, and prioritize self-care. remember, your health matters, and you deserve to prioritize it. share your favorite self-care tips or health advice for WOMEN in the comments below! together, let's support each other on our journey to optimal health. #WOMENshealthwednesday #healthyms #healthcantwait

Redesigned Peer Support Training for Parent Leaders
The EHDI 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 November 2024, January 2025, in partnership with the CARE Project training was provided on “Changing the Culture of Communication” for parent leaders, all professionals who are serving DHH families and children of hard of hearing. Cultural Sensitivity training November 2024 with CARE Project–parent leaders and professionals. EHDI conference February 2024–at Jackson, MS at the State School for the DEAF. In partnership with Families as Allies offered fall family trainings which is a series of trainings for parent leaders and parents of children who are deaf and hard of hearing on supporting their child in various settings. .

Advisory Committees

Some MCH programs 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 (EI), 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 6 years of age. The EI 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 limited physical conditions and their early childhood partners. The EI Program assembled a cross-state leadership team of 9 people, including a parent representative, to participate in guiding the state effort. The EI Program has supported this parent leader in ongoing participation on parent leadership initiatives at the state and national level.

EHDI Advisory Committee
The EHDI 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 plans and helped establish the family support program. The EHDI 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 (NBS) and birth defects, including adoption of conditions to the MS NBS Panel. The committee meets twice annually and is comprised of 13 volunteer members, including national experts, clinicians, consumers, parents, supporters, and partner agency representatives. In 2022, HB 927 was passed requiring the Mississippi NBS 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 MS NBS Panel, identifying and sharing testing and treatment options, providing guidance on public awareness and prevention efforts, and recommendations on NBS 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, support 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.

[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

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

Identifying Priority Needs and Linking to Performance Measures

Mississippi began this five-year cycle by conducting a comprehensive needs assessment. This assessment reviewed the MCH population needs, the program capacity, internal and external partnerships, and collaborations. Based on the findings of the Five-Year MCH/Title V Comprehensive Needs Assessment, seven (7) Title V MCH priorities where identified.

The data obtained from the town hall meetings, listening sessions, focus groups and surveys, along with use of other programmatic community assessments, captured the perceptions of consumers, families (including those with CYSHCN), adults, partners, and providers across the state. Following the collection of data, a one-day stakeholder meeting was held to review with statewide stakeholders the current priority list, the current Federally Available Data, the Mississippi Infant Mortality Report: Annual Report: Review of 2021 and 2022 Infant Deaths, the Health Service Workforce Survey, and summaries by domain of the strengths and deficits identified through the town hall meetings, listening sessions, focus groups and surveys. Working in small groups to discuss the data, each group developed what they thought would be beneficial priorities for the MCH / Title V program to address. These potential priorities were grouped and themed together for a list of potential MCH priorities.

Shortly after the stakeholder input, MSDH MCH Leadership held virtual internal meetings to discuss stakeholder opinions while incorporating their knowledge of agency capacity and other feasibility considerations in order to determine potential MCH Priorities. Bringing this information together with the Federally Available Data (FAD) allowed MSDH to consider the issues identified, the previous list of priorities, and the general findings across a broad spectrum. In February 2025, the MSDH MCH leadership team reviewed and refined this list, consolidating some overlapping priorities, to generate a potential list of seven key priorities.

Following the development of the potential MCH priorities, there was a change in MCH leadership. The remaining MCH / Title V Leadership were relatively new to the Title V/MCH Block Grant. MSDH outreached to University of North Carolina, Maternal Child Health Workforce Development Center for a one-day retreat regarding Title V/MCH Block Grant 101 and support in finalizing the identification of the 2025-2030 priorities, along with the NPMs, NOMs, and ESM for the 2025-2030 State Action Plan. During this retreat, discussions included: the proposed priority list, input from the stakeholder meeting, FAD and state data, agency capacity, and projections surround unstable funding and impact on agency and program capacity. Education was provided to the group regarding how the National Outcome Measures (NOMs) and National Performance Measures (NPMs) are provided, strategies for selection, and support in identifying Evidenced-Based Strategies (ESMs). Working with the MCH/Title V leadership, the UNC team lead capacity discussions per domain, addressing the previous priority/priorities, current FAD and other data, the

MCH/Title V grant requirements, review of the current workforce capacity, successes and challenges, along with the restructure of some programs and offices agency wide. Through these discussions the current MCH Leadership outlined top priorities to determine the 2025-2030 priorities, along with the NPMs, NOMs, and ESM for the 2025-2030 State Action Plan. After this meeting, the team worked together continuing to learn about the MCH Block Grant, reviewing information from TVIS, and MCH Navigator to identify the evidence-based strategies.

Changes in the Mississippi Priority List

The three sets of discussions about the Mississippi 2026-2030 Priority list assisted in evolution to the current list below.

During the stakeholder meeting, discussions surrounded changes in the state, areas where the state has not progressed, where the state has regressed, and what would be some beneficial activities to "move the needle". The group discussed the changes which have occurred since the end of the pandemic and areas where, as stakeholders, they would like to see the MCH / Title V programs heading.

Upon return to the office, individual groups were created by Public Health Domains and MSDH Health Service Program areas to discuss information obtained from the Stakeholder meeting, more detail about the current capacity of the staff, and the direction the Health Service Director would like for the MCH / Title V to begin moving.

Following these discussions, there was a change in MCH / Title V leadership. With the support of University of North Carolina, Maternal Child Health Workforce Development Center, the current MCH / Title V staff finalized the 2026-2030 Priority list.

Changes were made to improve the language from a deficit language to a strength-based language (reduce to improve); to clarify meaning of language (assure to ensure); elimination of ambiguous language (deleted appropriate); interpreted the view of the priority to encompass more to eliminate the number of priorities (pulled reduce maternal morbidity and mortality, and improve oral health into the new Improve Maternal Health Outcomes) and broadened the view to improve care (Improve Access to Mental Health Services Across MCH Populations to Increase Adolescent Health).

The Cross-Cutting/Systems Building 2026-2030 Priorities are to focus on improving care, through internal processes. (Improve Access to and Utilization of MCH-serving programs and activities available through MSDH; and Maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations.).

III.D. Financial Narrative

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$9,278,900	$9,305,490	$9,272,183	$9,738,802
State Funds	$6,959,175	$366,106	$731,224	$0
Local Funds	$0	$660,083	$1,095,262	$1,821,870
Other Funds	$0	$5,520,459	$3,871,552	$5,328,005
Program Funds	$216,034	$432,470	$1,256,100	$154,227
SubTotal	$16,454,109	$16,284,608	$16,226,321	$17,042,904
Other Federal Funds	$4,625,000	$48,599,460	$113,758,690	$40,601,553
Total	$21,079,109	$64,884,068	$129,985,011	$57,644,457

	2024		2025	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$9,305,490	$9,765,660	$9,738,802	
State Funds	$0	$0	$0	
Local Funds	$1,053,440	$2,504,193	$1,028,134	
Other Funds	$5,525,678	$4,820,052	$6,130,968	
Program Funds	$400,000	$0	$145,000	
SubTotal	$16,284,608	$17,089,905	$17,042,904	
Other Federal Funds	$106,139,568	$22,886,029	$94,229,078	
Total	$122,424,176	$39,975,934	$111,271,982	

	2026	
	Budgeted	Expended
Federal Allocation	$9,765,660	
State Funds	$0	
Local Funds	$1,263,759	
Other Funds	$6,050,486	
Program Funds	$10,000	
SubTotal	$17,089,905	
Other Federal Funds	$14,598,724	
Total	$31,688,629	

Expenditures

The Division of Finance and Accounting, within the Mississippi State Department of Health, is responsible for all fiscal management at the agency including the Maternal and Child Health Block Grant. MSDH staff uses the financial management system called MAGIC. MAGIC is Mississippi State Government's Enterprise Resource Planning (ERP) solution. It is the statewide accounting and procurement system of record, encompassing Finance (accounting, budgeting, grants management) and Logistics (procurement, fleet management, inventory management).

The Title V 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. One-third of Title V funding supports Children and Youth with Special Health Care Needs (CYSHCN), and an additional one-third supports the MCH work of departments across the state focused on children. The remaining one-third of Title V funding supports other critical MCH priorities such as regional perinatal care systems, lead poisoning prevention, oral health, infant safe sleep and breastfeeding initiatives, reproductive health, infant and maternal mortality reduction strategies, health equity initiatives, and PRAMS.

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. MCH program staff provide site visits and program monitoring at contract agencies to ensure compliance with the contract's scope of services. The Mississippi State Department of Health adheres to the policies and procedures developed by the Department of Finance and Administration. These policies can be found on the Department of Finance and Administration website and pertain to the multiple financial functions of the State.

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, Finance and Accounts. The total program expenditures as follow for FY 2024 was $17,089,905 of which $9,765,660 (57 %) is Title V and $7,324,245 (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

Services for pregnant women total program expended were as follows for FY 2024: $2,721,562 for federal funds (28% of the total federal award); $5,805,480 for non-federal funds (79% of total non-federal funds).

Child and Adolescent Health

The goal of the Child Health Program is to integrate services across agency boundaries for children and families to improve availability and accessibility of services and to improve child health outcomes and quality of life. The Adolescent Health Services Program provides technical assistance, educational resources and training opportunities for healthcare providers and community partners as they assess the needs to develop, implement, and evaluate health programs serving adolescents in their communities.

Services for the Child and Adolescent Health total program expended were as follows for FY 2024: $2,3,187,490 for federal funds (33% of the total federal award), $697,738 for non-federal funds (10% of total non-federal funds).

Children with Special Health Care Needs

The mission of the Children and Youth with Special Health Care Needs (CYSHCN) is to develop a statewide system of care for children and youth with special health care needs and their families, using resources of the Mississippi State Department of Health, University Medical Center, community health care providers, community agencies and other available resources. CYSHCN strives to identify impediments and gaps in current health care systems for CYSHCN and assists with resolution. *(On MSDH budget line as Children's Medical Program)*

In past years the program has provided direct care services to CYSHCN and their families. During the 2015-2016 year, the program experienced a reduction in program earnings. This reduction was due to CYSHCN and their families having greater access to specialty care services and health insurance, which decreased the need for services at Blake Clinic. Effective, fall 2015 the program now focuses on infrastructure building and other linkage to care services through increased parental involvement, provider partnerships and other stakeholders.

Services for children with special health care total program expended were as follows for FY 2024: $2,968,820 for federal funds (30 % of the total federal award), $821,07 for total non-federal funds (11% of total non-federal funds).

Administrative Costs
Administrative costs expended thus far are $887,787, 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 FY 2024 is greater than the State's maintenance of effort level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989.

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.

All salary and non-salary charges for the CYSHCN program are identified by budget. 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 and Oral Health.

III.D.2. Budget

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 FY26 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:

- FY26 Anticipated Federal Allocation: $9,765,660
- FY26 Budgeted State Match: $7,324,245

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 Health Service 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.

- ***Lead Poisoning Prevention and Healthy Homes*** – 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).

- ***First Steps Early Intervention Program*** (Part C of IDEA) – This funding supports the identification and serving of infants and toddlers with developmental delays 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.

- ***Early Hearing Detection and Intervention Program*** – 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.

- ***Maternal, Infant and Early Childhood Home Visiting*** Grant Program (MIECHV) – Theses funding 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-Extends 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 cardiovascular disease death rate in 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

- Northeast Mississippi Healthy Start Initiative-This funds is to improve health outcomes before, during, and after pregnancy and reduce the differences in rates of infant death and adverse perinatal outcomes.

- ***Alliance for Innovation on Maternal Health State Capacity Program (AIM)***- The AIM funds 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. The AIM Capacity program is a 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 (Optional)

State Action Plan Narrative Overview

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 women, 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 2024-2025 Five-Year Needs Assessment process including community organizations, providers, supporters, and families, identified critical priorities for each of the key MCH populations as well as additional Cross-cutting/Systems Building needs. As a result, the priority needs are listed below along with the associated national and state performance measures (NPM/SPM).

Domain: Women / Maternal Health

Priority: *Improve Maternal Health Outcomes*

- *NPM 1: % of women using a most or moderately effective contraceptive following a live birth*
- *NPM 2: % of women who have a postpartum visit within 12 weeks after birth.*
- *NPM 3: % of women who attended a postpartum checkup and received recommended care components.*
- *NPM 4: % of women screened for depression or anxiety following a recent live birth*
- *NPM 5: % of women who had a preventive dental visit during pregnancy.*

Domain: Perinatal / Infant health

Priority: *Reduce Infant Mortality*

- *NPM 6: % of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)*
- *NPM 7: % of infants who are ever breastfed*
- *NPM 8: % of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months*
- *NPM 9: % of infants placed to sleep on their backs*
- *NPM 10: % of infants placed to sleep on separate approved sleep surface*
- *NPM 11: % of infants placed to sleep without soft objects or loose bedding*
- *NPM 12: % of infants room-sharing with an adult*

Domain: Child Health

Priority: Increase access to timely, health, developmental, behavioral health screenings

- *NPM: % of children with and without special health care needs, 0 through 17, who have a medical home.*
- *NPM: % of children, ages 1 through 17, who had a preventive dental visit in the past year.*
- *SPM: % of babies who meet 1-3-6 recommendations for screened (passed and not passed) before 6 months of age; % of babies who meet 1-3-6 recommendations for diagnosis with permanent hearing loss: before 3 months of age; % of babies who meet 1-3-6 recommendations babies referred to Part C EI: before*

6 months of age.

- *SPM: % of First Step Early Intervention Program referrals who get an Individualized Family Service Plan*
- *SPM: Percentage of individuals who have been identified as having sickle cell trait and/ or disease by the Genetic program who were referred to the Lead poisoning prevention program*
- *SPM: % of Mississippi newborns screened. (Newborn Screening program)*
- *SPM: % of Mississippi newborns who received a newborn screenings during 24-48 hours after birth. (Newborn Screening program)*
- *SPM: % of Mississippi newborns who received a newborn screening during 24-48 hours after birth with an abnormal result. (Newborn Screening program)*

Domain: Adolescent Health

Priority: Improve Adolescent Health

- *NPM 15: % of adolescents, ages 12 through 17, with a preventive medical visit in the past year*
- *NPM 16: % of adolescents, ages 12 through 17, who received needed mental health treatment and counseling*

Domain: Children and Youth with Special Health Care Needs

Priority: Ensure a medial homes for CYSHCN

- *NPM 17: % of children with and without special health care needs, ages 0 through 17, who receive needed care coordination*
- *NPM 18: % of adolescents with and without special health care needs ages 12 through 17, who received services to prepare for the transition to adult health care.*
- *NPM 19: % of children with and without special health care needs, ages 0 through 17, who have a medical home*

Domain: Cross Cutting

Priority: Improve Access to and Utilization of MCH-serving programs and activities available through MSDH

- *SPM 7: # of social media messages focused on MCH-serving programs per year.*
- *SPM 8: # of community-based activities attended where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form.*
- *SPM 9: % of referrals by MSDH MCH-serving programs that are on the on-line Universal Referral Form.*

Priority: Maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations

- *SPM 10: % of MSDH MCH-serving programs that have administered a patient satisfaction survey in the past year to engage the community in program improvement.*

Priority: Increase access to timely, health, developmental, behavioral health screenings

- *SPM 11: Total number of referrals for social conditions affecting the health of patients being served by MSDH county health department clinics.*

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, infants,

adolescents, children with and without special medical needs, and their families across the state. Over the past four years through implementation of the 2020-2025 State Action Plan, the MCH Program leaders, with feedback from families and consumers, input from their advisory councils and boards, and support from community partners, have updated and refined these strategies and activities.

Over the course of the 2024-2025 MCH Block Grant Needs Assessment process, the current State Action Plan was developed. The 2026 application will continue the implementation of broad objectives, strategies, and activities across multiple MCH programs with a unified approach to improving health outcomes for women, infants, adolescents, children with and without special medical needs, and their families. Both are organized according to priorities and have been collectively developed by MCH program personnel and epidemiologists from the Office of Health Data and Research.

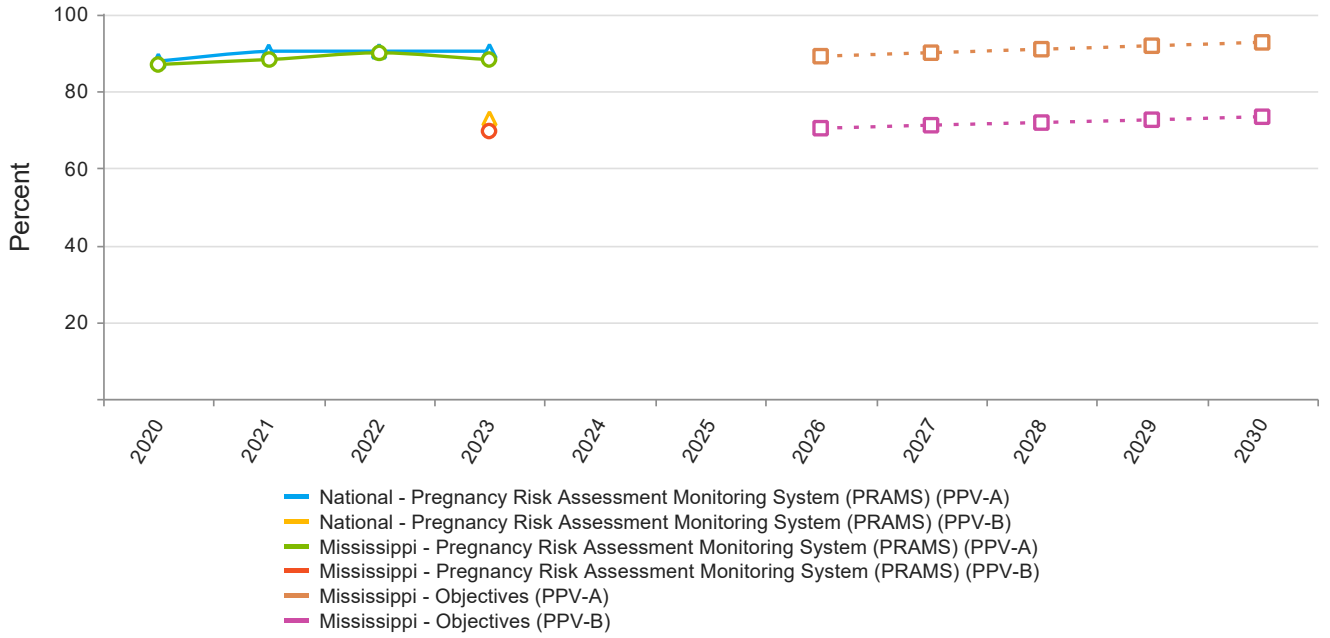
III.E.3 State Action Plan Narrative by Domain

If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.

Women/Maternal Health

National Performance Measures

NPM - 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 - PPV
Indicators and Annual Objectives



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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	88.1	88.1
Numerator	27,351	26,402
Denominator	31,060	29,977
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	89.0	89.9	90.8	91.7	92.6

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	73.6	69.7
Numerator	20,009	18,327
Denominator	27,196	26,287
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	70.3	71.1	71.8	72.5	73.3

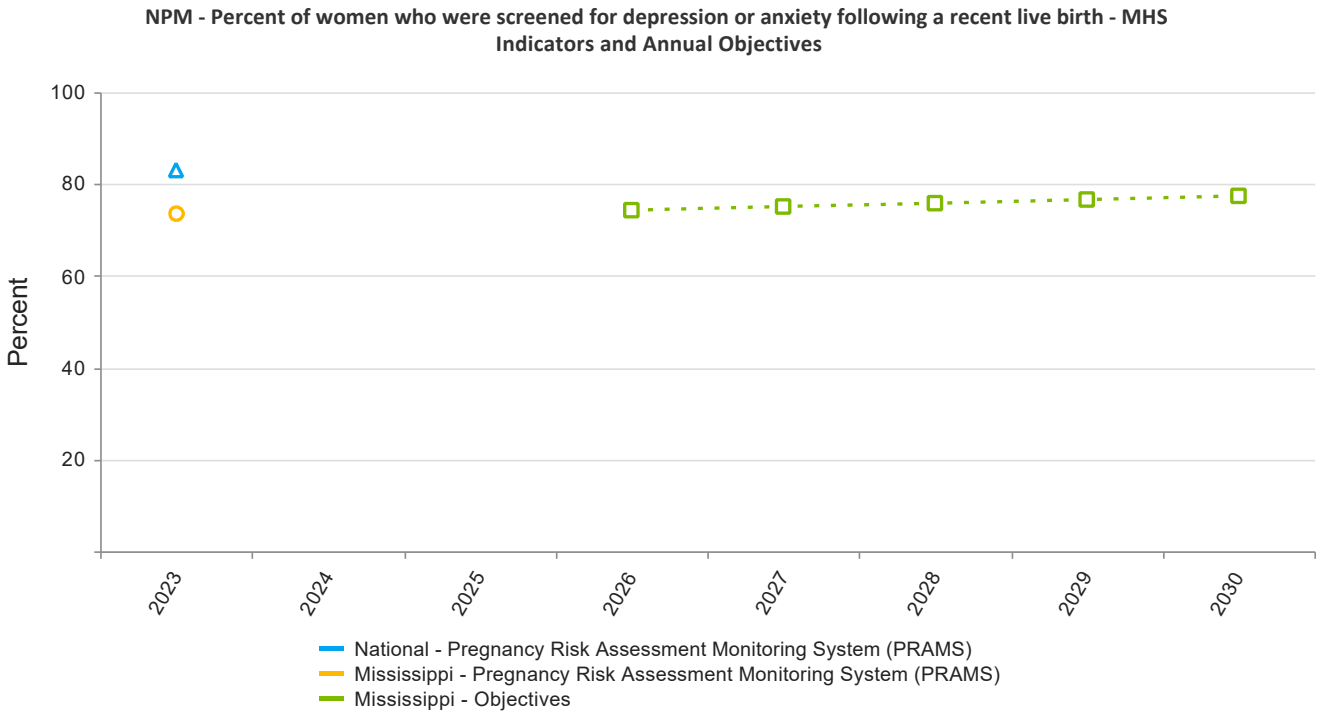
Evidence-Based or –Informed Strategy Measures

ESM PPV.1 - Percent of mothers enrolled in home visiting programs who received a postpartum visit with a healthcare providers within 84 days of delivery.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	45.0	60.0	70.0



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	73.5
Numerator	21,691
Denominator	29,516
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	74.2	75.0	75.7	76.5	77.3

Evidence-Based or –Informed Strategy Measures

ESM MHS.1 - Percent of pregnant and postpartum women screened positive for depression and are referred for appropriate follow-up care and support.

Measure Status:	Active

Baseline data was not available/provided.

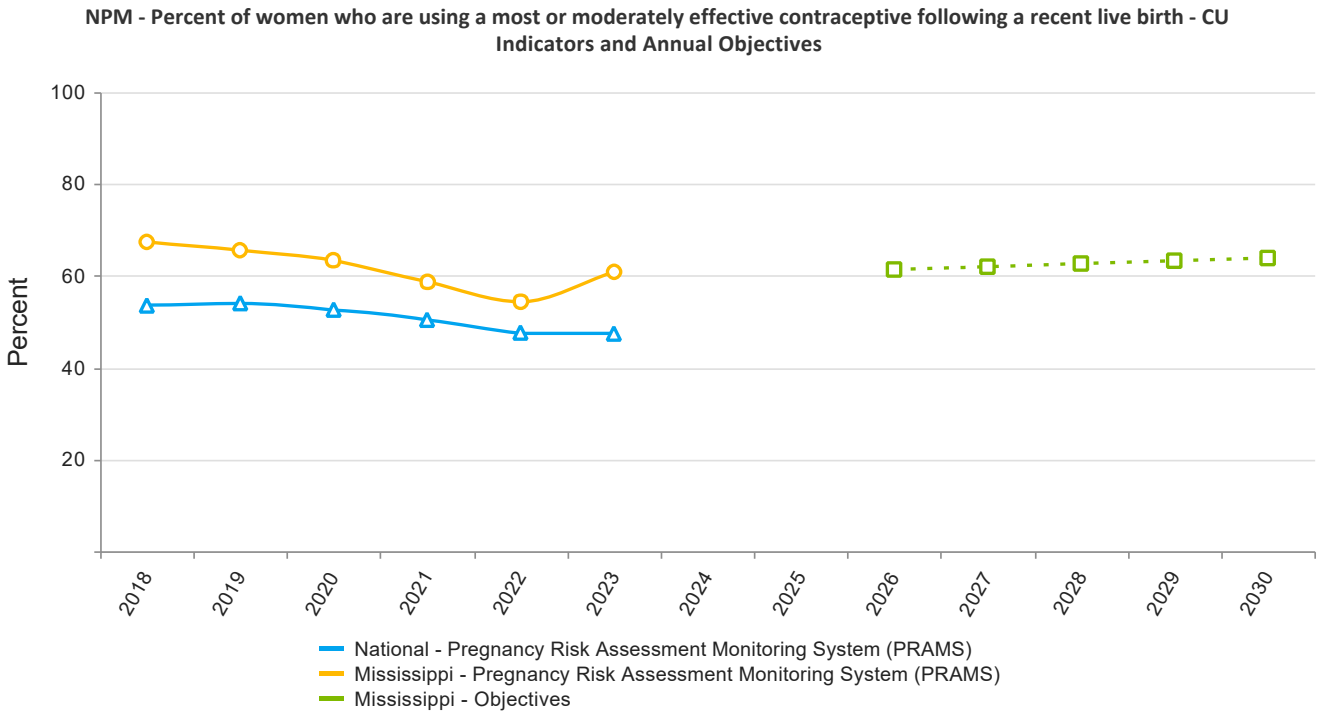
Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	45.0	60.0	70.0

ESM MHS.2 - Percent of pregnant and postpartum women screened for substance use disorder who receive appropriate follow-up care and support.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	45.0	55.0	70.0



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	60.7
Numerator	17,432
Denominator	28,722
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	61.3	61.9	62.6	63.2	63.8

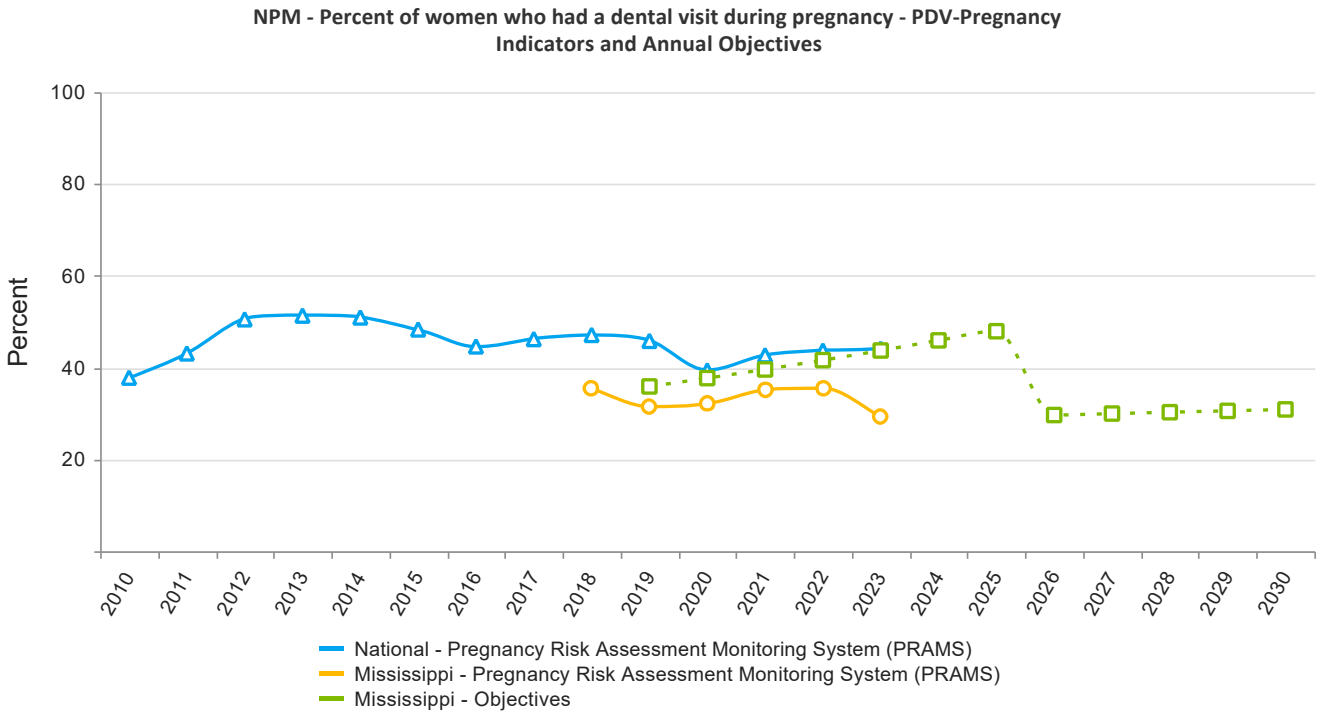
Evidence-Based or –Informed Strategy Measures

ESM CU.1 - Percent of females seen in the MSDH county health departments for family planning services who are screened for and accept the Family Planning Waiver.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	45.0	55.0	70.0



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	37.7	39.6	41.6	43.7	45.9
Annual Indicator	31.6	32.1	35.3	35.3	29.4
Numerator	10,696	10,493	11,307	11,307	9,112
Denominator	33,881	32,729	31,993	31,993	31,015
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		39.6	41.6	43.7	45.9
Annual Indicator	31.6	32.1	35.3		
Numerator	10,696	10,493	11,307		
Denominator	33,881	32,729	31,993		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2019	2020	2021		
Provisional or Final ?	Final	Final	Final		

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	29.7	30.0	30.3	30.6	30.9

Evidence-Based or –Informed Strategy Measures

ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education through the collaborative with WIC

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective	650	700	750	800	850
Annual Indicator	347	0	1,000	1,000	5,135
Numerator					
Denominator					
Data Source	MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health - REDCAP	MSDH Office of Oral Health - REDCAP	MSDH Office of Oral Health - REDCAP
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5,186.0	5,238.0	5,291.0	5,344.0	5,397.0

State Action Plan Table

State Action Plan Table (Mississippi) - Women/Maternal Health - Entry 1	
Priority Need	
Improve Maternal Health Outcomes	
NPM	
NPM - Postpartum Visit	
Five-Year Objectives	
Objective: By September 30, 2030, 80% of postpartum mothers participating in a case management / home visiting program received a postpartum visit with a healthcare provider within 84 days of delivery.	
Strategies	
Strategy: Home visiting/case management programs will develop and improve relationships with internal and external partners to increase referral and enrollments to the program.	
ESMs	**Status**
ESM PPV.1 - Percent of mothers enrolled in home visiting programs who received a postpartum visit with a healthcare providers within 84 days of delivery.	Active
NOMs	
Maternal Mortality	
Neonatal Abstinence Syndrome	
Women's Health Status	
Postpartum Depression	
Postpartum Anxiety	

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

Priority Need

Improve Maternal Health Outcomes

NPM

NPM - Preventive Dental Visit - Pregnancy

Five-Year Objectives

Objective: By September 30, 2030, increase the number of pregnant and postpartum women receiving education about importance of oral health care during pregnancy and postpartum period by 2% annually (baseline 3686).

Strategies

Strategy: Provide oral health education and distribute dental toolkits to women within WIC programs and community events.

ESMs	Status
ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education through the collaborative with WIC	Active

NOMs

Women's Health Status

Children's Health Status

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

Priority Need

Improve Maternal Health Outcomes

NPM

NPM - Postpartum Contraception Use

Five-Year Objectives

By September 30, 2030, increase the number of female family planning users, ages 13 to 44, within MSDH clinics by 5% (from 13,457 to 14,129).

By September 30, 2030, increase the number of female Family Planning Waiver beneficiaries receiving family planning services within MSDH clinics by 5% (from 3,475 to 3,648).

Strategies

Strategy: Increase access to subsidized or low-cost contraception methods to ensure greater utilization and uptake during the preconception and interconception periods.

ESMs	Status
ESM CU.1 - Percent of females seen in the MSDH county health departments for family planning services who are screened for and accept the Family Planning Waiver.	Active

NOMs

- Severe Maternal Morbidity
- Maternal Mortality
- Low Birth Weight
- Preterm Birth
- Infant Mortality
- Neonatal Abstinence Syndrome

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

Priority Need

Improve Maternal Health Outcomes

NPM

NPM - Postpartum Mental Health Screening

Five-Year Objectives

By September 30, 2030, 80% of pregnant and postpartum women participating in case management / home visiting programs are referred for services following a positive screening for depression.

By September 30, 2030, 80% of pregnant and postpartum women participating in case management / home visiting programs are referred for services following a positive screening for substance use disorder.

Strategies

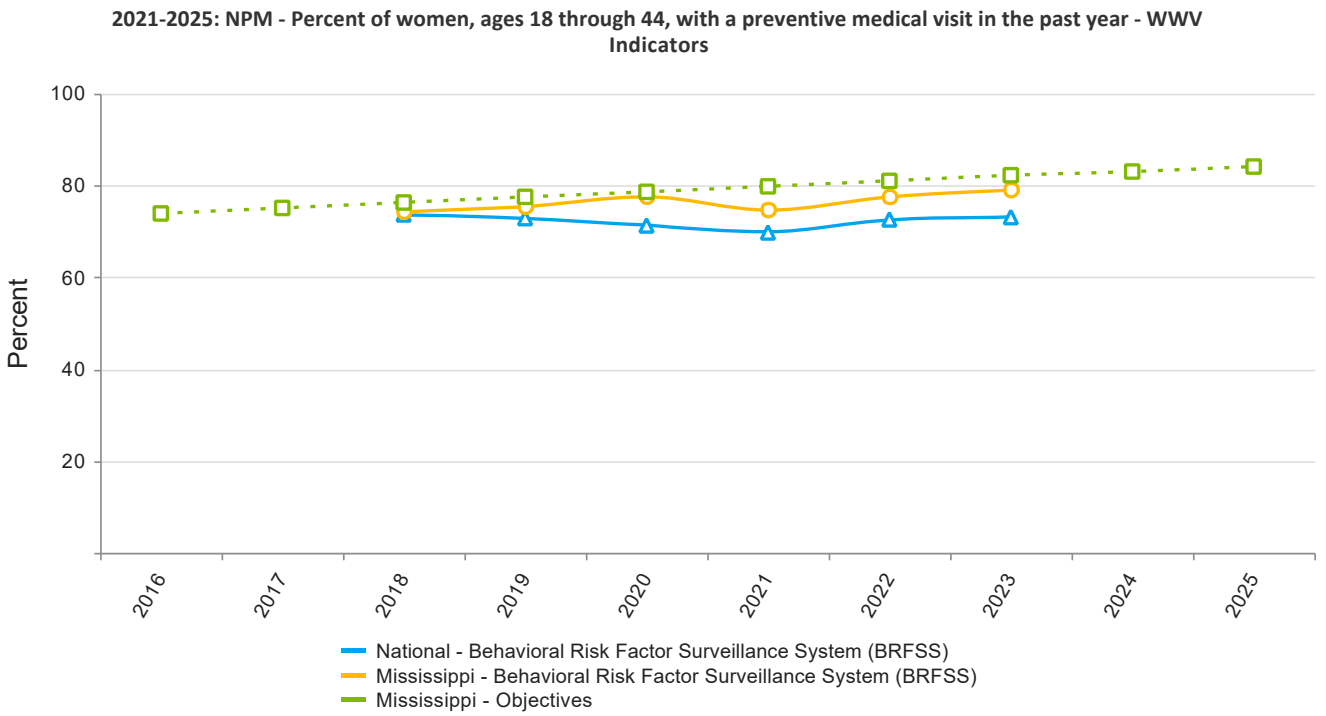
Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward improving maternal mortality based on MMRC recommendations.

ESMs	Status
ESM MHS.1 - Percent of pregnant and postpartum women screened positive for depression and are referred for appropriate follow-up care and support.	Active
ESM MHS.2 - Percent of pregnant and postpartum women screened for substance use disorder who receive appropriate follow-up care and support.	Active

NOMs

Maternal Mortality
Infant Mortality
SUID Mortality
Neonatal Abstinence Syndrome
Child Injury Hospitalization
Women's Health Status
Postpartum Depression
Postpartum Anxiety

2021-2025: National Performance Measures



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	78.5	79.7	80.9	82.1	82.9
Annual Indicator	75.4	77.5	74.7	77.3	79.0
Numerator	390,297	403,215	379,846	389,062	394,552
Denominator	517,720	520,497	508,347	503,084	499,169
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM WWV.1 - 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**	**2024**
Annual Objective			100	125
Annual Indicator	641	56	113	73
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	MS Quitline provider and Baby and Me Tobacco Free
Data Source Year	2022	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

2021-2025: State Performance Measures

2021-2025: SPM 10 - Percent of severe maternal morbidity events related to hypertension

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			2.2	2.1
Annual Indicator	3.5	3.4	3.9	4.2
Numerator	1,114	1,075	1,192	1,258
Denominator	32,010	31,331	30,637	30,291
Data Source	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data
Data Source Year	2022	2023	2024	2025
Provisional or Final ?	Final	Provisional	Final	Final

2021-2025: SPM 16 - Nulliparous, term singleton, vertex (NTSV) cesarean rate

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			28.5	25.7
Annual Indicator	31.7	30.5	30.3	30.1
Numerator	3,304	3,300	3,367	3,242
Denominator	10,439	10,830	11,096	10,776
Data Source	Mississippi Hospital Discharge Data	NTSV from Vital Records	NTSV from Vital Records	NTSV from Vital Records
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

Women / Maternal Health
Annual Report Year FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023 to 9/30/2024 to meet the objectives and show improvements on the measures related to women/maternal health.

PRIORITY: Access to Care (Women, Children, Adolescents, and Families)

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

Objective: 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)

Strategy: Collaborate with internal and external partners to develop promotional strategies to increase family planning users.

Activity: Train all MSDH clerical and clinical staff who support family planning users on the "Operation Going Gold" project to increase the number of Family Planning Waiver (FPW) beneficiaries accessing services.

Due to the unwinding of Medicaid coverage during 2023, many Mississippians who were able to maintain care previously would be losing their coverage. In June 2023, the Mississippi Division of Medicaid (DOM) began its first round disenrollments. By February 2024, over 116,705 people had been disenrolled from Mississippi Medicaid.

The MCH programs partnered with the DOM to assist with the dissemination of information about recertification of benefits. Care Coordinators, Service Coordinators, Case Managers, and Public Health Social Workers supported and assisted families with completing paperwork involved with MCH programs, as well as engaged their extended community connections to ensure consistent messages were offered about changes, the recertification process, and how to access services to mitigate any challenges and prevent service interruption. MSDH Coined this process "Operation Going Gold".

"Operation Going Gold" included enrollment of clients on FPW. MSDH clinic staff screened clients for FPW eligibility at each visit, educated clients on FPW benefits (gave a brochure), assisted clients with completing FPW application and faxed/mailed completed application to the local Medicaid office. Each health department, through "Operation Going Gold" project, continued to notify beneficiaries when it was time to renew their FPW eligibility via reminder system in place. A notification letter was mailed along with a copy of FPW Fact Sheet to the beneficiaries 2-3 months before their eligibility expired as a reminder to complete a new application to continue eligibility for the FPW program. During CY2023, a total number of 6,907 FPW applications statewide were submitted to the Division of Medicaid under the "Operation Going Gold" project; 27% (1,885) of the submitted applications were approved. During CY2024, a total of 7,949 FPW applications statewide were submitted to the Division of Medicaid reflecting an increase and 27% (2,126) of the submitted applications were approved (Source: MSDH County Health Department (CHD) District Monthly Progress Reports).

Activity: Optimize telehealth visits to provide family planning visits to MSDH patients.

The clinic-based FP telehealth services progressed across CY2023 and CY2024. The agency continued to collaborate with UMMC to increase services via telehealth, and with MSDH Information Technology and Health Informatics to improve telehealth infrastructure and broadband with the goal of expanding the provision of telehealth services in the health department clinics. The first family planning telehealth visits across eight (8) locations were scheduled and completed in June 2023. Thirty clinics were planned for activation by September 2023. As of May 2024, MSDH had equipped and empowered all 86 county locations with capabilities to complete telehealth services through clinic-based access. Any client with a pay source qualifies, including those with private insurance, Medicaid, Medicaid Family Planning Waiver, or self-pay.

The FP telehealth process follows: 1)Client arrives in person at a CHD anywhere in the state to be connected with a provider in a remote location. 2)A CHD nurse evaluates and connects the client to a remote provider with the use of an iPad. and 3)The remote provider uses Extended Care software integrated through the agency electronic health record, Epic to connect. Back-up source for connections include Zoom and/or phone.

Family planning services available through this telehealth approach include contraceptive resupplies, Depo-Provera administration, STD testing and treatment, birth control problems or method changes, syphilis treatment, and pregnancy testing. Annual well-woman exams may be provided via telehealth to younger aged women with no risk factors in accordance with ACOG guidelines and under the agency Gynecological MD consultant. A sexual history, pelvic and breast assessment screening tool must be completed to assist with any clinical concerns that may arise requiring an immediate hands-on exam for those in the above classification, in which case the next open appointment is scheduled. It is also required that said screeners be completed every 6 -12 months with an interim review of the questions upon every visit understanding MSDH serves a population who may not recognize a gynecological problem needing attention by a clinician without a targeted, health-literacy-appropriate screening tool.

Activity: Collaborate with other health systems on referrals for patients needing family planning services.

MSDH worked to improve the overall management and administration of the FP services aimed at improving community engagement and expanding the reach of FP services. Access has been improved through telehealth services, outreach and educational promotions, and the distribution of brochures and pamphlets. MSDH in collaboration with internal and external partners, designed posters for clinic displays and flyers featuring a QR code for clients' easy access to FP services when services are not rendered at MSDH. This design project was complete with all ordering finalized in mid-August 2024. For the reporting period, a total of 500 'Access Family Planning Services Today' flyers and 200 posters were produced and distributed to districts and health departments to assist clients in accessing these family planning services.

The Regional MCH Nurses support the needs of the family planning program. They work the LEEP clinics from arranging appointments, meeting the clients, and following up on results. They schedule the follow-ups, send out letters, work to outreach all missed appointments, and educate the client on importance of appointment compliance for those with abnormal pap results.

Nurses and clinicians who provide services to FP clients through CHDs, used the *One Key Question* ("Would you like to become pregnant in the next year?") to understand client's pregnancy intentions. The responses can be categorized as follows: I do not want to become pregnant; I want to become pregnant; I am okay either way; and I am unsure. Nurses and clinicians counseled and educated clients based on their responses. Clients 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.

Healthy Start works to increase the number of family planning users within CHD through targeted outreach and enhanced referral processes. The program connects participants with a Nurse Practitioner who provides individualized consultations and guidance on birth control methods, reproductive health, and pregnancy planning. The Healthy Start program staff work closely with participants to assess their needs, discuss available contraceptive options, and facilitate appointments with the Nurse Practitioner for further evaluation and medical recommendations.

Office of Women's Health (OWH) continued active outreach and educational efforts by partnering with coordinators from other Health Services programs who organized outreach events and health fairs with community partners to increase awareness and improve access to FP services. In CY2023, the office of FP mailed a total of 35,703 brochures: 13,800 FPW and 21,903 other brochures (English, Spanish and Vietnamese) to the CHD and 900 brochures to FQHCs, and FPW Fact Sheets (English, Spanish, and Vietnamese) are on the MSDH Family Planning web site. In CY2024, total of 3,760 brochures were distributed, (1,688 FPW brochures and 2,084 brochures on other educational topics) (Source: MSDH CHD District Monthly Progress Reports).

Multiple outreach and promotional activities were completed by MSDH staff from the central, regional, and county levels. These activities took place at several community-level, local events such as city and mayoral council

meetings, health fairs hosted by schools, faith communities, non-profits, and Greek organizations, observance days within communities, local medical clinics, community baby showers, conferences and educational summits, housing complex and multi-family units, Head Start Centers, high schools, and farmers markets. Across CY2023 and CY2024, an estimated 4,610 individuals were reached. (Source: MSDH CHD District Monthly Progress Reports).

MCH-serving programs partnered with the Office of Communications for social media messages and website updates. During CY2023, a total of 3,585 views were identified to the FP main page and 1,694 viewed FPW. In CY2024, the main Family Planning webpage garnered 5,144 views, while the FPW received 2,638 views (Source: MSDH Office of Communications). There was one Facebook posting which had 7,203 reaches). A greater focus on utilizing the agency's social media presence to promote family planning services will be prioritized for the next reporting period.

Other program improvement activities accomplished in the reporting period included a deep edit and update to all manuals and forms associated with family planning services, as well as public facing information on the website to remove any language consistent with the Title X services the program had been able to provide. Content regarding the Special Rate Program was added to the manual in March 2024.

Special Rate Program: Starting in early 2023, the OWH Director provided ongoing logistical support and facilitation of the FP Transition Workgroup. This Workgroup was comprised of individuals representing various departments of the agency, including the FP/CRH Program, Field Services, Clinical Operations, Legal, Internal Audit, Pharmacy, Revenue Cycle, Finance and Accounting, Health Data and Research, Communications, Clinical Technology Integration, MCH Block Grant Leadership, and Senior Leadership. The primary task of the Workgroup was to plan the transition of FP/CRH from being fully supported and funded by Title X to having no Title X funding and primarily relying on Family Planning Waiver earnings and other grant funding or revenue to sustain services. A major transition activity was the planning for a Special Rate Program, which would allow clients without insurance or who did not want to use their insurance to pay a deeply reduced rate for FP services available through MSDH. The Special Rate Program launched in June 2024. For the reporting period (October 1, 2023, to September 30, 2024, 484 distinct clients for a total of 489 visits received services under the Family Planning Special Rate Program (Source EPIC).

Objective: 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.

Strategy: Work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving women's/maternal health.

Activity: 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 social conditions and policies affecting the health of MCH program participants that improve women's/maternal health.

Activity: 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.

Maternal and Infant Health Bureau (MIHB) partnered with the University of Mississippi to provide a "Food as Medicine" project to improve access to healthy foods for expecting and postpartum women. The initiative included a produce prescription (FoodRx) for expecting mothers with pre-eclampsia, aiming to lower hypertension rates, enhance food security, boost fruit/vegetable intake, and increase knowledge of nutrition and chronic diseases. University of Mississippi staff were able to identify a local grocer to solidify the FoodRX purchasing process. The program served 40 participants in the town of Marks, MS. Program initiation and educational materials were supplied to expecting women and their families. University of Mississippi partnered with Delta Health Partners' via a community baby shower to begin recruitment for a focus group to better target the program in an effort to increase participation. Assessing successful outcomes for this program are ongoing.

MIHB partnered with Operation Shoestring (OS), to lead Rising Together: Connecting Mothers and Maternal Health Supportive Services, a project aimed at improving maternal health for communities in Jackson, MS (Georgetown, Midtown, Mid-City, and Virden Addition). The project initiative addressed key social conditions affecting health such as poverty and food insecurity. OS and its own partners worked to enhance cardiovascular health, promote wellness activities, and reduce obstacles to maternal care. Through workshops and peer support groups, the project fostered healthier lifestyles, increased health literacy, and better access to supportive services. OS planned for a total of 80 participants for this program. During this reporting period, 24 women/families were actively enrolled in the program. Six sessions were conducted by a certified dietician and included topics on 1)kitchen safety, 2) MyPlate method, 3)identifying simple vs. complex carbohydrates; 4)cooking with healthy grains; 5)preparing healthy fruits/vegetables; and 6)hands-on cooking experiences using the knowledge obtained during the workshops. Facilitated by a licensed physiologist, participants engaged in exercise education sessions including adaptive modifications, cardiovascular health, and demonstrations utilizing various exercise equipment. Sessions incorporated support services, conducted by a licensed professional counselor, to include behavioral health support and addressed issues of social cohesion and general mental health topics. Success for these sessions were measured using a survey that was completed by each participant.

Healthy Start Program hosted an inaugural Baby Shower for Dads event on June 2, 2024, at the Cadence Bank Conference Center in Tupelo, MS. 140 Participants received free gift bags with items such as diapers, blankets, wipes, sleepers, and gift cards. Session topics included: Caring for New Moms and Dads; Infant Care for New Dads; Nutrition; The Milk is Free. There was a hands-on car seat safety demonstration. Other activities resulted participants receiving additional gift giveaways, (1 Pack N' Play, 2 Car seats, and 1 stroller). Partner organizations were onsite to share information about mental health, affordable health insurance, early childhood education, Childcare, Tobacco cessation, Healthy Nutrition, WIC services, and FSEIP. 98% of the feedback highlighted the value of the event including the importance of fathers in maternal and infant health for the improvement of health outcomes. Attendees stated they "*gained new information that was helpful to their roles as fathers and that they would attend another event like this again*". news media report on the event **https://www.youtube.com/watch?v=PdVXF2wSNKI**

January 1, 2024, to September 30, 2024, Plan A Health hosted baby showers (305 participants), facilitated infant CPR classes, offered Baby 101 classes, launched the provision of obstetric and pediatric services through its clinics, distributed free baby items to those engaged in services, and distributed 20 handgun locking safes. Plan A Health engaged approx. 680 individuals, including expecting and postpartum women, infants, and women of reproductive age. Sixty-five (65) mother-baby dyads were seen on "OB/Peds Friday."

Beginning 2023, MSDH Office of Pharmacy piloted MS Opioid and Substance Use Disorder Program (MSUD) Program in Lauderdale, Adams, Alcorn, Pearl River, Panola, and Washington counties. By 10/2024, the program was statewide. Some patients received case at the CHD, while most care was telehealth, offering medications for outpatient treatment for opioid use disorder. The program collaborating with the MCH Engagement and Coordination Office for PHSW support and referrals for social conditions affecting health. The Alcorn County PHSW attended regular meetings with the MSUD program staff, trained on Motivational Interviewing, SBIRT (Screening, Brief Intervention, and Referral to Treatment) and assisted clients with information on local resources such as food, housing, clothing, and referrals for case management programs and/or treatment if needed. This position was transitioned to a full-time social worker hired directly in the MSUD's program.

HM/HB provided services to 674 mothers and 461 infants enrolled in the program. Among mothers of infants enrolled, 379 out of 461(82%) reported that they have a birth control method. 295 out of 674 (44%) maternity participants reported to an HM/HB Nurse that they were on some type of birth control at and/or after the Postpartum Neonatal Assessment/Postpartum Home Visit. HM/HB program nurses provide a Postnatal Assessment/Postpartum Home Visit to assess the woman's vital signs (weight, blood pressure), fundus, lochia, lacerations, mental health, provide nutritional guidance, health education about postnatal care, FP, breastfeeding, and newborn care. In the event further medical, psychosocial, nutritional, or other needs are identified at the home visit, the nurse will take action on referral or follow-up. If postpartum mother or the nurse identifies a risk in newborn, the infant is referred for risk screening. Other interventions include: infant safe sleep education (34), health education for families, such as the Partners for a Healthy Baby curriculum, from HM/HB and its collaborators (70), oral health education (30), depression/postpartum depression screenings (61), discussed and/or received contraceptive care options (325),

reproductive life planning options (43), STI/Safer sex education (16), and referrals for nutrition services, including a lactation specialist (25).

HM/HB began an initiative to focus on postpartum contraceptive toolkits, *Hello Options.* The Nursing case management staff received training on the effective use of the toolkits as interactive educational tools. The toolkits have been ordered. This project will continue in the next reporting period.

HM/HB worked internally with the Office of Communications to disseminate 9 communication announcements during the reporting period on the MSDH website and social media platforms to raise awareness about various maternal and infant health topics including gestational diabetes, safe sleep campaign, toxoplasmosis, birth defects, perinatal cardiovascular health, nutrition and prenatal care, and eclampsia and preeclampsia awareness.

Examples of the Facebook postings include:

- Your blood sugar can rise to higher-than-normal levels during PREGNANCY. this can cause problems when you deliver and put you and your BABY susceptible for developing type 2 diabetes. you can avoid #gestationaldiabetes by having your blood sugar checked regularly while PREGNANT, eating right, and planning on a healthy weight before you become PREGNANT. read more about gestational diabetes and what you can do: https://www.cdc.gov/PREGNANCY/diabetes-gestational.html you or someone you know may qualify for care management from MSDH for a healthier PREGNANCY. get in touch with our #healthyMOMshealthyBABIES program: healthyms.com/hmhb (1,677 reaches)

- Cats aren't always a MOM-to-be's best friend. cat droppings can spread toxoplasmosis, a bacterial infection that can cause health problems in your BABY after it's born. you can be infected when you change a litterbox or handle soil outdoors where cats live without washing your hands afterwards. PREGNANT WOMEN can then pass infection to their developing BABY, possibly causing eye and brain problems later in life. Staying safe isn't hard. you can keep your cat! but if you're PREGNANT, avoid contact with used cat litter and wash your hands immediately after working around dirt or litterboxes. (in fact, regular handwashing is recommended for all PREGNANT WOMEN to reduce the risk of a wide range of infections.) for more tips on caring for your feline friend and staying safe during PREGNANCY, check out https://www.cdc.gov/parasites/toxoplasmosis/gen_info/PREGNANT.html (5,344 reaches)

Objective: By September 30, 2025, increase the number of pregnant/postpartum women participating in a case management/home visiting program by 30% (from 291 to 378).

Objective: By September 30, 2025, increase the number of outside MSDH referrals for the case management/home visiting program by 20% (from 1,266 to 1,519).

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

Activity: 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.

MSDH was awarded a 5-year grant from HRSA to develop an Enhanced Healthy Start (HSE) program in Northeast MS. This program aims to improve health outcomes before, during, and after pregnancy and reduce differences in rates of infant death and adverse perinatal outcomes in NE MS. The Healthy Start Program has two major focal areas: 1)providing direct and enabling services (screening and referrals, case management, care coordination, health and parenting education, and linkage to clinical care) to enrolled HSE participants, who include men/women of childbearing age, expecting mothers, new fathers, fathers, infants and toddlers up to 18 months old); 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 NE MS. The target areas for the Enhanced Healthy Start Program are Lee, Prentiss, Chickasaw, Monroe, Clay, and Lowndes counties. The period of funding is September 2023 – September 2028. This program is positioned under the OWH.

The Healthy Start Program experienced remarkable growth in FY25. From a beginning of 10 participants, the program expanded dramatically to serve more than 100 participants across our six target counties. During monthly case management/care coordination, families are provided health education on pregnancy and postpartum care, Count the Kicks, breastfeeding support, and mental health support. Parents received breastfeeding education and support, referral to WIC, child development education using the Milestone Moments booklets, ABC of safe sleep education, interconception care and mental health support along with referrals to community resources.

Under OWH, MSDH was awarded a subgrant from Jackson State University (JSU) under the National Institute of Health's Centers of Excellence in Maternal Health program in late 2022. This project is a research study and is deemed a clinical trial. The initiative targets reducing maternal morbidity and mortality in the MS Delta region. The program, known as Time4Mom (T4M), received a commitment for funding for the period 8/1/2023, to 7/31/2030, contingent upon funding from NIH. T4M focuses on improving maternal health outcomes by facilitating postpartum home visits provided by nurses and community health workers, linking women with local health resources, referrals for mental health and lactation support, and providing educational support on postpartum health. There is heavy collaboration with JSW, the University of Mississippi Medical Center (UMMC), and Harvard University. The majority of the reporting period of 10/1/2023 to 9/30/2024, was dedicated to hiring a Program Manager and other staff, exploring and examining other MSDH programs offering similar services, finalizing the research protocol, IRB approval through JSU, executing subaward agreements with partners, building data collection instruments within the electronic health record, finalizing common and project specific data elements, and bi-weekly meetings with project leads, and an annual site visit with NIH and other leads. Per proposed design, MSDH will receive referrals for the program directly from UMMC, who will identify eligible women immediately after delivery. As part of the project, MSDH will collaborate with Mom.Me to provide mental health services to program participants as needed. The program is aiming to begin enrolling patients starting June 2025.

The MSDH WIC Program provides referrals to internal programs based on the needs of WIC Program participants. The total number of referrals from WIC was 6683, including 209 to Early Intervention, 5943 to Healthy Moms Healthy Babies, 303 to Lead and Healthy Homes, 4 to MS Opioid and Substance Use Disorder Program (MSUD) Program, 209 to Oral Health, and 15 to the Safe Sleep Program.

MIHB, HM/HB, T4M, MS-BCCP, and other OWH staff supported the planning and execution phase of the 2024 Maternal Health Conference held on September 20, 2024, in Vicksburg, MS, hosted by MIHB. The conference attracted stakeholders from multiple communities and areas of healthcare, social services, and community practice, all concerned with maternal health. Free Continuing Education Units (CEU) were available for CHES, nurses, and social workers. Session topics included: Paradigm Shifts in Maternal Health, Patient-Developed Maternal Care, Maternal-Related Drug Abuse/Misuse, Severe Maternal Morbidity Disparities, “Hear Her” Campaign/Urgent Maternal Warning Signs, and Dads as Doulas. There were over 180 attendees, of which 23 attendance certificates were requested and the following CEU certificates were distributed: 30 CHES Certificates; 43 Social Work Certificates.

Approximately 90% of the evaluations were positive; however, attendees acknowledged the issues with technology and acoustics, and some were not pleased with the location. News media report: https://www.mississippifreepress.org/mississippi-health-leaders-collaborate-to-reduce-infant-maternal-mortality/

MCH-serving programs supported the following outreach efforts to increase program visibility, strengthened partnerships, and helped connect individuals to resources:

- Molina Community Baby Shower- Jackson Medical Mall; 4/25/24
- Magnolia Centene Baby Shower-Jackson Medical Mall; 5/20/24
- MOMS Tour Baby Shower on 7/7/2024 sponsored by the U.S. Department of Health and Human Services
- Baby Shower for Dads- Cadence Bank Arena, Tupelo, MS; 6/2/2024 sponsored by HSE Program and Daddy University.

Health Fairs

- Black Family Expo Health Fair; 3/16/2024 sponsored by Jackson Hinds Comprehensive Health Center
- Music for Heart and Soul Event-Jackson Convention Center; 4/27/24
- Oak Grove M.B Church Community Health Fair-Columbus, MS; 6/22/24
- Total Health Saturday Community Health Fair; 9/28/2024 sponsored by Greater Pearlie Grove Missionary Baptist Church
- Grilling with Dads Pop-up Village event; 9/14/24 sponsored by HSE program and the Columbus Recreation Department
- NMMC Women's Hospital Breastfeeding 101-Tupelo, MS; 8/16/24

Conferences

- ACES Symposium: Strengthening Reproductive Health in America 4/18/25 in Madison, MS hosted by the Glenn Foundation
- MSDH Genetics Newborn Screening Regional Education and Skills Training Event 5/22/2024.
- MSDH Maternal Health Conference-Vicksburg, MS 9/20/25
- MSPQC Conference-Flowood, MS; 9/26/2024
- CHW Association Summit- Biloxi, MS; 6/11-13/2024 MS Gulf Coast Community College
- Maternal Health Innovation Taskforce Meeting; 7/16/2024 Hosted by MSPHI Flowood MS
- La Leche League of Starkville and Columbus; 8/14/2024
- Omega Psi Phi Maternal Health Conference 8/23-8/25 2024 Cadence Bank Arena Tupelo MS sponsored by HSE and Omega Psi Phi Fraternity, Inc Omega Mu Mu Chapter.

WIC Events

- WIC Breastfeeding All About Love 2024; 8/16/2024
- What UNO about Breastfeeding- West Point, MS; 8/16/2024

Activity: 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.

T4M is constructing a direct referral pathway from UMMC, Labor & Delivery (L&D) to MSDH via EPIC EHR. The referral form consists of three questions: Actual Date of Delivery, Discharge Date, and Reason for Referral. UMMC's research nurse or research coordinator will review L&D cases from the previous workday or the weekend to assess delivery cases for eligibility to the program. Completed referral forms will be sent to T4M's Program Director via in-basket message in EPIC. To be considered for referral to T4M, patients must be over the age of 18 at delivery, current reside in Bolivar, Carroll, Humphreys, Scott, or Washington county, have given live birth, been admitted to the hospital for fewer than 10 days, and have a risk for mortality or severe maternal morbidity.

For further information, see Priority Access to Care in the Perinatal section.

Objective: By September 30, 2025, increase the number of women enrolled in the MS Breast and Cervical Cancer Program by 10% (from 3,590 to 3,949).

Objective: 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: Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of women's/maternal health issues

OWH's and MS-BCCP Director participated in Human Rights Watch virtual interviews 9/19/2024 and 11/24/2024, to assist in the qualitative research for a report titled "More Can Be Done" Inadequate Cervical Cancer Prevention and Care for Black Women in the MS Delta. Human Rights Watch was working on exploring the challenges in rural MS Delta women face in accessing the information and services they need to prevent and treat cervical cancer. The findings of the report are instructive for MS-BCCP and increased targeted outreach and provider engagement will be prioritized in the MS Delta counties moving forward. The full report can be accessed online via:

https://www.hrw.org/sites/default/files/media_2025/01/wrd_mississippi0125web.pdf
MS-BCCP and its network of providers served 3,341 unduplicated participants across 14,021 encounters for enrollment, breast and cervical cancer screenings, diagnostic services, and/or patient navigation.

Activity: Submit work requests to 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.

MS-BCCP partnered with the Office of Communications for multiple projects. Activities included: created flyers and posters for an October 2024 screening event and coordinating media interviews for the day of the event; secured 8 billboards in 8 counties from May-December 2024, focusing on "When was your last Cervical Screening?"; and October - December 2024, the 8 billboards focused on "When was your last Breast Screening?". MS-BCCP secured a digital media ad campaign to run on Instagram, Facebook and Snapchat from May-December 2024 targeting the same 8 counties These 8 locations were chosen based on having some of the lowest MS-BCCP enrollment rates in the state that also had billboard vacancies. State and other non-federal funding supported this activity.

Activity: 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 [WISEWOMAN if funded])

MSDH, OWH was awarded funding for the MS WISEWOMAN Program in 2023. Current funding cycle, awarded under the CDC, operates from 9/30/2023, through 9/29/2028. 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. WISEWOMAN Program is limited to only specific geographic areas of the state having the highest burden of cardiovascular disease and stroke-related mortality and stationed in MS-BCCP contracted health systems (2 FQHCs in the initial year). Plans to expand sites is contingent upon funding, provider capacity, and data-driven decision making. During this period, the following was accomplished:

- A Program Manager was hired in April 2024 and immediately began working to secure partnerships with two FQHCs as implementation sites. Year 1 priority locations were: Franklin, Wilkinson, Lincoln, Amite, and Grenada counties. Sites received onboarding and training across Year 1.
- A program manual, data collection forms, and outreach materials were designed and distributed to participating sites.

The MS-BCCP data system was updated to include patient-level data variables for WISEWOMAN. Year 1 concluded with the first participant being enrolled on 9/29/2024. As of January 2025, the program has enrolled 48 participants.

MS-BCCP partnered with eleven (11) health systems and two (2) community-based partners to advance its work plan activities. These subgrantees included: Delta Health Center, Delta Health System, Family Health Care Clinic, G.A. Carmichael Family Health Center, Greenwood Leflore Hospital, Jackson-Hinds Comprehensive Health Center, Mary Bird Cancer Center, Memorial Hospital at Gulfport, North Sunflower Medical Center, Singing River Health System Cancer Center, and Southeast MS Rural Health Initiative, El Pueblo, and Test-Taking Solutions, LLC. Subgrantees were selected from a competitive RFP process to execute specific activities for recruitment, referral, enrollment, increasing screening, and providing patient navigation to address conditions and policies affecting the health of participants that reduce challenges to screening.

MS-BCCP focused its efforts on education and outreach, attending or participating in over 25 opportunities. These includes community health fairs, conferences, activities sponsored by faith communities and Greek organizations. Some key relationships built included those with the MSDH Community Health Workers and El Pueblo, an agency that specializes in providing support to Spanish-speaking individuals.

MS-BCCP leveraged non-federal funding to procure outreach items for distribution at health fairs, events, and trainings. The messaging and design are cohesive, focusing on the pink and teal colors, screening and early detection. Items include a thoughtfully designed fabric backdrop, tabletop banners, outdoor tent, and outreach times

(canvas tote bags with double ribbons, hand fans in the shape of a ribbon, double packs of neoprene car coasters, mini nail files, ribbon shaped jar grip openers in both pink and teal, ink pens in both pink and teal, pink and teal plastic carry bags, and pink and teal magnet chip clips).

In August 2024, MS-BCCP leveraged non-federal funding to purchase 5,000 pink pompoms that had MS-BCCP name and phone number on one side and “Does someone you love need a screening” on the other side of the handle. In MS during football season, high school, community colleges, and our Historically Black Colleges and Universities participate in “Pink Out Games” to recognize and support breast cancer awareness. Players wear anything from pink uniforms, cleats, gloves to helmets. Many schools recognize survivors and those that lost someone to breast cancer. Four high schools in Central MS and Jackson State University, a Historically Black College and University, were invited and selected for their willingness to participate. MS-BCCP staff volunteered to pass out the pink pompoms at the games. All 5,000 pompoms were passed out during the Fall 2024 football season. Members of the community shared their stories of being a survivors and their appreciation in MS-BCCP recognizing breast cancer. Stories of “going to pass this on” to friends, sisters, mothers, and aunts were heard multiple times.

PRIORITY: Maternal Morbidity and Mortality

Objective: By September 30, 2024, produce the annual Maternal Mortality Report inclusive of 2017-2021 maternal deaths to include recommendations for preventing maternal deaths

Objective: 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)

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 (MMRC)

MIHB continued to provide the administrative support and coordination with MSDH Offices, health facilities, and state agencies for the maternal mortality review case abstraction, exploration, and determination process for all maternal deaths through the MMRC. This work is primarily supported by a grant from the CDC, Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM).

MMRC activities included:

- From 1/1/2024 – 9/30/2024, the MMRC convened 5 times to discuss 54 maternal deaths that occurred in 2021 (averaging 11 cases per meeting).
- A state-level report was prepared and submitted to the MSi Legislature and made public-facing in December 2024; revised in April 2025. The report is accessible online at: https://msdh.ms.gov/page/resources/20860.pdf
- Spent time researching other state’s policies and procedures for MMRC, Child Death Review Panels, and FIMRs. Over the course of a near 12-month period, MIHB developed 3 distinct policy manuals, 13 standard operating procedures for MIHB staff and committee members, and 31 appendix documents (*application forms, By-Laws, data dictionaries, confidentiality statements, consent forms, and interview guides*). These documents are 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.
- The MIHB is currently developing an updated MMRIA Data Quality Assurance Plan to enhance the accuracy and efficiency of maternal mortality data management. In FY2024, as part of this initiative, a Standard Operating Procedures (SOP) guide was developed and approved for use to ensure consistency in data collection and reporting. It establishes clear expectations for staff members, reinforcing their responsibility to provide the MMRC with precise and reliable data. It mandates that all data be entered into MMRIA within 30 days of review, ensuring timely and organized record keeping.

Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward improving maternal mortality based on MMRC recommendations.

Activity: Engage with other Maternal Mortality Review Committees to share lessons learned to advance program knowledge. Activities may include hosting or participating in local/regional meetings or peer-to-peer calls, presentations delivered by webinar, mentoring other programs, technical assistance, etc.

OWH and MIHB Directors participated in the monthly virtual calls led by the Office of the Assistant Secretary for Health, Office of Regional Health Operations for Region IV Women's Health Analyst and Regional Health Administrator. These calls allowed interfacing with OWH leads in other state health departments and agencies around a variety of ongoing initiatives, projects, programs, and funding opportunities. Many calls featured discussions related to congenital syphilis, Talking Postpartum Depression campaign at the federal level, perinatal regionalization, Newborn Supply Kit project, M.O.M.S. tour, and interfaces between FIMR and MMRC in the states. Having counterparts in other states who had successfully navigated processes, OWH or MIHB was not only just starting helpful, as lessons learned and technical knowledge was routinely shared both within and outside of the virtual meetings. Dr. Greene also broadcast a monthly newsletter which provided robust content on observances and awareness days/weeks/months forthcoming, links to awareness campaigns related to maternal and infant health, webinars and virtual events, resources, and funding opportunities.

OWH and the MIHB Directors participated in collaboration meetings with leads of the Mississippi Perinatal Quality Collaborative. The chief aim of these meetings was to identify ways we could support one another for collective impact, while avoiding duplication of effort. Specific plans for partnership included MIHB supporting MSPQC's launch of the Postpartum Discharge Bundle across participating AIM facilities.

Activity: Partner with other stakeholders to promote/expand offerings of Advanced Life Support in Obstetrics (ALSO) and Stabilizing OB and Neonatal Patients, Training for OB/Neonatal Emergencies, Outcome Improvements, Resource Sharing, and Kind Care for Vulnerable Families (STORK) training to maternal healthcare providers.

Did not address this activity during the reporting period.

Activity: Implement a focus group project to gather impressions, perceptions, experiences of women who have given birth in Mississippi to understand drivers of maternal health outcomes and gain recommendations for improvements.

MIHB partnered with Teen Health Mississippi to conduct focus groups from March through April 2024 among women ages 14-44 years old who delivered and/or were expecting in MS from 2021-2024. Similar to prior evidence-based research, overall themes from the focus groups suggested that non-Hispanic African American women systemically face greater challenges during and after pregnancy compared to non-Hispanic women in other groups. The insight from participants highlight the urgent need for foundational reforms, more empathetic and well-trained healthcare providers, robust community support systems, and a focus on mental health and patient autonomy. The results are located at the following website address: https://msdh.ms.gov/page/resources/20749.pdf.

Activity: Launch maternal hypertension and gestational diabetes support program, to include education on urgent maternal and postpartum warning signs, for participants of MSDH home visiting/case management programs.

A Pharmacy Consultant was partially-funded by the MCH Block Grant and works under the OWH to support patients of HM/HB. She provided medication management education (*focused on at-home management techniques, recognition of warning signs, and strategies for medication adherence*), referrals, patient support and outreach, and health education, to and for patients with diabetes, gestational diabetes, hypertension, pregnancy induced hypertension, and preeclampsia. There were a total of 87 patient referrals for hypertension and/or diabetes support. Through a partnership with MIHB, she sent 48 blood pressure cuffs to patients who needed to self-monitor their hypertension in pregnancy and postpartum. Each patient who received a monitor was counseled on proper use, interpretation of readings, and when to seek medical attention based on their measurements.

The pharmacist also began "Pharmacy Corner" in summer of 2023, which provided virtual staff education, including staff from HM/HB, Healthy Start and T4M. She also provides direct oversight and leadership for the Vitamin Angels

Prenatal Vitamin Distribution Project.

The Healthy Start program addressed hypertension, recognizing its impact on maternal and infant health. Participants receive tailored informational resources that highlight the dangers of high blood pressure during pregnancy and the postpartum period, including conditions such as preeclampsia, gestational hypertension, and postpartum hypertension. To further support participants, Healthy Start issues blood pressure monitors to those who need them, allowing for regular at-home monitoring.

Activity: 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.

Activity: Support the launch/uptake of new AIMS Safety Bundles (i.e., postpartum discharge transitions, perinatal mental health) in birthing hospitals and other health systems.
Activity: Host the Annual Maternal Health Symposium to support future strategic planning on maternal health issues and mortality/morbidity prevention approaches.

Since October 2023, MSDH leads the implementation and operational maintenance of the Alliance for the Innovation on Maternal Health (AIM) patient safety bundles in partnership with birthing hospitals across the state. 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. Ongoing AIM activities in MS included continuing to provide education and technical assistance to providers in relation to urgent maternal warning signs and bundle implementation. MS has adopted 4 patient safety bundles: Severe Hypertension; C-Section Reduction; Hemorrhage; and Discharge Transition.

MSDH supports participating AIM facilities in increasing the number of bundles being implemented and/or sustained by supporting the fidelity of bundle delivery, providing technical assistance, and supporting effecting data collection and reporting. The following was accomplished under the AIM grant:

- MIHB staff affiliated with the project had all separated from MSDH in the fall of 2022. A Program Specialist was hired to lead the administrative work of the project and establish new connections and partnerships with the birthing hospitals. Hired a Maternal Health Consultant, who functioned as a champion in encouraging the adoption of the AIM bundles across facilities, as well as a technical assistance lead.
- 36 birthing hospitals participated in the AIM project.
- The Mississippi Perinatal Quality Collaborative (MSPQC) seated with the Mississippi Public Health Institute led the work to adopt and launch the Postpartum Discharge Transition Bundle within birthing hospitals.

Key findings from the AIM data portal include:

- Participating AIM facilities overall recorded an increase in measure number PPDT P3 (Postpartum Visit Scheduling), which assessed “Among all maternal discharges following a live birth, whether from sample or entire population, those who had a postpartum visit scheduled before or within 24 hours of discharge from birth hospitalization.” There was a percentage increase in this measure from 80.1% in 2023 to 85.7% in 2024.
- In addition, the percentage/proportion of patients who had a hemorrhage risk assessment completed and risk level assigned at least once between admission and birth (measure number HEM P3) increased from 93.1% in October 2023 to 94.8% in September 2024.
- MSDH developed a model in which participating AIM hospitals could be paired with medical students to assist them with entering their data into the AIM data portal, as well as have the students assist with calls to patients recently discharged after giving birth. This model was developed in partnership with the Mississippi Public Health Association, who led the recruitment of medical students and partnered with MSDH to identify appropriate hospital placements.
- MIHB partnered with Mississippi State University, Social Science Research Center to complete Phase 1 of a statewide qualitative and quantitative evaluation of AIM. The SSRC developed research and evaluation methodologies, data collection instruments including questionnaires and interview questions utilizing focus group guides and processes. The evaluation was completed in August 2024.
- MIHB partnered with a Maternal Fetal Medicine consultant to launch the Severe Maternal Morbidity workgroup. This workgroup is currently comprised of 11 representatives from 10 AIM hospitals. The members

are tasked with reviewing their own hospital's cases/incidences of severe maternal morbidity (SMM) and discuss any possible trends, prevention opportunities, interventions, and/or recommendations based on the review.

- MIHB provided free "Badge Buddies" to participating AIM birthing hospitals throughout the state. The badge buddies were created to support hospital staff in providing bedside education on urgent maternal warning signs. A total of 400 badge buddies were requested for the state. Of this number,328 (82%) were distributed to participating AIM hospitals, county health departments, private providers, and community-based organizations.

MIHB led efforts to assess the maternal health landscape and seek the learned and lived expertise of stakeholders from multiple communities and areas of practice throughout the state. As a result, the Mississippi Maternal Health Symposium Workgroups were developed in 2023 from total of 58 participants based on the following maternal health priorities: Maternal Safety/Interpersonal Violence Prevention; Preconception/ Interconception Health and Education; Postpartum/Fourth Trimester Care; Mental Health/ Substance Use Disorders; and Social Determinants of Health. Comprised of public health professionals, community leaders, policy makers, and clinicians who met periodically for 13 months, they developed strategies and recommendations for policy makers, healthcare providers, community leaders, and patients/families. The report can be viewed online at: https://msdh.ms.gov/page/resources/20750.pdf

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

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

Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward improving 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 focused activities that improve maternal health (prenatal, perinatal, postpartum, and/or interconception).

April 2023, syphilis testing during pregnancy was made a requirement for those, who were expecting, in their first trimester, third trimester, and at delivery as a part of MS's efforts to prevent congenital syphilis in infants and providers were informed through a Health Action Network notice. MSDH had a Syphilis Task Force that focused efforts to reduce syphilis in areas with higher disease burden, including Hinds, Rankin, Jones, DeSoto, Harrison, and Forrest counties. Some of these efforts included: point of care syphilis testing and same-day treatment within the CHD clinics, educational campaigns for providers and the public, billboards, sponsored ads on social media, digital ads, and acquiring a robust supply of medications to treat infection through the MSDH Pharmacy. MSDH partnered with hospitals, individual OB/GYNs, and community providers like federally qualified health centers and free clinics to roll out POC testing across all prenatal care settings. The effort included training clinicians and reorganizing workflows to ensure rapid testing could be completed during routine visits. Between January and February 2025, 9 cases of congenital syphilis were reported compared with 29 cases during the same period in the previous year (Source: https://www.medscape.com/viewarticle/could-rapid-syphilis-testing-turn-tide-worsening-crisis-2025a1000b1r).\

October 2023 to August 2024, HM/HB, received 46 maternal referrals and 34 infant referrals exposed to syphilis. These referrals are prioritized for enrollment to assure that both mother and infant receive all necessary treatments.

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

Strategy: Lead the promotion of health observances, and other outreach/engagement strategies to increase public

awareness of maternal health issues.

Activity: Submit work requests to 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.

Activity: 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.

June 2023, various Health Services programs partnered with the MS Attorney General's Office to carry out the legislative mandate in SB2781SG. It 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 expecting and new mothers. The legislation charged that the Mississippi Access to Maternal Assistance (MAMA) program website had to be active by 10/1/2023 and the MAMA mobile app by 1/1/2024. This partnership between MSDH and the MS AGO was overseen by the OWH Director. To view the MAMA website, visit: www.ago.state.ms.us/mama

As a sister state agency, MSDH was expected to help promote MAMA through its website and any other channels of public communication. MSDH began supporting MAMA on its website effective 10/2023, as well as social media. MAMA brochures were ordered and distributed across and from numerous Health Services programs, including HM/HB, MIHB, and Healthy Start.

The Region MCH Nurses collaborated with the various programs around the state to provide community outreach. Partnering with the Community Health Workers, they provide health literature for community health fairs and events and attend baby showers. *One such shower focused solely on dads.*

- 10/11-10/12/2023- Community Health Fair- Mental Health Awareness and Teen Empowerment Summit- Discussed services provided at the CHD (FPW applications and handouts given, BCCP brochure), HPV vaccines, and EPSDT. around 100 attended.
- 10/18/2023-Community Health at Columbus Housing Authority- Discussed services provided at the CHD, around 75 attended.
- 11/29/2023- Visited 2 clinics in Oktibbeha County- reviewed with staff their services provided at the CHD, immunization schedule, and discussed assisting with family planning waiver applications
- 12/8/2023-Healthy Heart Ambassador Program - Self Monitored Blood Pressure & Nutrition Education in Aberdeen MS- discussed services provided at the CHD; about 100 attended
- 1/18/2024- North Forest Housing Complex (Monroe County)- Discussed services provided at CHD (FPW applications and handouts given, BCCP brochure).
- 2/2/2024- Community Counseling Youth (Winston County)- Discussed HPV vaccine and handouts given. Family planning brochures given.
- 3/21/2024- Workshop at Prairie Opportunity in Clay county- Family planning and BCCP brochures given as well as FP waiver applications- about 75 attended
- 7/26/2024-Health Fair at Christian Hill Church- Family planning brochures, HM/HB handouts, and BCCP brochures provided; about 50 attended.
- 8/22/2024- Health Fair at Sportsplex in Starkville, MS- Family planning and BCCP brochures given; about 150 attended
- 9/14/2024- Health Fair in Lowndes County- Family planning, immunization schedule, BCCP brochures given; about 200 attended.
- 9/25/2024- Health Fair in Winston County- Family planning, immunization schedule, BCCP brochures given; about 100 attended.

HM/HB developed three projects.
May 2024, HM/HB participated in the distribution of pregnancy journals to African American women enrolled in the program. The journal titled "*A Pregnancy Journal for Black Mothers*" was created by a Mississippi-based organization, Six Dimensions, LLC., to help expectant African American mothers document their emotional experiences, medical milestones, and any questions or concerns they had during the pregnancy and postpartum period. The project was to be evaluated to determine whether the journals were helpful to participants, improved

participant engagement with HM/HB staff, and whether the project contributed to improved maternal health outcomes for the participants. Eligible clients included newly and/or currently enrolled African American women within their first or second trimester. If the participant chose to participate, the nurse case manager provided the participant a journal. An initial survey was emailed to participants 7-14 days after they received the journal to gather feedback on first impressions. A follow-up survey was emailed 4-6 weeks postpartum to collect additional insights about their experience with the journal throughout pregnancy and to inform future quality improvement efforts.

Birth Preparedness and Readiness Plan, a document to discuss birth preparations and the importance of planning. It is an interactive tool to discuss plans for expected and unexpected circumstances that may occur, home birth preparedness, immediate postpartum, and emergency disaster preparedness. The discussion guided by the tool allows the participant to communicate their preferences, identify any concerns, and outline important medical or personal information that can influence their care during labor, delivery, and postpartum. The Plan was sent to a printing company for production and copies and guidelines were sent to HM/HB nursing staff in 10/2024 to be implemented.

HM/HB Program created the Pregnancy Guide, a conversation starter and reference around important facts related to pregnancy, labor, delivery, and postpartum. It includes information on urgent maternal warning during pregnancy and postpartum, signs of labor, packing for the hospital, etc. The Guide was submitted for printing in 9/2024 and completed for dissemination 10/2024.

PRIORITY: Oral Health

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.

Activity: Implement oral health promotion and messaging through WIC Shopper app

Activity: Coordinate efforts with the WIC and home visiting/case management programs to improve access and utilization of dental services for WIC recipients (both children and expecting mothers)

1,763 expectant mothers in 16 counties received oral health education. WIC Program partnered with the Office of Oral Health, Regional Oral Health Consultants to provide oral health education and aides to WIC participants as part of the nutrition education process. A total of 3,121 contacts have been made, including 77 infants, 2,433 children, 53 expecting mothers, 134 postpartum breastfeeding women, and 424 postpartum non-breastfeeding women.

Collaborating with the Office of Oral Health, HM/HB, the comprehensive assessment contains a section titled “Dental History”, including 5 questions to determine if oral health education and/or referral to the Office of Oral Health is to be made. HM/HB completed 87 (75 maternal, 12 infant) oral health screenings among expecting and postpartum mothers and infants who had a scheduled HM/HB visit. Of those screened, 16 individuals received further assistance and education based on their screening results addressing identified oral health concerns and encouraging appropriate follow-up care. Office of Oral Health distributed 871 dental kits, comprised of oral health related supplies including, but not limited to toothbrushes, toothpaste, and floss, to nurse case managers for distribution to HM/HB’s participants.

Healthy Start collaborates with the Office of Oral Health to provide dental kits, comprised of oral health related supplies including, but not limited to toothbrushes, toothpaste, and floss, to program participants. Healthy Start integrates WIC education into its outreach efforts, helping families understand the importance of proper nutrition during pregnancy and early childhood development. Healthy Start participants are referred to WIC. Healthy Start collaborated with WIC to provide joint workshops, informational sessions, and individualized support for participants. For example, WIC staff in Lee County engaged in providing education during the June 2024 Baby Shower for Dads event and the WIC staff participated in the September 2024, Grillin’ with Dads event in Lowndes County.

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. Unfortunately, in Mississippi, once a mother has aged out of comprehensive dental coverage, age 20, if expecting, she can only receive limited exams and extractions through the Division of Medicaid. With this program, we are identifying many women are in need of urgent dental care.

Women/Maternal Health
Application Year FY2026

The following section outlines strategies and activities to be implemented between 10/1/2025-9/30/2026 to meet the objectives and show improvement on the measures related to women/maternal health:

Priority: Improve Maternal Health Outcomes

Objective: *By September 30, 2030, increase the number of female family planning users, ages 13 to 44, within MSDH clinics by 5% (from 13,457 to 14,129).*

Objective: *By September 30, 2030, increase the number of female Family Planning Waiver beneficiaries receiving family planning services within MSDH clinics by 5% (from 3,475 to 3,648).*

Strategy: Strategy: Increase access to subsidized or low-cost contraception methods to ensure greater utilization and uptake during the preconception and interconception periods.

Activities:

(1) MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services, leading initiatives geared towards improving contraceptive access and uptake, and assess impact on the availability of support (i.e., MSDH Operation Going Gold, Medicaid presumptive eligibility, Healthy Start, MIECHV, HM/HB, Time4Mom, prenatal vitamin dispensing, telehealth initiatives, social conditions impacting health and needs of program participants, MSDH Communications, Medicaid Postpartum Risk Assessment, TMAH, Maternal Health Innovation Task Force)

(2) Collaborate with home visiting programs to support mothers in obtaining timely postpartum contraceptive access.

Objective*: By September 30, 2030, 80% of postpartum mothers participating in a case management / home visiting program received a postpartum visit with a healthcare provider within 84 days of delivery.*

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

Activities:

(3) Identify 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.

(4) Explore pilot of a targeted high risk maternal case management program high burden areas.

(5) 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.

Objective: *By September 30, 2030, 80% of pregnant and postpartum women participating in case management / home visiting programs are referred for services following a positive screening for depression.*

Objective*: By September 30, 2030, 80% of pregnant and postpartum women participating in case management / home visiting programs are referred for services following a positive screening for substance use disorder.*

Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward improving maternal mortality based on MMRC recommendations.

Activities:

(6) Provide administrative support and coordination with other internal and external stakeholders to operationalize processes and activities for the MMRC.

(1) Partner with internal and external stakeholders to operationalize programming consistent with MMRC recommendations (i.e., AIM activities, SMM reviews, OB Levels of Care System, subgrants for addressing OB readiness training – ALSO, STORK, provider continuing education, Talking Postpartum Depression, TLC MAMA, HEAR HER, MSDH Communications).

a. Explore partnership between MCH-serving programs and MSUD to assure pregnant and postpartum women are prioritized for identification, screening, assessment, and treatment referrals.

(2) Expand access to perinatal mental health supports and resources, including support for those experiencing perinatal loss (i.e., PSI International-trained providers/resources, CHAMPS for MOMs, support groups).

Objective: *By September 30, 2030, increase the number of pregnant and postpartum women receiving education about importance of oral health care during pregnancy and postpartum period by 2% annually (baseline 3686).*

Strategy: Provide oral health education and distribute dental toolkits to women within WIC programs and community events.

Activity:

c. Regional Oral Health Consultants will collaborate with the WIC program to provide oral health education to pregnant and postpartum women.

Perinatal/Infant Health

National Performance Measures

NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC Indicators and Annual Objectives

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

State Provided Data	
	2024
Annual Objective	
Annual Indicator	2.1
Numerator	711
Denominator	33,525
Data Source	CDC Wonder
Data Source Year	2023 - 24
Provisional or Final ?	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	2.1	2.1	2.0	2.0	2.0

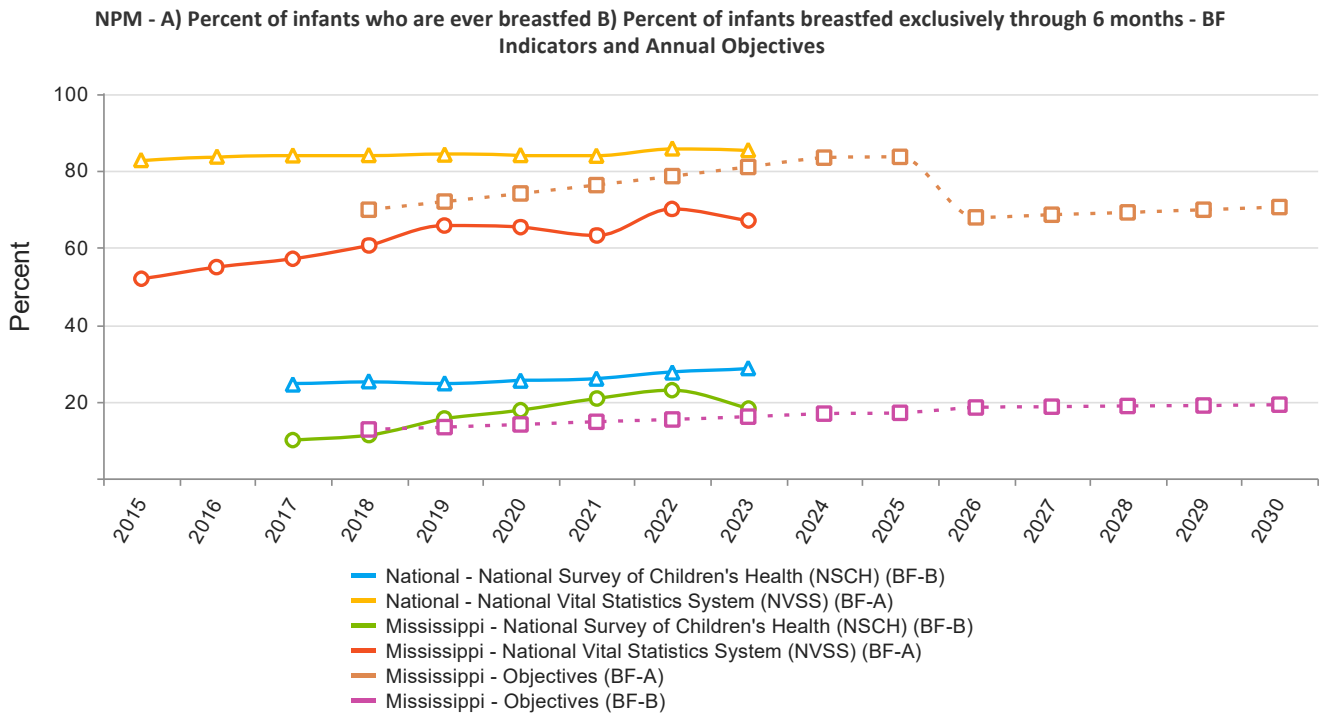
Evidence-Based or –Informed Strategy Measures

ESM RAC.1 - Number of Child Death Review and Fetal Infant Mortality Review recommendations implemented annually (Risk Appropriate Perinatal Care)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	3.0	3.0	3.0	3.0	3.0



NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	80.9	83.3
Annual Indicator	69.8	67.1
Numerator	23,756	22,734
Denominator	34,054	33,867
Data Source	NVSS	NVSS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	67.8	68.5	69.1	69.8	70.5

NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	16.1	16.9
Annual Indicator	23.0	18.3
Numerator	19,896	16,718
Denominator	86,365	91,499
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	18.5	18.7	18.9	19.0	19.2

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:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	5	6	24	26	28
Annual Indicator	21	22	25	29	30
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Provisional	Final	Final

ESM BF.2 - Number of Child Death Review and Fetal Infant Mortality Review recommendations implemented annually (Breastfeeding)

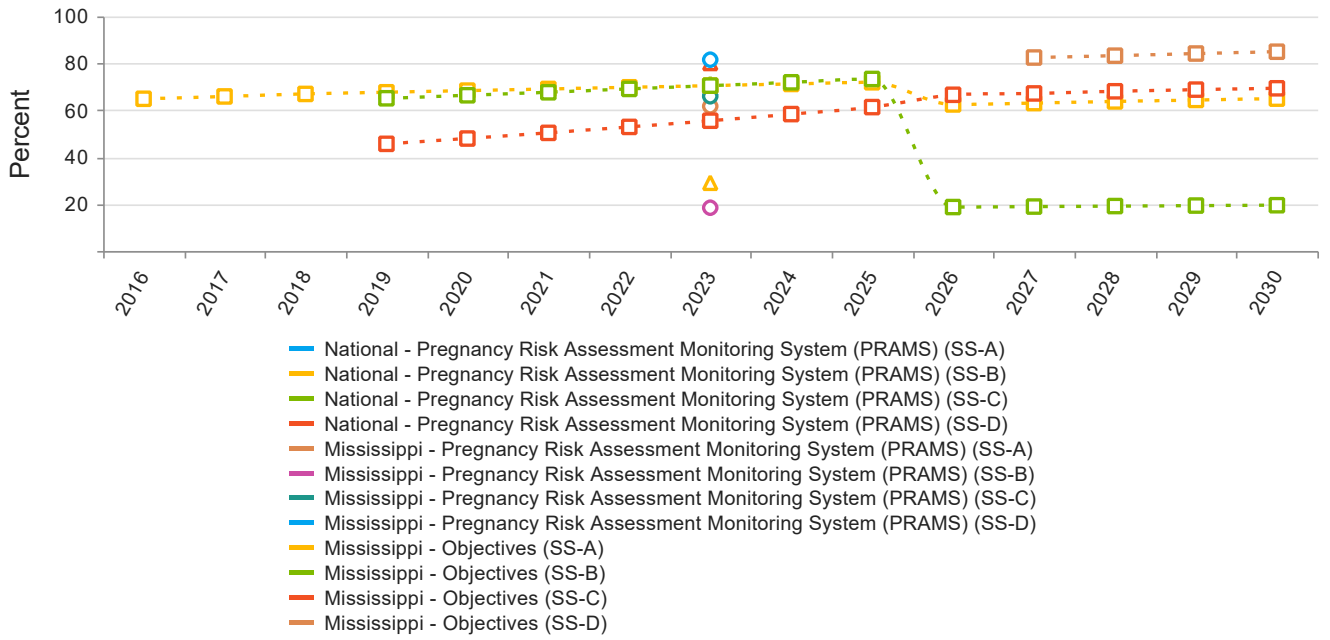
Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	3.0	3.0	3.0	3.0	3.0

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 - SS

Indicators and Annual Objectives



NPM - A) Percent of infants placed to sleep on their backs - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	68.2	68.9	69.6	70.3	71
Annual Indicator	69.4	64.3	70.7	70.7	61.7
Numerator	22,384	20,451	21,727	21,727	16,487
Denominator	32,256	31,790	30,728	30,728	26,713
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	62.3	62.9	63.6	64.2	64.8

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	66.2	67.5	68.9	70.3	71.7
Annual Indicator	34.4	32.7	30.7	30.7	18.6
Numerator	10,964	10,154	9,166	9,166	5,259
Denominator	31,829	31,010	29,840	29,840	28,328
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	18.8	19.0	19.2	19.4	19.6

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	47.9	50.3	52.8	55.4	58.2
Annual Indicator	41.3	42.4	41.9	41.9	65.7
Numerator	12,948	13,078	12,497	12,497	18,870
Denominator	31,323	30,870	29,808	29,808	28,723
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	66.4	67.0	67.9	68.6	69.2

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	81.4
Numerator	23,570
Denominator	28,961
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	82.2	83.0	83.9	84.7	85.6

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:	Inactive - Completed

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective	20,450	20,700	21,000	21,250	21,500
Annual Indicator	14,880	9,560	11,863	13,950	13,601
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	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM SS.2 - Number of cribs distributed to participants of MCH-serving programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	200.0	300.0	400.0	500.0

State Action Plan Table

State Action Plan Table (Mississippi) - Perinatal/Infant Health - Entry 1	
Priority Need	
Reduce Infant Mortality	
NPM	
NPM - Risk-Appropriate Perinatal Care	
Five-Year Objectives	
By September 30, 2030, implement three or more recommendations that are provided from the Child Death Review and FIMRs across the state directed towards reducing infant deaths.	
Strategies	
Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward improving infant mortality based on FIMR and Child Death Review recommendations. (Risk-Appropriate Perinatal Care)	
ESMs	**Status**
ESM RAC.1 - Number of Child Death Review and Fetal Infant Mortality Review recommendations implemented annually (Risk Appropriate Perinatal Care)	Active
NOMs	
Stillbirth	
Perinatal Mortality	
Infant Mortality	
Neonatal Mortality	
Postneonatal Mortality	
Preterm-Related Mortality	

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

Priority Need

Reduce Infant Mortality

NPM

NPM - Breastfeeding

Five-Year Objectives

By September 30, 2030, implement three or more recommendations that are provided from the Child Death Review and FIMRs across the state directed towards reducing infant deaths.

Strategies

Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward improving infant mortality based on FIMR and Child Death Review recommendations. (Breastfeeding)

ESMs	Status
ESM BF.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals	Inactive
ESM BF.2 - Number of Child Death Review and Fetal Infant Mortality Review recommendations implemented annually (Breastfeeding)	Active

NOMs

Infant Mortality

Postneonatal Mortality

SUID Mortality

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

Priority Need

Reduce Infant Mortality

NPM

NPM - Safe Sleep

Five-Year Objectives

By September 30, 2030, distribute 500 cribs to infants in need through MSDH and Title V MCH-serving programs.

Strategies

Strategy: Provide safe sleep education and distribute cribs to individuals in need through MCH-serving programs and community events.

ESMs	Status
ESM SS.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals	Inactive
ESM SS.2 - Number of cribs distributed to participants of MCH-serving programs	Active

NOMs

Infant Mortality
Postneonatal Mortality
SUID Mortality

2021-2025: State Performance Measures

2021-2025: SPM 12 - Percent of women who are enrolled in WIC and initiate breastfeeding

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			51	51.5
Annual Indicator	49.3	54	55.9	53.9
Numerator		11,007	21,547	20,635
Denominator		20,401	38,512	38,306
Data Source	WIC Spirit database	WIC Spirit database	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

2021-2025: SPM 17 - Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			78.5	79
Annual Indicator	75.6	77.9	77.3	82.6
Numerator	67,008	56,332	73,729	89,443
Denominator	88,608	72,327	95,345	108,331
Data Source	MS BRFSS	MS BRFSS	MS BRFSS	MS BRFSS
Data Source Year	2021	2019 2021	2021 2022	2022-2023
Provisional or Final ?	Final	Provisional	Provisional	Provisional

Perinatal/Infant Health
Annual Report Year FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023 to 9/30/2024 to meet the objectives and show improvements on the measures related to perinatal/infant health.

PRIORITY: Access to Care (Women, Children, Adolescents, and Families)

Objective: By September 30, 2025, increase the number of infants participating in a case management/home visiting program by 30% (from 291 to 378)

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

Activity: 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 social conditions impacting the health of MCH program participants that improve perinatal/infant health

During the reporting period, HM/HB provided services to 674 mothers and 461 infants enrolled in the program. Intervention services included infant safe sleep education (34), health education for families, such as the Partners for a Healthy Baby curriculum, from HM/HB and its collaborators (70), oral health education (30), depression/postpartum depression screenings (61), discussed and/or received contraceptive care options (325), reproductive life planning options (43), STI/safer sex education, and referrals for nutrition services, including a lactation specialist (25).

HM/HB nurse case managers provide a postpartum home visit, 2-4 weeks after delivery, no later than 6 weeks. Using the Postnatal Assessment, identify any needs of the woman and make referrals. They also assess the infant for any risk and need for enrollment into HM/HB.

HM/HB has made several partnerships with internal and external programs and organizations to extend the reach of the program and increase access to social and health services to newborn infants. To achieve this HM/HB has partnered with WIC, Office of Tobacco Control (Baby and Me Tobacco Free), Maternal and Infant Health Bureau (MIHB), Office of STD/HIV Prevention, Mississippi SIDS Alliance/Cribs for Kids, Healthy Birthday, Inc., Count the Kicks, Mississippi Department of Child Protective Services (MDCPS), Office of Oral Health, and the Office of Lead Poisoning Prevention.

HM/HB partnered with a Certified Nurse Midwife. She led Midwife Mondays, an educational hour on various maternal and infant health education and provide clinical consultation, updates, and trainings for HM/HB staff (nurses, nutritionists, and social workers). She was the liaison between providers and HM/HB staff.

HM/HB's Clinical and Program Directors hosted a monthly clinical Case Rounds involving nurses, nutritionists, and social workers. On a rotating schedule, the Nurse Team Lead or Nurse Case Manager from a single public health district presented one case (maternal or infant) in which there were challenges in meeting the patient or family's needs or in which there were still questions about how best to serve the patient. During the review, challenges were staffed for a team approach on additional resources and support. Each month a success case was also presented outlining resources and supports provided for the family.

During the reporting period, Healthy Start provided services to 90 participants including expecting mothers, parents, and infants 0-18 months enrolled in the program. During monthly meetings, participants are provided health education on pregnancy and postpartum care, Count the Kicks, breastfeeding support, and mental health support. Parents received breastfeeding education and support, referral to WIC, child development education using the Milestone Moments booklets, ABC of safe sleep education, interconception care support, and mental health support.

The MSDH WIC Program provides referrals to internal programs based on the needs of WIC Program participants. The total number of referrals from WIC was 6683, including 209 to Early Intervention, 5943 to Healthy Moms Healthy

Babies, 303 to Lead and Healthy Homes, 4 to Opioid Program, 209 to Oral Health, and 15 to the Safe Sleep Program.

Because the county level nurses serve a vital role in identifying woman and infant who would benefit from enrollment in one of the Health Service case management programs, the Regional MCH nurses provide an orientation to new nurses and ongoing support for current county level nurses. During the "new nurse orientation", all nurses learn the following regarding HM/HB, MIECHV, and Healthy Start, within the county health departments: eligibility criteria, location of programs, benefits of the program, what are the differences between the various case manager and care coordination programs, and how to enroll a person. Because of their knowledge, infants are routinely identified and referred for other MSDH services.

In February 2024, the MSDH Genetics Bureau was invited to collaborate with other regional states to assess hospital birthing facilities, tertiary clinical data to increase newborn screening and follow-up timeliness through the HRSA, Co-Propel Collaborative. The HRSA Co-Propel (Cooperative Newborn Screening System Priorities Program) Collaborative assists in strengthening state and regional consortia newborn screening programs through financial and technical support. The goal is to increase accuracy and improve timely newborn screening, as well as identify conditions for early diagnosis and treatment. Finally, the program collaborates with state agencies, families, communities, and various organizations to increase patient and family care coordination. The collaborative includes Georgia, Florida, Louisiana, and Mississippi. Genetics received acknowledgement of the award and began reporting approved newborn screening data in July 2024.

Activity: 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.

As part of the University of North Carolina (UNC), MCH National Workforce Development, *Learning Journey*, a team from UNC came to MS for a two-day onsite program. The theme was "Building Stronger Links for Better Outcomes". The purpose was to:

- Reconnect with our collective why- rediscover the shared purpose that drives us and how each Health Service program contributes to our vision
- Illuminate each Health Service program's mission to ensure we all know who we serve and how we do it
- Create collaborative synergy-explore new ways to collaborate and support each other, so we have unified efforts to support our clients
- Strength our relationships by building meaningful connections with colleagues across all Health Services programs, nurturing a "no wrong door" environment for children and families we serve.

Activities included learning about the collective "why", conversational capacity, mutual learning teams, lesson on and creating an ecosystem map, along with whole system mapping. The outcome of the event was a "quilt" identifying how each Health Service Program interconnects with other programs illustrating the importance for internal referrals for services.

The CYSHCN Director is the MSDH team member for Developmental Understanding and Legal Collaboration for Everyone (DULCE), a pediatric primary care intervention designed to address social conditions impacting the health for families with infants birth to six months of age. DULCE is comprised of medical providers, behavioral health specialists, early childhood system representatives, legal partners and family specialist trained in child development and problem-solving. As the acting representative, the CYSHCN Director shares information with the team regarding MSDH MCH-serving programs for referrals.

The MCH Engagement and Coordination Office Director is the MSDH team member for the Children's Trust Fund hosted by MDCPS. The Children's Trust Fund focuses on seeking ways to reduce abuse and neglect in MS before it occurs. As the acting representative, the MCH Engagement and Coordination Office Director shares information with the team regarding MSDH MCH-serving programs for referrals.

Objective: By September 30, 2025, increase the number of outside MSDH referrals for the case management/home visiting program by 20% (from 1,266 to 1,519)

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

Activity: 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

Through the University of North Carolina, MCH National Workforce Development, *Learning Journey*, the Health Service team worked on developing a "no wrong door" referral form for expecting/postpartum mothers, infants, children, and children with special health care needs. This moved the current Health Service form (#1037) from paper to an online portal within REDCap. Incorporated in this online portal are the following programs for easy review, determination of what is appropriate for the person, and completing of the referral (HM/HB, FSEIP, CYSHCN, MIECHV, WIC, EHDI, Newborn Screening, Oral Health). This portal has been added to the MSDH front page website for easy access by providers and families for referrals. The desired outcome is for the "no wrong door" Universal Referral Form to increase the number of referrals from external and internal MCH-serving programs.

From October 2023 to September 2024, HM/HB utilized multiple referral pathways and received a total of 2,741 referrals (maternity = 1,226; infant = 1,515). This represented an increase in referrals to the program from the prior reporting period due to an updated referral process, increased collaborative initiatives with other internal and external and internal maternal health programs and organizations, and increased program awareness in the surrounding communities. Using multiple methods (email, REDCap, fax, EPIC, and mail), key sources including health departments, three Coordinated Care Organizations contracted by the Mississippi Division of Medicaid, obstetric and pediatric practices, genetics, STD/HIV, and Child Protective Services sent referrals to the program.

Activity: 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.

Healthy Start strengthened its referral pathways by optimizing MSDH's electronic health record (EPIC) to facilitate referral management processes between different MSDH programs i.e., HM/HB and Family Planning, improving efficiency for internal referral sources. There were 114 total referrals (17 from external providers and 107 from MSDH program i.e., HM/HB and WIC)

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

Activity: 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

Office of Communications posted Facebook messages to increase awareness of perinatal/infant health issues. An example includes:

- Your blood sugar can rise to higher-than-normal levels during PREGNANCY. this can cause problems when you deliver and put you and your BABY susceptible for developing type 2 diabetes. you can avoid #gestationaldiabetes by having your blood sugar checked regularly while PREGNANT, eating right, and planning on a healthy weight before you become PREGNANT. read more about gestational diabetes and what you can do: https://www.cdc.gov/PREGNANCY/diabetes-gestational.html you or someone you know may qualify for care management from MSDH for a healthier PREGNANCY. get in touch with our

#healthyMOMshealthyBABIES program: healthyms.com/HMHB (1,019 reaches)

- your diabetes can make your BABY grow larger than normal, creating complications during delivery. it can mean a greater chance that your CHILD will develop diabetes, too. controlling your blood sugar, staying active, and seeing your doctor regularly can keep your PREGNANCY a healthy one — for you and your BABY. if you have diabetes, you may qualify for free, personalized care management during PREGNANCY. learn more at healthyms.com/HMHB #healthyMOMs #healthyBABIES #healthyms (1,677 reaches)
- September is INFANT mortality awareness month! did you know MS has one of the highest INFANT mortality rates in the nation? at the MSDH, we are committed to changing this. INFANT mortality rate (IMR): the number of INFANTs who die per 1,000 BIRTHs. in 2021, MS had an IMR of 9.3, but we have seen a slight improvement to 9.2 in 2022. while progress is being made, we have more work to do! programs & resources to help: community BABY showers providing essentials like car seats and sleep sacks healthy MOMs/healthy BABIES program with home visits and caregiver education count the kicks initiative for stillBIRTH prevention maternal, INFANT, and early CHILDhood home visiting program (MIECHV) maternal center of excellence in partnership with JSU early intervention services, genetic screenings, and EPSDT screenings how you can help lower IMR risks: practice safe sleep habits encourage early prenatal care avoid alcohol and tobacco during PREGNANCY focus on improving maternal health before and between pregnancies take steps to lower pre-term delivery risks by addressing the social conditions of health and encouraging safe practices, we can create a healthier future for MS's BABIES! please visit our website for more information, link in bio! #healthyms #healthcantwait #INFANTmortalityawareness (3,058 reaches)

Activity: 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

No activities were done on this during the reporting period.

PRIORITY: Increase Breastfeeding, Healthy Nutrition, and Healthy Weight

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

Strategy: Partner with other MCH-serving programs on the Community Innovation and Outreach (CIAO) project

Activity: Maintain and create additional community partnerships as referral sources to the MSDH WIC Program

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

The MSDH WIC Programs CIAO (Community Innovation and Outreach) project aimed to increase WIC enrollment and participation for target populations annually through partnership, outreach, and promotional activities while addressing language, cultural, and environmental challenges. Strategies included establishing partnerships with internal entities to enhance the referral process and facilitate resource sharing. Internal entities included Office of Oral Health, Office of Lead and Healthy Homes, Healthy Moms Healthy Babies, and the Office of Early Intervention. Monthly meetings were conducted to discuss collaborations, allocate funds, review monthly reports, share outreach materials, and plan future activities. The partnering programs provided WIC information at 206 partner locations, distributed over 13,864 WIC-centered education items, and made 7 social media posts (including 937 likes and 116 shares).

1,763 expectant mothers in 16 counties received oral health education. Regional Oral Health Consultants participated in the WIC CIAO grant activities where they distributed flyers, handouts, and postcards about the WIC program. From June to October 2024, 471 flyers, 339 handouts, and 183 postcards were disseminated at school and community events. Twenty-one hundred (2,100) people received oral health education provided by WIC nutritionists during appointments and reenrollment sessions.

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

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

Activity: Provide breastfeeding education and support to prenatal WIC participants

The MSDH WIC Program operates the WIC Breastfeeding Promotion and Support Program. 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. This includes providing peer breastfeeding support to prenatal and breastfeeding participants. WIC Peer Counselors provide prenatal education to participants during WIC clinic visits. Families receive peer support, access to an IBCLC to address any complex breastfeeding issues, and access to breastfeeding devices and supplies. A total of 10,432 contacts were made, including 132 home visits, 75 hospital visits, 3,673 office visits, and 6,552 phone calls. The MSDH WIC Program also provides 24/7 free access to IBCLCs for breastfeeding support via the Pacify tele-lactation mobile app.

WIC breastfeeding staff receive referrals from interagency, hospitals, and community organizations. WIC Peer Counselors provide education about the benefits of breastfeeding, addressing individual breastfeeding issues, and providing support and reassurance for women and families. Peer counselors provide group classes based on the needs of the clinic. Some topics include basic evidence-based techniques that help ensure a successful start in breastfeeding, including milk production, skin-to-skin care, positioning and latch, and milk expression and storage. Breastfeeding education follows the Ready, Set, Baby curriculum which was developed for counseling women about breastfeeding benefits and management including education on optimal maternity care practices.

Families served by HM/HB and Healthy Start are potentially eligible WIC participants. HM/HB distributed health education and items such as breastfeeding kits, to support breastfeeding for pregnant and postpartum mothers. The kits included a silicone handheld breast pump with strap and cap, topical cream to help with breastfeeding soreness and cracking, hot and cold packs, nursing pads, and milk storage bags. HMHB leveraged funding from the MIHB and WIC CIAO grant to purchase a small supply of kits. Educational materials used include those from WIC and the Partners for A Healthy Baby Home Visiting Curriculum (Florida State University). Healthy Start delivered comprehensive breastfeeding support and education services through a multi-faceted approach. One of the Healthy Start staff, a dually trained CHW and IBCLC provided individualized breastfeeding education and counseling, and assisted families with essential infant supplies (i.e., diapers, wipes, grooming kits, health education, and gift cards). Approx. 21 pregnant/postpartum women were served. Through case management services, the staff connected mothers with certified lactation specialists within MSDH, creating a sustainable support network.

Activity: Support hospitals in achieving Baby Friendly designation

The MSDH WIC Program established memorandums of understanding (MOU) with delivering hospitals in Mississippi to support Steps 3 (prenatal breastfeeding education) and 10 (post-discharge support) of the Baby-Friendly Initiative. Thirty (30) of the 41 delivering hospitals in Mississippi have been designated as Baby Friendly. The MSDH WIC Program continues to support delivering hospitals with retaining the Baby Friendly designation by providing prenatal breastfeeding education at local hospitals and a referral source for post-discharge support. Formal MOUs for a period of 3 – 5 years have been signed by 5 of the 30 Baby- Friendly delivering hospitals in MS.

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

Activity: Maintain and create additional community partnerships as referral sources to the MSDH WIC Program

Activity: Provide WIC participants access to certified lactation consultants

The WIC Program partners with the Mississippi Breastfeeding Coalition (MBFC) to establish and staff MILC

Leagues. The Mississippi MILC League stands for Making an Impact in the Lactation Community. The purpose of the MILC League is to improve breastfeeding rates in Mississippi by offering access to lactation support statewide. MILC Leagues offer free peer support groups for new and expectant mothers virtually or in-person in communities throughout Mississippi. Support groups are facilitated by certified lactation professionals, with most leagues meeting weekly. There is a total of 12 MILC Leagues across the state.

WIC participants are referred from peer counselors to IBCLCs for complex breastfeeding needs. Participants may access IBCLCs via the WIC clinic (where applicable) and the Pacify app. The Pacify app provides 24/7 access to IBCLCs free of charge for WIC participants. IBCLCs provide support for complex breastfeeding issues outside of the scope of breastfeeding peer counselors. They conduct various components of a comprehensive assessment, including feeding history, feeding assessment, breast assessment, and infant assessment. The WIC Breastfeeding Program provides a variety of devices to meet the specific needs of breastfeeding participants. Devices are only issued to WIC participants by the WIC designated breastfeeding expert, peer counselor, and/ or regional breastfeeding coordinator. Available devices include manual breast pumps, single user electric pumps, multiuser electric pumps with kits, Supplemental Nursing Systems, car adapters, Breast shells, and flanges.

PRIORITY: Infant Mortality (and associated preterm/low birth weight factors)

Objective: By September 30, 2024, produce the annual Child Death Review Report to include recommendations for preventing infant deaths

Objective: By September 30, 2025, participate in at least 18 community outreach events to address infant mortality and promote Child Death Review and FIMR Committee recommendations

Objective: By September 30, 2025, expand the FIMR program to all 9 public health districts of Mississippi

The Fetal and Infant Mortality Review (FIMR) is a community-based process designed to examine fetal and infant deaths to improve maternal and infant health outcomes. Its purpose is to identify and address factors contributing to these deaths through comprehensive case reviews and community engagement. The goals of FIMR include improving systems of care, and informing local public health initiatives. MSDH had only one operational FIMR program during the reporting period, located in the lowest six counties, the Gulf Coast area. From the Case Review Team meetings, recommendations centered on the regulation of Kratom, education on unregulated products such as nutrition supplements, tobacco and marijuana prevention, stillbirth prevention, infant CPR education at discharge, referrals to case management for high-risk neonates and infants, increase treatment options for pregnant and parenting women with opioid and other drug addiction, breastfeeding, infant safe sleep, and syphilis testing and treatment during pregnancy.

MIHB began the initial infrastructure work to expand FIMR to the other 8 public health districts across the state. This included engaging other organizations charged with FIMR for their areas, other Healthy Start programs, developing policy, forms, data collection documents, and standard operating procedures based off of the National Center for Fatality Review and Prevention's guidelines, securing MCH Block Grant funding to support modest subgrants to external organizations, developing a request for proposals and recruiting organizations to lead the FIMR work in their areas. By May 2024, four organizations had been identified to lead FIMRs in public health district's 5, 6, 7, and 8. The existing Tougaloo Healthy Start program will lead FIMR in districts 1 and 3. The existing MSDH Healthy Start Enhanced program will lead FIMR in Districts 2 and 4. To support these organizations in their work, MIHB will provide orientation, training, and ongoing technical assistance. The 8 new FIMRs are expected to be fully operational by September 30, 2025.

The MIHB was also awarded a competitively funded capacity building grant from the National Center for Fatality Review and Prevention in the reporting period. This grant aimed to provide resources for training coroners and medical examiners statewide in completing SUIDI forms, enable more accurate death scene investigations by equipping coroners and medical examiners with anatomically correct infant dolls, hiring a temporary staff member to catch up data entry and improve data quality in the fatality reporting systems, and to support the implementation of Community Action Team recommendations.

Objective: By September 30, 2024, add informant interviewing of family members/next-of-kin to the Child Death Review and FIMR case exploration processes

Strategy: MIHB will 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

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

Activity: Extend existing or select by competitive RFP, subgrantees, including health systems or community- based partners, to execute specific activities for providing health promotion and health education focused activities that improve infant health

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.

The Mississippi SUID Prevention Task Force, a subset of individuals serving on Mississippi's Child Death Review Panel and organized in 2023, requested help from MIHB to better understand the practices of safe sleep education among birthing facilities. The MIHB led work to organize a survey during the reporting period to explore the types of information and resources provided to parents and caregivers at discharge, the types of teaching provided on safe sleep/SUID prevention prior to discharge, materials provided to encourage safe sleep, and obstacles to providing safe sleep education. Responses from 18 facilities, including some non-birthing facilities, were received upon conclusion in June 2024 and informed additional strategies around safe sleep initiatives. Results of the surveys showed that nearly all birthing hospitals offered some type of safe sleep education, instruction, or materials, had dedicated staff for those activities, and partnered with other agencies or organizations to support safe sleep messaging and activities.

Additionally, at the request of the SUID Prevention Task Force, MIHB led work to organize three focus groups starting in April 2024. Focus groups invited families and caregivers of infants ages 2 to 12 months old to provide feedback on infant safe sleep practices, known/given information regarding infant safe sleep, as well as the challenges around infant safe sleep. Virtual sessions were held over three separate days and times and followed a structured set of questions approved by the Task Force. Participants were offered $50 gift cards for their participation. A total of 15 individuals participated. Results of the focus groups showed that most parents/caregivers received some type of information or instruction on safe sleep prior to hospital discharge, most knew the safest position for infant sleep is on the back, and co-sleeping was common due to convenience (i.e., not wanting to get up, breast feeding, and wanting to have the infant close out of care and worry). The groups were also shown two short videos on safe sleep, concluding them to be informational but not new information to them. Overall, the groups suggested that if stakeholders were to do a Back to Sleep or Infant Safe Sleep Campaign, social media campaigns, TV ads, and mailout would all be effective methods of getting this information out. The groups also suggested having in-person training/birthing classes at the local health departments or day care during or after pregnancy, to cover topics like safe sleep practices, swaddling and having these trainings during accessible hours for working parents.
Informed partly by the work of the FIMR, the state-level Child Death Review Panel, and information gained from the surveys and focus groups, a state-level infant mortality report was prepared and submitted to the Mississippi Legislature and made public-facing in December 2024, however, was later revised in April 2025 for improved formatting and additional content. The report is accessible online at: https://msdh.ms.gov/page/resources/21026.pdf Staff of the MIHB, the Office of Health Data and Research, and the Office of Vital Records assisted in the preparation of the revised report.

Some key findings included:

- The top three causes of infant deaths in 2022 were (1) congenital malformations/chromosomal abnormalities, birth defects/ malformations, (2) accidents which includes death related to unsafe sleep or Sudden Unexpected Infant Death, and (3) deaths related to short gestation and low birthweight.

- The rate of Sudden Unexpected Infant Death (SUID) decreased from 87 to 82 or from 2.5 per 1,000 to 2.4 per 1,000. But this SUID rate is over twice the United States. Deaths due to ASSB (accidental suffocation and strangulation in bed) was up from 18 to 34 in 2022 accounting for 41% of SUID.
- 120 babies born less at than 27 weeks accounted for 38% of all infant deaths in 2022. These infants either died in the hospital or at home within the first year.
- Of the 48 SUID cases reviewed from 2021, 65% were found to have sleep environment related factors. Among sleep-related factors, 58% were not sleeping in a crib, bassinette, side sleeper, or baby box, 27% were not sleeping on their back, 29% had unsafe bedding or toys in the sleeping area, 50% were co-sleeping with other people (including adult caregivers or siblings) in an adult bed, couch, or recliner, and 10% cases had the caregiver/supervisor to fall asleep due to tiredness or while feeding (including bottle and breast feeding) while co-sleeping. Unsafe sleep practices (infants not sleeping alone on their back, or in a crib, bassinet, or pack n' play) continue to be a contributing factor of sudden unexpected infant deaths.

Key recommendations included:

1. Early and Comprehensive Prenatal Care
    a. Promote preconception health and ensure early obstetric care through policies like presumptive Medicaid eligibility, which can provide care up to 6 weeks earlier.
    b. Provide screening and treatment for syphilis and substance use, and refer women with high-risk pregnancies for additional support (e.g., mental health, tobacco cessation, remote monitoring, nutrition).
2. Safe Sleep Education
    a. Educate caregivers about the risks of co-sleeping and promote safe sleep practices through mass media campaigns, prenatal care, and hospital discharge education.
3. Enhanced Perinatal Systems
    a. Incentivize obstetricians to transfer high-risk mothers to hospitals with NICUs.
    b. Strengthen education and training in all delivery hospitals to manage preterm or complicated deliveries.
    c. Develop a referral system for mothers and babies to deliver at appropriate facilities, potentially involving out-of-state partners.
    d. Prioritize maternal over neonatal transports to reduce newborn complications and mortality.
4. Better Data and Oversight
    a. Require coroners to complete death scene investigations (SUIDI forms).
    b. Track maternal and neonatal transports and NICU outcomes.
    c. Strengthen collaboration between the MS Perinatal Quality Collaborative, Child Death Review Panel, Fetal Infant Mortality Review (FIMR) programs, and the Maternal and Infant Health Bureau.
    d. Require full information sharing from all agencies involved in infant death reviews.
    e. Expand and operationalize FIMR programs, especially in high-risk areas.
    f. Establish an expert physician committee to review and analyze infant mortality statistics annually.

Many of these recommendations are already being materialized with progress to be shared in future MCH Block Grant reports.

The Child Death Review Panel (CDRP) remained active holding its case review meetings on a regular schedule throughout the year. Informed partly by the work of the existing FIMR, and surveys and focus groups, a mortality report was prepared and submitted to the Mississippi Legislature and made public facing in December 2024, however was later revised in February 2025 for improved formatting and additional content. The report is accessible online at: https://msdh.ms.gov/page/resources/21025.pdf
Staff of the MIHB, the Office of Health Data and Research, and the Office of Vital Records assisted in the preparation of the revised report.

One key finding included:

- The leading causes of external death among all cases reviewed from 2022 was (1) Sudden Unexpected Infant Death, (2) firearm-related deaths, (3) homicides, and (4) motor vehicle/transport accidents.

Key recommendations included:

- Challenges to Reviewing Child Deaths: Many child deaths can't be reviewed due to lack of access to full records, even though the Child Death Review (CDR) has legal authority. Hospitals, police, and coroners often ignore requests, and there is no way to enforce compliance. More staff and accountability are needed to obtain records.
- Sudden Unexpected Infant Death (SUID): SUID is the leading external cause of child death. There is a critical need for better education on safe sleep practices—starting in prenatal classes, and continuing through hospitals, doctors, and a statewide coalition-led campaign. A dedicated team should lead this education effort.
- Distracted Driving and Child Deaths: First responders report an increase in child fatalities from car crashes linked to phone use. Stronger laws, educational traffic stops, and incentives like usage-tracking insurance apps are recommended to reduce distracted driving. Coordination with the insurance commissioner is encouraged.
- Gun-Related Child Deaths: These now exceed motor vehicle deaths. Many involve unsecured firearms in homes. Although gun safety discussions are governmental sensitive, the committee stresses the need for accountability laws and public education, possibly through PSAs using real cases (with family consent), to highlight the preventable nature of these tragedies.

Many of these recommendations are already being materialized with progress to be shared in future MCH Block Grant reports.

The MIHB staff also dedicated effort to developing policy, forms, data collection documents, and standard operating procedures based off of the National Center for Fatality Review and Prevention's guidelines for the operational/administrative work related to the Child Death Review Panel.

Activity: 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

During the reporting period, Health Service Programs actively participated in community outreach events to promote safe sleep and to educate the public about the danger of SIDS, SUIDS. HM/HB provided health education to patients, provided access to cribs (pack n plays), and demonstrated how to properly utilize a crib. HM/HB Central Office team has participated in over multiple community outreach events which have been previously described in other sections of this report. A total of 13,650 safe sleep educational materials were distributed by the LPPHHP to birthing hospitals statewide for distribution to new parents.

Activity: Initiate and launch a statewide stillbirth awareness campaign (i.e., Count the Kicks ™)

MIHB partnered with Healthy Birthday, Inc. to launch public-facing evidence-based stillbirth prevention activities and programming throughout the state through its Count the Kicks™ (CTK™) program. CTK™ educates expectant parents on how to track their baby's movements and identify changes in fetal movements. The free CTK™ app is available in more than 20 languages in the Google Play and iOS app stores and has more than 260,000 registered users in all 50 U.S. states, and more than 140 other countries. There were 7,474 visits to the Count the Kicks website by those in Mississippi from July 1, 2023, to June 30, 2024. There were 648 new app users. Two webinars were held with healthcare providers and community-based organization support staff. There were 82 requests for materials, which were co-branded with MSDH's logo, and 25,340 pieces of CTK materials distributed. Additionally, 100 toolkits were shipped to Mississippi providers. This partnership was supported by MCH Block Grant funding. HM/HB and Healthy Start were active partners for distributing information about the Count the Kicks ™ MSDH was delighted to receive word of a "Baby Save" in March 2024. A news article about the baby who was saved when his mother alerted her doctor about reduced fetal movement can be found at: https://jacksonadvocateonline.com/mississippi-mom-uses-count-the-kicks-saves-her-babys-life/

Activity: Partner with National SIDS Alliance and Cribs for Kids ™ to establish centralized resource for Mississippi families in need of cribs/safe sleep environments

MIHB served as a safe sleep resource distribution center for internal programs and community and health systems by obtaining and distributing safe sleep materials and resources. These resources included, but were not limited to, pack-n-play cribs, sleep sacks, and safe sleep educational resources. MIHB provided funding to Cribs for Kids® to purchase “cribettes,” which have all the safety features of the Pack n Play and brings the infant safe sleep message front and center to all caregivers with “A B C – Alone on my Back in a Crib” imprinted on the fabric. From July 1, 2023, to June 30, 2024, 199 cribs were distributed from MIHB through other MSDH programs, including HMHB and Healthy Start.

Perinatal/Infant Health
Application Year FY2026

The following section outlines strategies and activities to be implemented between 10/1/2025-9/30/2026 to meet the objectives and show improvement on the measures related to perinatal/infant health:

Priority: Reduce Infant Mortality

Objective: *By September 30, 2030, implement three or more recommendations that are provided from the Child Death Review and FIMRs across the state directed towards reducing infant deaths.*

Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward improving infant mortality based on FIMR and Child Death Review recommendations.

Activities:

(1) Increase capacity of existing FIMR program and expand FIMR teams to additional areas of the state to assure comprehensive reviews of fetal and infant deaths inform actionable recommendations at various levels of local/regional interventions.

(2) Establish a state-level Infant Mortality Review Committee to review neonate, other infant deaths, and infant mortality statistics for the purpose of making targeted state/system-level recommendations for improvement in infant health outcomes.

(3) Partner with internal and external stakeholders to operationalize programming consistent with FIMR and Child Death Review recommendations (i.e., MSDH Communications, breastfeeding/ lactation support, Count the Kicks, OB Levels of Care System, MSPQC, prenatal/maternal health care initiatives, telehealth initiatives, social conditions impacting needs of program participants).

Objective: *By September 30, 2030, distribute 500 cribs to infants in need through MSDH and Title V MCH-serving programs.*

Strategy: Provide safe sleep education and distribute cribs to individuals in need through MCH-serving programs and community events.

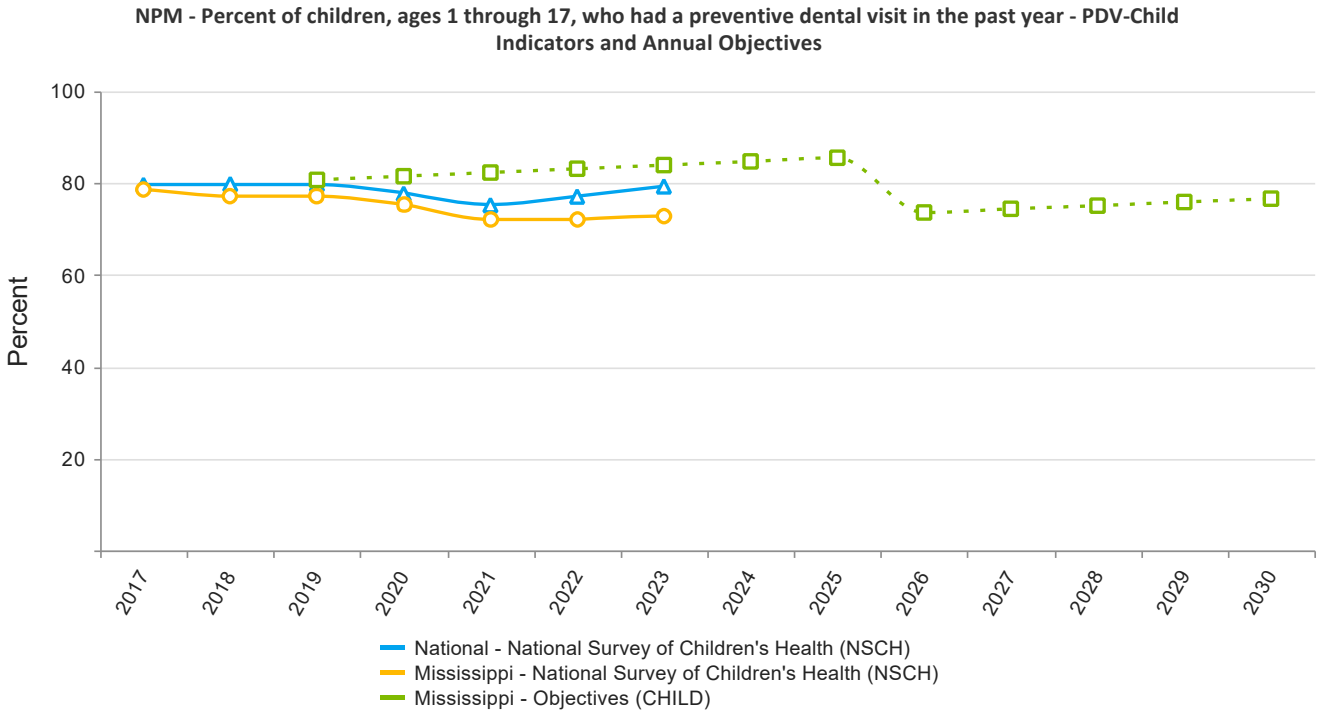
Activities:

(4) Build infrastructure for a single source crib distribution resource under Title V. Establish universal expectations, standard operating procedures, and education for MCH-serving programs and providers to use. Establish data tracking and end user assessment tools.

(5) Partner with internal and external stakeholders to provide direct safe sleep training and identify infants in need of and refer for crib distribution (i.e., Healthy Start, MIECHV, HM/HB, WIC, FSEIP, CYSHCN, Genetics, EHDI, LPPHHP, hospital discharge personnel, EPSDT providers, childcare providers, CBOs, housing complexes, community baby showers, crib clinics, etc.).

Child Health

National Performance Measures



NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	81.4	82.2	83	83.8	84.6
Annual Indicator	77.1	75.0	72.0	72.1	72.8
Numerator	500,754	484,100	468,061	474,563	471,424
Denominator	649,719	645,270	650,503	658,109	647,786
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	73.5	74.3	75.0	75.8	76.5

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:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	2,000	3,000	4,000	100	150
Annual Indicator	903	0	29	38	2
Numerator					
Denominator					
Data Source	Office of Oral Health	Office of Oral Health	EPIC	EPIC	MSDH Office of Oral Health
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

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

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	2,000	3,000	4,000	450	500
Annual Indicator	976	424	20	3	17
Numerator					
Denominator					
Data Source	EPIC	EPIC	EPIC	EPIC	MSDH Office of Oral Health
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

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

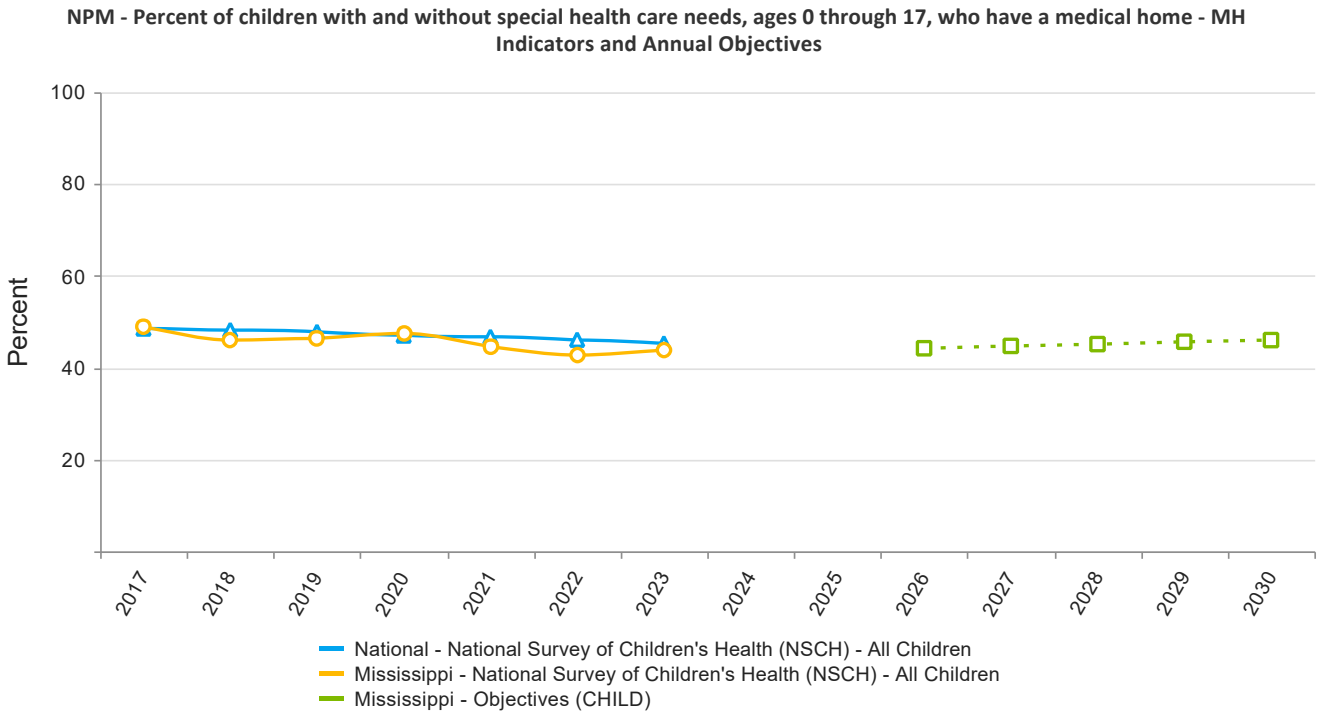
Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	65	70	75	20	25
Annual Indicator	2	8	14	6	35
Numerator					
Denominator					
Data Source	Office of Oral Health	Office of Oral Health	MSDH Office of Oral Health REDCAP	MSDH Office of Oral Health REDCAP	MSDH Office of Oral Health REDCAP
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

ESM PDV-Child.4 - Number of referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	100.0	150.0	200.0	250.0	300.0



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	42.7	43.8
Numerator	293,703	298,389
Denominator	687,740	681,154
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	44.2	44.7	45.1	45.6	46.0

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:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	50	52	54	56	58
Annual Indicator	100	0	30	51	41
Numerator					
Denominator					
Data Source	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and insurance access.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	20.0	40.0	60.0	80.0	100.0

ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months old in county health department clinics annually.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	3.3	3.3	3.4	3.4	3.4

State Performance Measures

SPM 6 - Percentage of individuals who have been identified as having sickle cell trait and/ or disease by the Genetic program who were referred to the Lead poisoning prevention program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.1	25.5	25.8	26.0	26.3

Evidence-Based or –Informed Strategy Measures

None

SPM 7 - Percentage of First Step Early Intervention Program referrals who get an Individualized Family Service Plan

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	44.0	44.0	44.0	45.0	45.0

Evidence-Based or –Informed Strategy Measures

None

SPM 8 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for screened (passed and not passed) before 6 months of age.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	91.8	92.7	93.7	94.6	95.5

Evidence-Based or –Informed Strategy Measures

None

SPM 9 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for diagnosis with permanent hearing loss: before 3 months of age.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	46.1	46.6	47.0	47.5	48.0

Evidence-Based or –Informed Strategy Measures

None

SPM 10 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for babies referred to Part C EI: before 6 months of age

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	33.6	34.0	34.3	34.7	35.0

Evidence-Based or –Informed Strategy Measures

None

SPM 11 - Percent of Mississippi newborns screened (Newborn Screening program)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	100.0	100.0	100.0	100.0

Evidence-Based or –Informed Strategy Measures

None

SPM 12 - Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth. (Newborn Screening Program)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	92.9	93.9	94.8	95.7	96.7

Evidence-Based or –Informed Strategy Measures

None

SPM 13 - Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth with an abnormal result. (Newborn Screening)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	92.9	93.9	94.8	95.7	96.7

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Mississippi) - Child Health - Entry 1	
Priority Need	
Increase access to timely, health, developmental, behavioral health screenings	
NPM	
NPM - Medical Home	
Five-Year Objectives	
By September 30, 2030, increase the number of EPSDT screenings performed among children 0-36 months old in CHDs annually by 5%. (Baseline: 353)	
Strategies	
Strategy: Promote education and awareness timely health, developmental, and behavioral screenings, and EPSDT visits for children ages 0 to 17.	
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	Inactive
ESM MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and insurance access.	Active
ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months old in county health department clinics annually.	Active
NOMs	
Children's Health Status	
CSHCN Systems of Care	
Flourishing - Young Child	
Flourishing - Child Adolescent - CSHCN	
Flourishing - Child Adolescent - All	

State Action Plan Table (Mississippi) - Child Health - Entry 2

Priority Need

Increase access to timely, health, developmental, behavioral health screenings

NPM

NPM - Preventive Dental Visit - Child

Five-Year Objectives

Increase the referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses by 2% annually. (baseline to target)

Strategies

Strategy: Provide professional development opportunities for healthcare professionals and providers to educate on best practices regarding developmental screenings.

ESMs	Status
ESM PDV-Child.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist	Inactive
ESM PDV-Child.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurse	Inactive
ESM PDV-Child.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting	Inactive
ESM PDV-Child.4 - Number of referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses.	Active

NOMs

Tooth decay or cavities
Children's Health Status
CSHCN Systems of Care

State Action Plan Table (Mississippi) - Child Health - Entry 3

Priority Need

Increase access to timely, health, developmental, behavioral health screenings

SPM

SPM 11 - Percent of Mississippi newborns screened (Newborn Screening program)

Five-Year Objectives

By September 30, 2023, increase the number of newborns receiving timely screening and timely referrals by 3%.

Strategies

Strategy: Strengthen collaborative efforts for timely newborn screenings and referrals with internal and external partners through strategic planning and implementation.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Mississippi) - Child Health - Entry 4

Priority Need

Increase access to timely, health, developmental, behavioral health screenings

SPM

SPM 6 - Percentage of individuals who have been identified as having sickle cell trait and/ or disease by the Genetic program who were referred to the Lead poisoning prevention program

Five-Year Objectives

By September 30, 2030, to increase referrals of individuals with sickle cell trait and/ or disease from the Genetic Newborn Screening program to the Lead Poisoning Prevention Program by 2% (from BASELINE TBD to TARGET TBD).

Strategies

Strategy: Maintain and enhance coordinated infrastructure and partnerships between Lead Poisoning Prevention and Healthy Homes and Genetic Newborn Screening programs for referrals.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Mississippi) - Child Health - Entry 5	
Priority Need	
Increase access to timely, health, developmental, behavioral health screenings	
SPM	
SPM 7 - Percentage of First Step Early Intervention Program referrals who get an Individualized Family Service Plan	
Five-Year Objectives	
By September 30, 2030, the percent of First Steps Early Intervention Program (FSIEP) referrals who get an Individualized Family Service Plan (IFSP) will increase by 5%	
Strategies	
Strategy: Maintain and enhance infrastructure to increase referrals where an Individualized Family Service Plan is obtained.	
ESMs	Status
No ESMs were created by the State. ESMs are optional for this measure.	

State Action Plan Table (Mississippi) - Child Health - Entry 6

Priority Need

Increase access to timely, health, developmental, behavioral health screenings

SPM

SPM 8 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for screened (passed and not passed) before 6 months of age.

Five-Year Objectives

By September 30, 2030, EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% (from BASELINE TBD to TARGET TBD) (for screened (passed and not passed) before 6 months of age.)

Strategies

Strategy: Maintain and enhance coordinated infrastructure and partnerships with health care providers to conduct follow-up with families for referral, training, and information sharing to meet 1-3-6 recommendations and reduce LTF/D.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Mississippi) - Child Health - Entry 7

Priority Need

Increase access to timely, health, developmental, behavioral health screenings

SPM

SPM 9 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for diagnosis with permanent hearing loss: before 3 months of age.

Five-Year Objectives

By September 30, 2030, EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% (from BASELINE TBD to TARGET TBD) (for diagnosis with permanent hearing loss: before 3 months of age.)

Strategies

Strategy: Maintain and enhance coordinated infrastructure and partnerships with health care providers to conduct follow-up with families for referral, training, and information sharing to meet 1-3-6 recommendations and reduce LTF/D.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Mississippi) - Child Health - Entry 8

Priority Need

Increase access to timely, health, developmental, behavioral health screenings

SPM

SPM 10 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for babies referred to Part C EI: before 6 months of age

Five-Year Objectives

By September 30, 2030, EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% (from BASELINE TBD to TARGET TBD) (for babies referred to Part C EI: before 6 months of age.)

Strategies

Strategy: Maintain and enhance coordinated infrastructure and partnerships with health care providers to conduct follow-up with families for referral, training, and information sharing to meet 1-3-6 recommendations and reduce LTF/D.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Mississippi) - Child Health - Entry 9

Priority Need

Increase access to timely, health, developmental, behavioral health screenings

SPM

SPM 12 - Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth. (Newborn Screening Program)

Five-Year Objectives

By September 30, 2023, increase the number of newborns receiving timely screening and timely referrals by 3%

Strategies

Strengthen collaborative efforts for timely newborn screenings and referrals with internal and external partners through strategic planning and implementation.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Mississippi) - Child Health - Entry 10

Priority Need

Increase access to timely, health, developmental, behavioral health screenings

SPM

SPM 13 - Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth with an abnormal result. (Newborn Screening)

Five-Year Objectives

By September 30, 2023, increase the number of newborns receiving timely screening and timely referrals by 3%.

Strategies

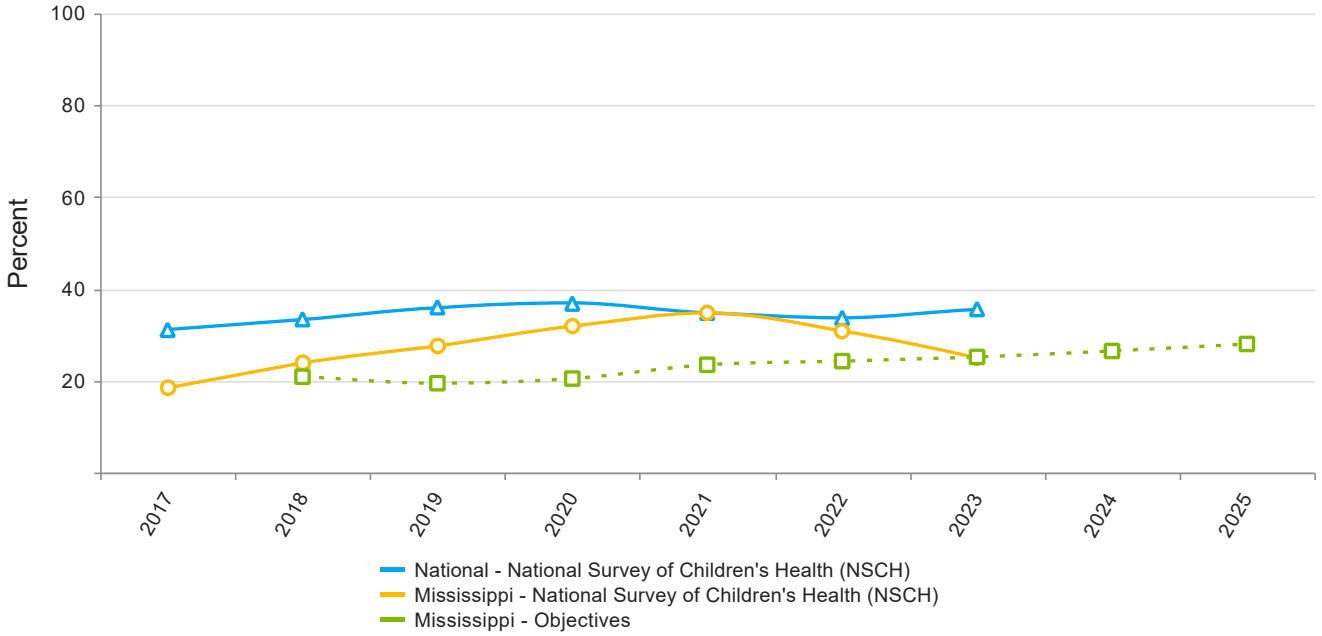
Strengthen collaborative efforts for timely newborn screenings and referrals with internal and external partners through strategic planning and implementation.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS Indicators



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	20.5	23.5	24.3	25.2	26.5
Annual Indicator	28.0	31.5	34.1	30.9	25.1
Numerator	19,663	25,115	28,605	25,435	21,422
Denominator	70,109	79,686	83,842	82,348	85,290
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM DS.1 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			20	30
Annual Indicator	0	1,162	2,928	2,033
Numerator				
Denominator				
Data Source	Early Intervention Child Find Log	Early Intervention Child Find Log	Early Intervention Child Find Log	Early Intervention Child Find Log
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Provisional	Final	Final

2021-2025: SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			3.9	4	4.1
Annual Indicator		3.8	5	11.7	7.9
Numerator		5,554	7,297	16,977	12,937
Denominator		144,844	146,681	145,661	164,715
Data Source		Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			11.2	10.7
Annual Indicator	11.7	7.1	18.4	28.4
Numerator	5,221	2,995	7,342	10,397
Denominator	44,528	42,144	39,888	36,668
Data Source	WIC Spirit database	WIC Spirit database	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

2021-2025: SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Measure Status:	Inactive - Completed
State Provided Data	

	2021	2022	2023	2024
Annual Objective			67	77
Annual Indicator	46.9	40.4	40.8	58.1
Numerator	30	23	20	36
Denominator	64	57	49	62
Data Source	EPIC	EPIC	EPIC	EPIC
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

2021-2025: 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:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			341	375
Annual Indicator	310	272	291	199
Numerator				
Denominator				
Data Source	EPSDT Visits in EPIC	EPSDT Visits in EPIC	EPSDT Visits in EPIC	EPSDT Visits in EPIC
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Final	Final

2021-2025: SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			100	100
Annual Indicator	100	93.2	90	84.6
Numerator	60	2,722	72	77
Denominator	60	2,922	80	91
Data Source	Newborn Screening data	MS Newborn screening database and EPIC database	EPIC database	EPIC database
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

2021-2025: SPM 21 - Percent of children with and without special healthcare needs who have a medical home

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**

	2021	2022	2023	2024
Annual Objective			46.5	46.7
Annual Indicator	46.2	43.2	40.8	41.1
Numerator	72,719	68,226	64,583	86,541
Denominator	157,506	157,885	158,168	210,647
Data Source	National Survey of Childrens Health	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	2022-2023
Provisional or Final ?	Final	Final	Final	Final

Child Health
Annual Report Year FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023 to 9/30/2024 to meet the objectives and shows improvement on the measures to Child Health issues:

Priority: Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

Objective: By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

Objective: By September 30, 2025, extend the early childhood hearing screening program for children 6-36 months of age to increase identification of children with last onset hearing loss

Objective: By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

Strategy: Develop a comprehensive, coordinated, and integrated system of services for children

Activity: Develop and implement policies and procedures in child health programs to support a comprehensive, coordinated, and integrated system of services for children

Health Services developed and is piloting the use of a REDCap a Universal Referral form for referrals to MIECHV, CYSHCN, FSEIP, HM/HB, Oral Health, WIC, EHDI-MS, and LPPHHP, and Genetic/Newborn Screening. Over the next reporting period, baselines and surveys to users will be implemented.

LPPHHP developed a REDCap form to capture data from environmental assessments conduced for families of children with a blood level of 15 or higher. The form allows easier tracking and accessibility to environmental data, allowing for reports to be pulls for specific time periods, detailing where samples were collected, what the substrate is, and whether the results were X-ray fluorescent readings, soil sample results, dust sample results, or water sample results. A Risk Assessment Questionnaire and 4 Healthy Home questions were developed in EPIC to capture data on children being tested for lead to ensure children receive a lead test during their EPSDT visits at the CHD.

During the reporting period, the FSEIP began reviewing and updating current policies and procedures for the program.

The 288 MSDH Hearing Screening Report Form is a standardized document used by hospitals in Mississippi to report newborn hearing screening results to the Early Hearing Detection and Intervention (EHDI) Program. This form collects critical information such as the infant's demographic data, birth hospital, screening dates, screening methods used (such as Auditory Brainstem Response (ABR)), results of each ear tested, risk factors and any follow-up recommendations. Hospitals are mandated to submit the completed 288 form to the EHDI Program within 48 hours of the last qualifying screening event to ensure timely tracking and intervention for infants susceptible for hearing loss. Between October 1, 2023, and September 30, 2024, a total of 6,437 288 Hearing Screening Report Forms were submitted to the EHDI Program, reflecting the program's ongoing efforts to monitor and encourage early hearing detection across the state.

The term "Screen-Pass, High-Risk" refers to infants who pass their initial newborn hearing screening but are identified as having one or more risk factors for late-onset or progressive hearing loss, as outlined in Table 1 of the Joint Committee on Infant Hearing (JCIH) 2019 position statement. These risk factors may include a family history of permanent childhood hearing loss, extended NICU stays, in utero infections, craniofacial anomalies, or certain syndromes associated with hearing loss. Although these infants pass the initial screening, continued audiological monitoring is essential to detect any delayed onset of hearing loss. Between October 1, 2023, and September 30, 2024, a total of 2,764 infants were reported to the Early Hearing Detection and Intervention (EHDI) Program as screen-pass, high-risk. The EHDI Program conducted follow-up with both the pediatricians and families of these infants to ensure awareness of the risk factors and to support ongoing monitoring and timely referrals for diagnostic evaluation if needed.

The Form 53 MSDH Hearing Diagnostic Report is used by audiologists and diagnostic providers to report the results of follow-up hearing evaluations to the Mississippi Early Hearing Detection and Intervention (EHDI) Program. This form collects essential diagnostic information, including the infant's demographic details, referring provider, type, and results of audiologic testing performed (such as ABR or OAE), and the degree and type of hearing loss if

present. The Form 53 is a critical tool for tracking infants who did not pass their newborn hearing screening or who are considered high-risk, ensuring that diagnostic outcomes are documented and monitored. Between October 1, 2023, and September 30, 2024, a total of 1,137 Form 53s were submitted to the EHDI Program. Of these, 66 infants were confirmed to have permanent hearing loss, underscoring the importance of timely diagnostic follow-up for early detection and intervention.

Between October 1, 2023, and September 30, 2024, a total of 66 infants aged 0–3 who were diagnosed with permanent hearing loss were referred by the Mississippi Early Hearing Detection and Intervention (EHDI) Program to the Mississippi First Steps Early Intervention Program. This referral ensures that families are connected with appropriate developmental services as early as possible, which is critical for supporting communication, language, and social-emotional development in children who are Deaf or Hard of Hearing. Early intervention plays a vital role in improving long-term outcomes, and coordination between EHDI and First Steps helps families access services without delay.
In addition to early intervention referrals, all 66 families were also referred to the EHDI Family Support Program. This program is designed to offer emotional support, guidance, and community connections to families navigating a new hearing loss diagnosis. The EHDI Family Support Program includes a Family Support Program Coordinator and a Family Follow-Up & Support Coordinator, who helps ensure follow-up with families for missed hearing screening or diagnostic appointments. The program also includes four family advisors—parents of children who are Deaf or Hard of Hearing—who offer peer support based on their own lived experiences. Additionally, a Deaf or Hard of Hearing Role Model is available to share her personal journey and provide a positive perspective on living with hearing loss. Together, this team provides comprehensive, compassionate support tailored to meet families' unique needs.

Strategy: Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Activity: Coordinate with the state lab, birthing hospitals, tertiary centers, and other specialists to maintain a robust newborn screening program

The Genetics Bureau partners with St. Jude Children Research Hospital to service children with sickle cell disease. St. Jude's operates a telehealth clinic in Tupelo, MS aimed at strengthening patient support for children with chronic hematological diseases. Their clinic increased service hours from a half-a-day to full day due to the success of their program. Their multi-disciplinary referral team includes nurse care coordinators, social workers, mid-level providers, social workers, academic coordinators, child life specialists, genetic counselors, health educators and nutritionists. The clinic is held weekly and staffed by a physician, three mid-level providers, and at least one case manager. Interdisciplinary collaborative team members including social workers, academic coordinators, child life specialists and genetic educators are scheduled during each patient's sickle cell clinic visit as appropriate. During the visits, electronic medical notations are processed in EPIC.

The Early Hearing Detection and Intervention (EHDI) Program provides essential training to hospitals to ensure accurate and timely reporting of newborn hearing screening data. One key focus of this training is on the proper completion and submission of the Form 1100 Hospital Newborn Hearing Screening Log. This form is critical for documenting hearing screening results for all newborns prior to hospital discharge. The EHDI Program guides hospital staff through each section of the form, clarifying data requirements and addressing common errors to improve data quality and consistency across facilities.

In addition to the Form 1100, hospitals are trained on how to accurately complete the Form 288 Hearing Screen Report, which captures more detailed information about individual screening outcomes. The EHDI Program also provides instruction on the technical requirements for submitting hearing screening device data, specifically in the required XML or TXT formats. This technical guidance ensures that screening results can be integrated smoothly into the EHDI data system, allowing for timely follow-up and analysis. Hospitals receive clear instructions on formatting standards and file transfer processes to minimize data submission issues.

The EHDI Program maintains strong, collaborative relationships with all birthing hospitals through continuous communication and support. Program staff are readily available via email and phone to answer questions, troubleshoot problems, and provide clarification as needed. This open line of communication allows the EHDI Program to address concerns in real time and develop a shared commitment to early identification and intervention for infants who are deaf or hard of hearing. Regular contact also helps reinforce best practices and ensures hospitals remain aligned with EHDI goals and reporting standards.

Activity: Expand the number of healthcare providers, interventionists, and specialists who provide screening and ongoing monitoring for timely identification of medical, environmental, or developmental concerns

The Genetics Bureau partnered with the MCH Engagement and Coordination Office, Public Health Social Worker team to address staffing shortages. The PHSW notify families and providers of an infant newborn screening report for Sickle Cell Trait, Hemoglobinopathy or BARTS with the recommendation for follow-up with medical provider. Through this collaboration, the team developed standard operating procedures and the Genetic nurses offers on-going support and training to the PHSWs.

The FSEIP partners with various specialists around the state to provide ongoing specialist services for children ages 0-3. FSEIP is continually recruiting for contractual pediatric therapists (Speech Language Pathologists, Physical Therapists, Occupational Therapists and Special Instructors) to provide multi-disciplinary comprehensive evaluations and developmental services to infants, toddlers, and their families. The MSDH FSEIP website contains the application packet for interested providers.

Activity: Refer families to local primary healthcare providers for screening and monitoring for timely identification of medical, environmental, or developmental concerns

LPPHH program received 22 referrals from the WIC Program for families who were identified during the WIC Nutritional Assessment as being at possible risk for lead exposure. Contact was made with these families to assess their risks for lead exposure and provide recommendations on what could be done to reduce future exposure.

HM/HB performs screenings through the Comprehensive Assessment at enrollment to identify individual needs for medical, educational, social, nutritional and/or other services, including the components of social conditions impacting health. Through the Social Needs Security screening, which focused on food, housing and transportation insecurities, the programs will refer families to support services and community partners. HM/HB works with families with infants, 0-12 months, regarding medical home and importance of EPSDT visit per the periodicity table. Because the 9-month EPSDT visit is no connected with a routine childhood vaccination, the HM/HB team places emphasis on the importance of the 9-month EPSDT visit, discussing challenges which may impact the families. HM/HB team uses the Ages and Stages Questionnaire and other recommended American Academy of Pediatrics (AAP) Bright Future guidance to observe developmental progress of infants in the program. When a developmental concern is identified, the infant is referred to their provider and/or FSEIP.

Of the birth cohort in 2023 served by the EHDI-MS program, 57 infants were referred to the FSEIP for services.

During FY2023, 1,670 infants (0-1 years) were referred to FSEIP. During FY2023, 4,632 infants and toddlers (0-3 years) were referred to FSEIP.

Activity: Provide information to families and primary health care providers supporting timely follow-up

LPPHHP collaborated with the MS Early Learning Alliance to share lead poisoning, healthy homes, and safe sleep information on the Alliance’s website/portal for childcare providers.

June 2024, LPPHHP participated in the MS Capture of the AAP Chat regarding lead screening process, Risk Assessment Questionnaire, the recommended actions based on blood levels, recommended actions for providers based on confirmed venous blood lead level, and shared surveillance data for 2017-2021.

Utilizing a strategy centered on the "no-wrong-door" approach when families reached out for specific services, the Healthy Start team conducted comprehensive needs assessments to identify additional MSDH and community support opportunities. For example, connecting families with FSEIP, developmental screening programs, or specialized healthcare providers. This also includes follow-up support to ensure successful connections and ongoing case management to monitor family progress and adjust service referrals as needed.

Strategy: Develop and implement plans to increase coordination and integration with traditional early childhood partners to improve timely identification

Activity: 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

Activity: Provide tailored education and outreach with traditional and non-traditional early childhood partners

LPPHHP participated in events across the state with traditional and non-traditional early childhood partners (Head Start centers, schools, community-based organizations, and associations) both as a vendor and speaker. Through this outreach, 20 presentations were conducted, and 600 families were educated about lead poisoning and the risk it poses to young children.

Through partnerships, HM/HB participated in 15 health fairs, community baby showers (Sims Foundation, Magnolia Centene, MS Health Advocacy, MSDH Worksite Wellness Expo, and Breastfeeding: All About Love) and Maternal/Infant Health conferences statewide to increase visibility and connect high-risk families to services.

Genetics program began discussions with the CYSHCN and St. Jude's to brainstorm didactic education for school administration, staff, parents, and students on Sickle Cell Trait Awareness and effects of Sickle Cell Disease. This project is ongoing.

The Mississippi State Department of Health (MSDH) Genetics Bureau collaborated with St. Jude Children's Research Hospital (SJCRH) and The Mississippi State Department of Education (MDE) to strategically plan didactic education for traditional and non-traditional partners who serve the Sickle cell Disease and Sickle Cell Trait populations. The training is developed for the Mississippi Department of Education and other designated staff. The purpose of the curriculum is to educate about Sickle Cell Disease and Trait education, and to better support students and parents of students with the disease or trait in navigating the symptoms and avoiding pain crisis and gain awareness for future family planning. The training offers certificates for successful course and assessment completion and should be available for the Department of Education by August 2025. So far, MSDH, MDE, and SJCRH met September 26, 2023, January 30, 2024, February 16, 2024, and August 6, 2024, to discuss and review strategic planning implementation outcomes.

There were 33,310 recorded births in 2023 and 32,646 recorded births in Mississippi birthing facilities. Of the births, for the Title V MCH Block reporting period, 113 infants born in the state were diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel received screening within 24-48 hours of life and were referred to a tertiary center. The Genetics Bureau uploads referral cases into EPIC for internal Health Service program access. External tertiary clinics receive notification by phone and secured electronic mediums. In addition to diseased cases, 1,722 newborns in the reporting period were labeled Hemoglobin Trait and Sickle Cell Trait cases and referred to regional nurse case managers and state social workers to receive trait counseling.

Objective: By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

Strategy: Provide professional development opportunities for health care professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Genetics Bureau distributed approximately 49,015 newborn screening supplies and educational pamphlets to internal and external partners to include: birthing centers, midwifery, health departments, and community health event planners.

The EHDI-MS Program provides outreach and training to hospitals and diagnostic clinics to ensure timely reporting of hearing screenings and diagnostic reports. Hosted the EHDI-MS Conference for professionals and family members. Besides presentations from national speakers and family panels, but there were educational vendors participants could engage with included Auditory Processing Center, Disability Rights Mississippi, Discovery Toys; E3 Diagnostic,; Families as Allies, Magnolia Speech School, The Children's Center, MS Dept. of Child Protective Services, MS Dept. of Education – Office of Parent Engagement; MED-EL, MS School for the Deaf, Hands and Voices of MS, MS Parent Training Information Center, Phonak, Regional Early Acquisition of Language, and MS Hearing-Vision Project.

The EHDI-MS Program provides professional development opportunities through the yearly EHDI-MS Conference and virtual professional development with The CARE Project. EHDI-MS 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.

Activity: 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.

Genetics Bureau provided quarterly educational training in the form of virtual and in-person, hands-on training. Genetics Nurse Case Managers conducted the sessions for health network stakeholders in birthing facilities. October 2023, Genetics Bureau provided professional development for 60 nurses and first responders, during St.

Dominic's Skills Building Day.

Collaborating with Revvitty, the state appointed NBS lab, two virtual professional development sessions on proper processes and procedures in newborn screening were advertised. The training provided overviews of hospital performance, including specimen, collection, screening, and reporting procedures among hospitals in laboratory findings to determine gaps with the newborn screening program. Genetics and Revvity discussed an overview of the screening data identifying areas gaps and areas needing improvement.
60 health professionals attended.

The Genetics Bureau Director facilitated each event. Internal MSDH partners in Health Services (Healthy Moms Health Babies (HMHB), Early Hearing Detection and Intervention (EHDI), MSDH Lead, Children and Youth with Special Health Care Needs (CYSHCN) provided supplemental updates and educated submitters on early hearing, lead, and extended services and resources and support to established medical homes and provide holistic care-coordination. Virtual Education was conducted January 11, 2024. Revvity Omics provided education and submitter performance updates. There were 79 submitters in attendance. The in-person regional workshops were conducted on May 21-23, 2024. The Southern Region was on the campus of William Carey University, Hattiesburg, MS. The Central Region was at the Jackson State University E-Center, Jackson, MS. The North Region was at Courtyard Marriot, Columbus, MS. A total of 129 nurses, social workers, newborn screening staff, hospital staff, and health department staff attended the workshops.

A Newborn Screening Workshop series was conducted May 21st-23rd, 2024 regionally, and covering updates in newborn screening, newborn screening from A-Z, Sickle Cell disease and trait awareness and self-management, case studies, scenarios, etc. Revvity Omics, Labs and St. Jude Children's Research Hospital were the featured presenters. The invited target audience consisted of specialists, HD nurses, birthing hospital staff, midwifery, social workers, etc. The workshops also included hands-on training for proper heal-stick preparation and proper blood sample saturation techniques, proper completion, processing, and shipment of the blood spot card. MSDH internal programs collaborated as exhibitors providing educational materials and program awareness. The exhibitors included: Healthy Moms Health Babies (HMHB), Lead, Early Hearing Detection Intervention (EHDI-MS), and Children and Youth with Special Healthcare Needs (CYSCHN).

Training opportunities provided through the SJCRH and MSDH partnership is included in the chart below.

Monthly Educational Webinar Series & In Person Conferences

October 23-24, 2023	MS Conference in Biloxi
October 30 – November 3, 2023	SCD Nursing Bootcamp
December 2023	Mindfulness Therapy for SCD
January 2024	Gene Therapy/Bone Marrow Transplant
February 2024	School Information (IEP/504 Plans)
March 2024	Aplastic Anemia
April 2024	Sickle Cell Trait Counseling
May 2024	Hemophilia
June 2024	Transition from Pediatric to Adult Medical Care
July 13, 2024	Methodist Comprehensive Sickle Cell Center Community Health Fair

Activity: Provide tailored education and outreach to communities, partner organizations, and stakeholders to address identified issues and concerns.

LPPHHP partners with the MSDH Pharmacy Resident program to provide outreach regarding lead testing, follow-up testing, and reporting requirements. Of the 54 providers referred, 13 providers agreed to the participate in the virtual/in-person learning sessions.

February 2024, LPPHHP provided MSDH District MCH Coordinators a lead training on processes of lead screening: blood lead risk assessment tool; recommended actions based on blood lead levels, to include when a confirmatory venous should be done based on the initial blood lead level and when a follow-up testing should be done; and what other assessments (iron, nutritional, development) are needed based on the child's blood lead level. This training was recorded and placed on HealthStream for MSDH staff to review/revisit.

Objective: By September 30, 2025, increase screening rates in low-resource areas of the state

Objective: By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

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

Healthy Start uses a comprehensive data collection and analysis, to identify specific service gaps unique to each target community (Chickasaw, Clay, Lee, Lowndes, Monroe, and Prentiss counties), allowing for understanding of local needs and challenges. The data tracking systems measured both program participation rates and intervention effectiveness, providing valuable metrics that inform decision-making processes. This data-driven approach enabled staff to make strategic adjustments to service delivery methods and resource allocation. This analytical approach has strengthened the ability to respond to community needs while ensuring accountability in program delivery across all six counties.

Activity: 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

November and December 2023, Nurse Case Managers visited 16 low performing hospitals to provide professional development, corrective action planning, and educational materials.

Activity: Analyze data on screening rates and identify low-resource areas with gaps to be addressed collectively through program improvement or development

Activity: Analyze root causes of loss to follow up and loss to documentation with internal and external partners to implement quality improvement efforts

As the reporting period begins October 1, 2023, six months after the federal declaration of the end of the pandemic, MSDH continues to have difficulty with hiring staff. Review of different Health Service programs continue to indicate a root cause for loss to follow-up is provider shortages. One solution to the provider shortage has been to design the role of a cohort of Public Health Social Workers. This group varied their skill set to blend across four different Health Service Programs (Lead, Genetics, CYSHCN, and HM/HB). Each program developed a standard operating procedure guidance tailored to the specific duties of this group. For support, professional development and regular programmatic meeting occur.

Activity: 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

Due to the vacancy in the Child Health Director position during most of this reporting period, not action was taken on this activity.

Activity: Develop improved functionality and reports in program databases to support data-driven quality improvement efforts

Due to the vacancy in the Child Health Director position during most of this reporting period, not action was taken on this activity.

Activity: 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

Due to the vacancy in the Child Health Director position during most of this reporting period, no action was taken on this activity.

Objective: By September 30, 2025, provide publicity for 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms for timely, appropriate, and consistent health and developmental screenings.

Strategy: Collaborate on health promotion activities, health observances, and other outreach/ engagement strategies 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

Activity: Submit work requests to the Office of Communications to give publicity to national and state messaging related to child health issues etc. Prepare social media post schedules and templates for observance months/days.

Office of Communications posted Facebook messages to increase awareness of child health issues regarding screenings. An example includes:

- MSDH helps daycare programs to provide dental services to children enrolled in early education learning centers. a licensed dental hygienist will perform a dental screening for your child at no cost to identify problems or disease conditions that need further evaluation by a dentist. find out more about the program by calling the MSDH office of oral health at (601) 206-1590 healthyms.com//page/43,0,151,479.html #healthykids #healthyms (346 reaches)

Activity: Conduct outreach and public awareness campaigns to increase awareness of child health issues

HM/HB disseminated communication announcements on the Mississippi State Department of Health website and social media platforms to raise awareness about various maternal and infant health topics such as: Safe Sleep Campaign, Birth defects, Heart health, Nutrition, and lead exposure.

The Genetics Advisory Committee (GAC) and MSDH Genetics Bureau met the first Wednesdays in April and September of 2024 in a virtual public to view heritable educational presentations from families and organizations who sponsor infants with Genetic disorders. The topics covered were Cytomegalovirus, a disease caused by a common virus dangerous to infants, and Pyruvate Dehydrogenase Complexity Disease, a rare mitochondrial disease that leads to neurological disruptions. The Genetics Advisory Chair and team of specialists reviewed possible conditions to recommend added to the local screening panel. The following diseases were scheduled for a future presentation and possible Board of Health recommendations: Globoid Cell Leukodystrophy (Krabbe); Guanidinoacetate methyltransferase (GAMT); and Mucopolysaccharidosis Type II in the upcoming GAC meetings.

Priority: Improve Access to Family-Centered Care

Objective: By September 30, 2025, increase the percentage of children enrolled in family-centered services in a medical home.

Strategy: Provide professional development opportunities for healthcare professionals to learn about family-centered care practices and medical homes

Activity: 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

See information written in Child Health Section, Priority: Increase Access to Timely, Appropriate and Consistent Health and Developmental Screenings. Professional Development offerings regarding screenings are described there because they fit in both sections.

Activity: Provide tailored education and outreach to healthcare providers, interventionists, and specialists to encourage family-centered care practices

HM/HB collaborates with hospitals, pediatric centers, MDCPS, community agencies, mental health centers, and other internal/external programs to identify infants susceptible for morbidity and mortality. Medical professionals conduct a risk assessment and refer eligible participants to HM/HB case management for ongoing support.

Strategy: Coordinate and collaborate with birthing hospitals, healthcare providers, interventionists, and specialists to implement family-centered care practices

Activity: Expand the number of birthing hospitals, healthcare providers, interventionists, and specialists who implement family-centered care practices

The Mississippi State Department of Health (MSDH) Genetics Bureau actively collaborates with St. Jude Children's Research Hospital (SJCRH) to provide medical case management for Sickle Cell Disease (SCD) general patient referrals, newborns screened for follow-up and patients receiving genetic counseling. In addition, SJCRH collects data in accordance with MSDH requirements. SJCRH provides patient care outreach through community liaisons to provide education, intervention, and training. Reports are submitted quarterly in January, April, July, and October of the contract year based on MS contract guidelines.

Activity: Link children with potential and identified needs to local primary healthcare providers, interventionists, and specialists who implement family-centered care practices

Due to the vacancy in the Child Health Director position during most of this reporting period, no action was taken on this activity.

Strategy: Increase knowledge and awareness among families on family-centered care practices

Activity: Provide tailored education and outreach to families, communities, partner organizations, and stakeholders about medical homes and family-centered care practices

The Early Hearing Detection and Intervention (EHDI) Family Support Program is designed to provide guidance, education, and emotional support to families of infants and young children who are deaf or hard of hearing. Recognizing that a child's hearing loss can be an overwhelming discovery for families, the program ensures that caregivers receive timely, accurate information and access to resources that encourage informed decision-making. The EHDI Family Support Program includes a dedicated team: a Family Support Program Coordinator, four Family Advisors who are parents of children who are deaf or hard of hearing, a Deaf or hard of hearing role model who shares her own lived experiences, and a Family Follow-Up & Support Coordinator who reaches out to families after missed follow-up newborn hearing screens or diagnostic audiology appointments. Between October 1, 2023, and September 30, 2024, the EHDI Program referred 66 babies confirmed with permanent hearing loss to the EHDI Family Support Program.

At the heart of the EHDI Family Support Program is a commitment to family-centered care. The Family Advisors play a critical role by offering peer-to-peer guidance, sharing personal insights, and helping families navigate the emotional and practical aspects of raising a child with hearing differences. The Deaf or hard of hearing role model adds another valuable perspective by demonstrating the possibilities and strengths of the deaf and hard of hearing community. Together, these team members provide a variety of experiences and support, helping families feel understood, empowered, and less alone during a potentially overwhelming time.

The EHDI Family Support Program also collaborates closely with healthcare providers, audiologists, early intervention specialists, and community organizations to create a seamless network of care. The Family Follow-Up & Support Coordinator plays a key role in ensuring that no child falls through the cracks by contacting families who miss critical hearing screenings or diagnostic appointments. By encouraging early diagnosis and creating family engagement from the beginning, the program helps improve language, social, and academic outcomes for children who are deaf or hard of hearing. Ultimately, the EHDI Family Support Program strengthens the foundation for lifelong success by ensuring families are connected, informed, and supported every step of the way.

Activity: Refer families to local primary healthcare providers, interventionists, and specialists who implement family-centered care practices and can serve as a medical home

Due to the vacancy in the Child Health Director position during most of this reporting period, no action was taken on this activity.

Activity: Encourage and support families on demanding family-centered care practices in their systems of care and medical homes

Due to the vacancy in the Child Health Director position during most of this reporting period, no action was taken on this activity.

Objective: 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%

Objective: By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5%

Objective: 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

Activity: 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

See information written in Child Health Section, Priority: Increase Access to Timely, Appropriate and Consistent Health and Developmental Screenings. Promotional activities are described there because they fit in both sections.

Activity: Review data to identify areas with low or late referrals and provide tailored outreach to communities, partner organizations, and stakeholders for early intervening services

Due to the vacancy in the Child Health Director position during most of this reporting period, no action was taken on this activity.

Strategy: Implement interventions with families to encourage the adoption of home- and community-based strategies to further the progression of the health and development of their children (e.g., safe sleep, healthy homes, nutrition, and physical activity)

Activity: Provide tailored education to families on home/community-based strategies to further the progression of the health and development of their children

Office of Communications posted Facebook messages to educate families about health and development of their children. Examples include:

- Lead exposure remains a problem for many kids in MS. it can be caused by dust and dirt from outdoors, older window blinds or wall paint, and even household objects like keys. read about ways to keep kids lead-free at healthyms.com/leadfree #leadfreekids #healthyms (348 reaches)
- It's never too early to start good #oralhealth! when kids learn good habits, they last for life. how you brush, when you floss, and what you eat all make a difference. learn about brushing right and eating right at healthyms.com/cavityfree #dentalhygienemonth #healthykids #healthyms (259 reaches)
- Recall update: cinnamon flavored apple pouches from three companies are being recalled for containing excessive levels of lead. these items were sold online and in stores nationwide. MSDH has identified 5 MS families with children having elevated blood levels who reported consuming the recalled pouches. exposure to high amounts of lead is harmful to children's health and development. do not let children consume these products. throw away any of these items you may have immediately. if you think you child may have consumed any of these products, contact the child's doctor or call MSDH's lead poisoning prevention program at 601-576-7620. full information on this recall: https://tinyurl.com/396nzddu
  (1107 reaches)

Activity: Provide ongoing supports for families to implement home/community-based strategies to further the progression of the health and development of their children

CYSHCN provides care coordination services to families and their youth distributing health education about growth, nutritional needs, and development, as well as, parenting skills and community resources.

Healthy Start uses interventions to support families and create positive health outcomes. Families are provided information about safe sleep practices, emphasizing back-to-sleet positioning, proper sleep environment, and room-sharing recommendations for infants. Teams personalize education on child development milestones, teaching parents to track and celebrate their child’s developmental progress from birth to 18 months, with special attention to motor skills, language development, social-emotional growth, and cognitive achievements.

Activity: Provide ongoing peer-to-peer supports for families to further the progression of the health and development of their children

A key achievement of the Healthy Start program was the development of a fatherhood engagement initiative, which worked to create meaningful connections and support within the community. This initiative worked in tandem with our other community support activities to highlight the importance of men and fathers in discussions and targeted activities to address maternal and infant health outcomes, creating a holistic approach to maternal and infant health and family wellbeing. Through these coordinated efforts, we have established a strong foundation for continued community engagement and health education.

Strategy: Implement evidence-based approaches using family-centered practices to improve health and developmental outcomes for young children, including school readiness

Activity: 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)

Activity: Provide ongoing support for personnel to implement adopted evidence-based models with fidelity

The MIECHV focused on building the infrastructure of the program, developing policies and procedures, standard operating procedures, hiring, and training of staff. Six staff began mandatory trainings: Ages and Stages, PICCOLO, PAT evidence-based model. MIECHV adopted the evidence-based model, Parents as Teachers.

FSEIP uses the Routines-Based Model for Early Intervention developed by Robin McWilliam as their comprehensive model for delivery of services. It is family-focused, routines-based and uses transdisciplinary approaches. It consists of six key practices and is grounded in research on assessment and intervention planning, home- and community-based supports.

Priority: Improve Oral Health

Objective: By September 30, 2025, increase the percent of children with a preventive dental visit by 1%

Strategy: Encourage the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals and nondental providers

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

Strategy: Work with internal and external partners to identify obstacles and solutions to access and utilization of preventive dental services

Activity: Increase oral health awareness regarding oral disease indicators

Activity: Conduct a basic health surveillance of Mississippi's children enrolled in Head Start

Activity: Coordinate efforts with the WIC program to improve access for WIC recipients (both children and pregnant mothers) to dental care

Activity: Monitor dental care coordination efforts among children 1-17 years

Activity: Strengthen the collaborative partnership with the Division of Medicaid

Activity: Continue to build connections and strengthen opportunities with the UMMC SOD and with other schools offering dental hygiene degree programs.

Office of Oral Health provided fluoride varnish applications to Head Start (686), elementary schools (145), 2 daycare facilities (197), a community event (17) and 2 Boys and Girls Clubs (17) for a total of 1,062 children reached in 15 counties. In addition, they provided screenings to school-aged children in Head Start, daycare facilities, and after school care in through the Make A Child's Smile events and regular screening events, reaching a total of 1,751 children. (Citation: 2025 Office Oral Health MCH Report)

During the reporting period, Office of Oral Health completed the following activities:
A total of six (9) Cavity Free Kids trainings occurred during the period between September 2023 and October 2024. Oral health education was provided to early childhood educators in nine (9) counties. The numbers per each county is as follows:

- Two (2) trainings in Adams County for a total of 88 educators
- Two (2) trainings in Forrest County for a total of 45 educators
- One (1) training in Harrison County of 12 educators
- Four (4) trainings in Hinds County for a total of 278 educators
- One (1) in Jasper County of 14 educators
- Two (2) in Madison County of 40 educators
- One (1) in Pike County of 20 educators

- One (1) in Pontotoc County of 15 educators
- One (1) in Rankin County of 18 educators

Cavity Free Kids is a free train-the-trainer oral health curriculum that provides education about dental cavities and how they can be prevented. This curriculum was developed for childcare directors and staff who work closely with parents and children. Those who participate will acquire knowledge, skills, and resources to educate families and children. Hands-on training includes exercises that are fun and easy for parents and children to understand. Childcare staff receives two contact hours for attending.

A total of six (3) Cavity Free in MS trainings occurred:
- In July 2024, one training was held in Desoto County with 30 medical students from Baptist Memorial Hospital in Southaven, MS.
- In August 2024 at Ole Brook Kids Pediatric Urgent and Wellness Clinic in Lincoln County, 3 staff were trained.
- In August 2024 at Lackey Pediatric Clinic in Forrest, MS, 4 professionals were trained

Across the reporting period and informed by the assessments, 6 HM/HB patients were referred to the MSDH Regional Oral Health Consultants for follow up, 2 patients were in the urgency category (1) pain, 1 patient had no insurance, and 3 patients needed a dental home. Two patients were left a voice message, 1 patient was unable to be reached by phone, 1 patient visited the local FQHC but was unable to pay for the treatment, 1 patient was referred to the local FQHC, and 1 was referred to two dentists, 50 hygiene and educational products was donated to a HM/HB staff member who then provided education and tools to families.

Three Regional Oral Health Consultants (ROHCS) provided trainings to 1,764 mothers participating in WIC programs in 13 counties (Forrest (118), Rankin (587), Quitman (76), Coahoma (103), Harrison (36), Washington (94), Bolivar (17), Hinds (153), Sunflower (70), Jones (50), George (50), Warren (310), Newton (100) counties). According to the WIC SPIRIT report (October 2023-July 2024), a total of 2,114 women received oral health education and toothbrush kits which consist of a toothbrush, floss, and toothpaste from these face-to-face trainings during nutrition education sessions. Additional oral health kits were donated to children and other adults attending the mother's WIC. Office of Oral Health partnered with WIC to address the oral health needs of families. 84 WIC participants were referred to dental team members for follow-up phone calls on dental needs.

To strengthen the relationship with the DOM, Office of Oral Health staff participate in a quarterly calls between Health Service programs and DOM. During these calls, discussion about program activities occur.

No collaborative work was conducted between UMMC SOD or hygiene schools during this grant period.

Priority: Increase Breastfeeding, Healthy Nutrition and Healthy Weight

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

Strategy: Implement evidence-based practices to decrease obesity in early childhood

Activity: Maintain and create additional community partnerships as referral sources to the MSDH WIC Program

Activity: Provide breastfeeding education and support to prenatal WIC participants

Activity: Provide WIC participants access to certified lactation consultants

The WIC Program continues to provide nutrition assessment, goal-centered nutrition education, breastfeeding encouragement 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 WIC Program operates the WIC Breastfeeding Promotion and Support Program. This includes providing peer breastfeeding support to prenatal and breastfeeding participants. WIC Peer Counselors provide prenatal education to participants during WIC clinic visits. Families receive peer support, access to an IBCLC to address any complex breastfeeding issues, and access to breastfeeding devices and supplies. A total of 10,432 contacts were made, including 132 home visits, 75 hospital visits, 3,673 office visits, and 6,552 phone calls. The MSDH WIC Program also provides 24/7 free access to IBCLCs for breastfeeding support via the Pacify tele-lactation mobile app.

Every pregnant woman and breastfeeding mother has access to free breastfeeding support through a Healthy Start IBCLC credentialed staff or WIC staff. Breastfeeding is encouraged and education on the benefits of breastfeeding for both mother and baby is provided.

Child Health
Application Year FY2026

The following section outlines strategies and activities to be implemented between 10/1/2025-9/30/2026 to meet the objectives and show improvement on the measures related to Child Health:

Priority: Increase access to timely, health, developmental, behavioral health screenings

Objective: *By September 30, 2030, increase the number of EPSDT screenings performed among children 0-36 months old in CHDs annually by 5%. (Baseline: 353)*

Strategy: Encourage education and awareness timely health, developmental, and behavioral screenings, and EPSDT visits for children ages 0 to 17.

Activities:

(1) Partner with families, programs, schools, providers, and professional organizations to host community events, trainings, and other activities regarding health, developmental, and behavioral screenings.

(2) Engage with Title V MCH staff, internal and external stakeholders to increase referrals to appropriate programs, health professionals, and providers.

(3) Analyze data on screening rates to provide targeted support to identified deficit demographical and/or geographical populations.

(4) Collaborate with families, internal, and external partners to determine needed resources, identify root causes and impediments to timely screenings and implement improvement efforts.

Strategy: Provide professional development opportunities for healthcare professionals and providers to educate on best practices regarding developmental screenings.

Activities:

(5) Collaborate with healthcare professionals and providers to identify the impediments to timely developmental screenings in their geographical district/region.

(6) Invite providers to participate in trainings, education sessions, conferences, workshops, lunch-and-learns, and learning communities on timely health, developmental and behavioral screenings

(1) Collaborate with healthcare professionals and providers to provide education on MSDH programs and referral sources.

Objective: *By September 30, 2030,* to increase referrals of individuals with sickle cell trait and/ or disease from the Genetic Newborn Screening program to the Lead Poisoning Prevention Program *by 2% (from BASELINE TBD to TARGET TBD)*

Strategy: Maintain and enhance coordinated infrastructure and partnerships between Lead Poisoning Prevention and Healthy Homes and Genetic Newborn Screening programs for referrals.

Activities:

a. Explore any data sharing agreements needed for programs to share database information for analysis.

(2) Obtain the necessary data for comparison between Lead Poisoning Prevention and Healthy Homes and Genetic Newborn Screening programs.

c. Work with data team for analysis of data to develop next action plan.

Objective: *Increase the referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses by 2% annually.*
(baseline to target)

Strategy: Provide professional development opportunities for healthcare professionals and providers to educate on best practices regarding developmental screenings.

Activity:

(3) Collaboration between the Office of Oral Health and Office of Public Health Transformation / Field Services (county level staff) to provide training regarding Oral Health Screenings during the EPSDT visit.

Objective: *By September 30, 2030, EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% (from BASELINE TBD to TARGET TBD)*

Strategy: Maintain and enhance coordinated infrastructure and partnerships with health care providers to conduct follow-up with families for referral, training, and information sharing to meet 1-3-6 recommendations and reduce LTF/D.

Activities:

(1) Contact health care providers to conduct active surveillance to ensure screening, evaluation, and referral data are reported in a timely manner

(2) Enhance an integrated data system to:

☎🗎◑ Document screening, diagnosis, and early intervention referral and enrollment

☎🗏◑ Track follow-up activities

(3) Send letters to families and primary health care providers explaining the need for follow-up

(4) Receive contacts from families and/or contact families to assist them with arranging screenings, evaluations, and referrals to early intervention

Objective: *By September 30, 2030, the percent of First Steps Early Intervention Program (FSIEP) referrals who get an Individualized Family Service Plan (IFSP) will increase by 5%*

Strategy: Maintain and enhance infrastructure to increase referrals where an IFSP is obtained.

Activities:

(3) Engage using Child Find for FSEIP, collaborating with internal and external stakeholders to operationalize referrals to the program.

(4) Engage and collaborate with internal and external partners to facilitate continuous quality improvement and use of best practices to identify impediments regarding patient enrollment.

Objective: *By September 30, 2023, increase the number of newborns receiving timely screening and timely referrals by 3%.*

Strategy: Strengthen collaborative efforts for timely newborn screenings and referrals with internal and external partners through strategic planning and implementation.

Activities:

(1) Participate in monthly meetings, providing regular feedback with internal and external partners to include consortium initiatives *(i.e. performance measures, root cause and timely follow-up, corrective action planning, and continuous quality improvement*).

(2) Collaborate with interdisciplinary team (birthing facility staff, nurse case management, health department workers, state social workers, and specialist) to ensure timely screening, timely follow-ups, and patient-centric care coordination.

(3) Analyze policies and procedures, activities and emerging issues, during the period of performance.

(4) Synthesize gaps identified and initiate required virtual and in-person TA(s). Execute actionable steps for proposed implementations.

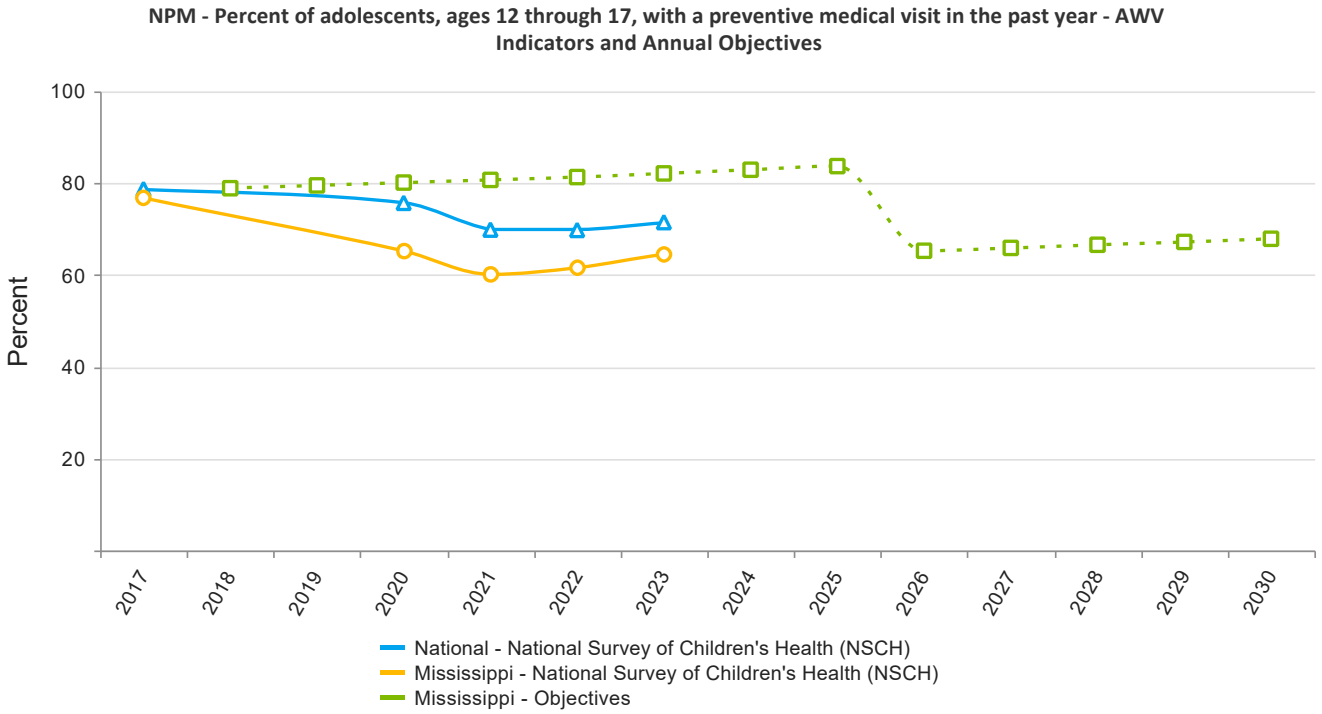
(5) Examine data collection and strategic plans alignment, report progress to proposed outcomes, data collections, and measures of success.

(6) Strategically execute NBS data collection plans, data sharing, continuous quality improvement plans, and submit de-identified and aggregate NBS data for HRSA Co-Propel Consortium project and APHL NewSTEPs annual reports.

(7) Continue to scan referrals in EPIC media and fax to HMHB. Initiate internal referral on prosed EPIC dashboard and externally with UMMC/specialists, pediatricians, etc.

Adolescent Health

National Performance Measures



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	80	80.6	81.2	82	82.8
Annual Indicator	66.2	65.1	60.5	61.6	64.5
Numerator	155,497	155,882	145,341	148,228	158,015
Denominator	234,939	239,310	240,226	240,436	244,893
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	65.2	65.8	66.5	67.1	67.8

Evidence-Based or –Informed Strategy Measures

ESM AWV.1 - 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:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			100	100
Annual Indicator	100	100	100	82
Numerator				
Denominator				
Data Source	MSDH County Health Department information	MSDH County Health Department information	MSDH County Health Department information	MSDH County Health Department information
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Final	Final

ESM AWV.2 - Percentage of adolescents ages 13-17 who received all recommended doses of the human papillomavirus (HPV) vaccine

Measure Status:	Active

Baseline data was not available/provided.

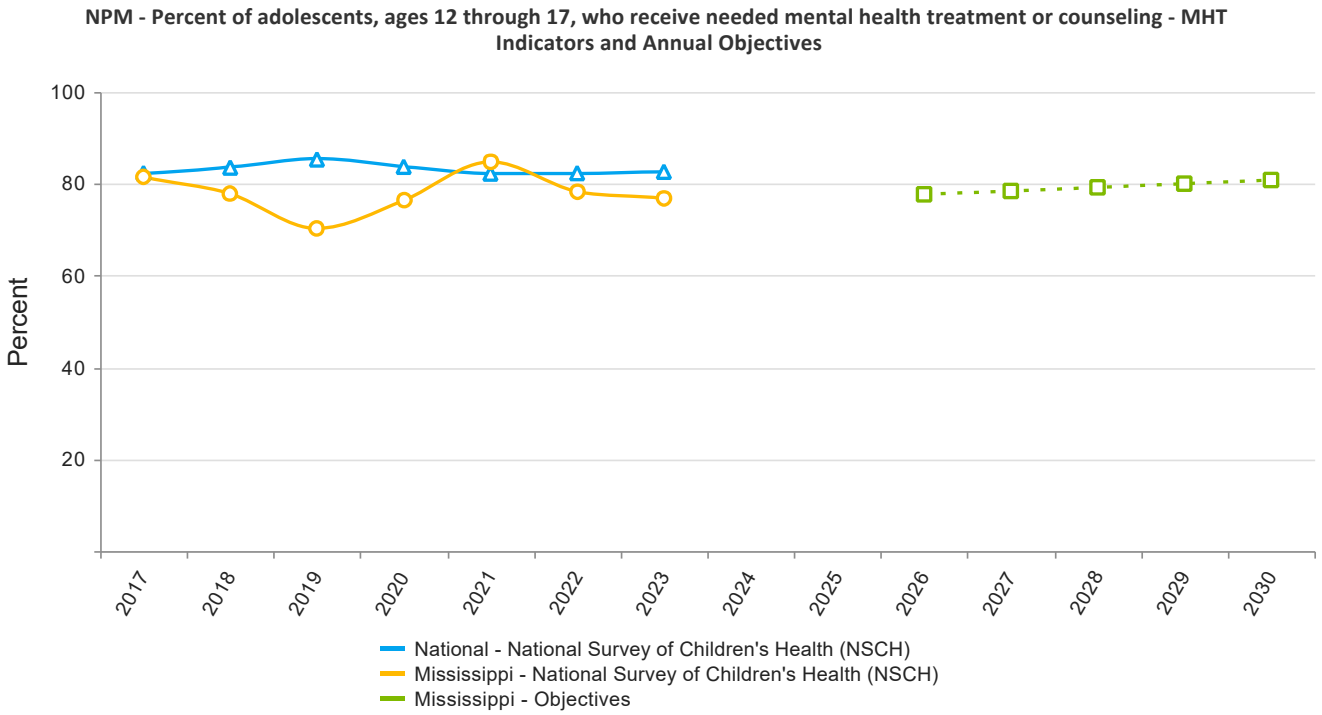
Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	38.8	39.2	39.6	40.0	40.4

ESM AWV.3 - Percent of adolescents, ages 12-17, with an EPSDT medical visit and screening in the MSDH county Health Departments

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	0.7	0.7	0.7	0.7	0.7



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	76.8
Numerator	40,575
Denominator	52,825
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	77.6	78.3	79.1	79.9	80.7

Evidence-Based or –Informed Strategy Measures

ESM MHT.1 - Number of presentations surrounding suicide awareness for youths

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	27.0	28.0	29.0	30.0	32.0

ESM MHT.2 - Percent of community partners in a collaboration addressing youth mental health care and suicide prevention awareness.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	30.0	40.0	50.0	60.0	70.0

State Action Plan Table

State Action Plan Table (Mississippi) - Adolescent Health - Entry 1	
Priority Need	
Improve Adolescent Health	
NPM	
NPM - Adolescent Well-Visit	
Five-Year Objectives	
By September 30, 2030, increase access to timely, health, developmental, and behavioral health screenings performed among 13–20-year-olds in CHDs annually by 5%. (Baseline: 102)	
Strategies	
Strategy: Provide training and professional development to adolescents, school staff, partners, and providers to educate on adolescent health factors.	
ESMs	**Status**
ESM AWV.1 - 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	Inactive
ESM AWV.2 - Percentage of adolescents ages 13-17 who received all recommended doses of the human papillomavirus (HPV) vaccine	Active
ESM AWV.3 - Percent of adolescents, ages 12-17, with an EPSDT medical visit and screening in the MSDH county Health Departments	Active

NOMs

Teen Births
Adolescent Mortality
Adolescent Motor Vehicle Death
Adolescent Suicide
Adolescent Firearm Death
Adolescent Injury Hospitalization
Children's Health Status
Child Obesity
Adolescent Depression/Anxiety
CSHCN Systems of Care
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

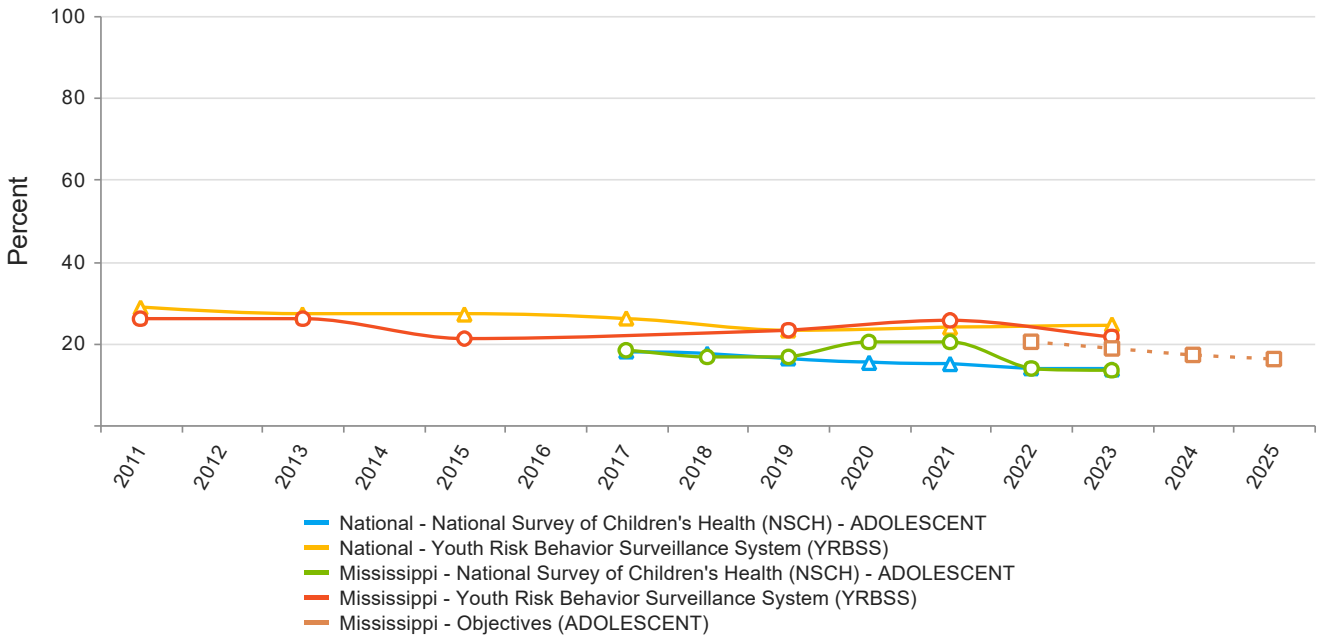
State Action Plan Table (Mississippi) - Adolescent Health - Entry 2
Priority Need
Improve Adolescent Health
NPM
NPM - Mental Health Treatment
Five-Year Objectives
By September 30, 2030, reduce youth suicide attempts by 5% (baseline to target)
By September 30, 2030, increase youth access to mental health resources by 5% (from BASELINE TBD to TARGET TBD).
Strategies
Strategy: Launch a Youth Mental Health Awareness campaign focused on mental health care.

ESMs	Status
ESM MHT.1 - Number of presentations surrounding suicide awareness for youths	Active
ESM MHT.2 - Percent of community partners in a collaboration addressing youth mental health care and suicide prevention awareness.	Active

NOMs
Adolescent Mortality
Adolescent Suicide
Adolescent Firearm Death
Adolescent Injury Hospitalization
Children's Health Status
Adolescent Depression/Anxiety
CSHCN Systems of Care
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

2021-2025: National Performance Measures

2021-2025: NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day - PA-Adolescent Indicators



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			20.4	18.8	17.2
Annual Indicator	23.4	23.4	25.5	25.5	21.7
Numerator	29,043	29,043	31,054	31,054	25,177
Denominator	123,981	123,981	121,794	121,794	116,160
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2019	2019	2021	2021	2023

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			20.4	18.8	17.2
Annual Indicator	16.7	20.6	20.5	14.0	13.3
Numerator	38,663	48,356	48,374	34,225	33,131
Denominator	231,717	234,684	235,476	243,942	249,624
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: 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**	**2024**
Annual Objective			22	23	24
Annual Indicator	20.6		20.5	14	13.3
Numerator	48,356		48,374	34,225	33,131
Denominator	234,684		235,476	243,941	249,624
Data Source	National Survey of Childrens Health		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	2022-2023
Provisional or Final ?	Final		Final	Final	Final

Adolescent Health
Annual Report Year FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023 to 9/30/2024 to meet the objectives and show improvements on the measures related to adolescent health.

Priority: Improve Access to Care

Objective: By September 30, 2025, increase percentage of youth who complete an annual ESPDT visit.

Objective: 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 other MSDH offices as well as external partners to provide information to healthcare professionals about teen-friendly health practices.

The Regional MCH Nurses provide educational packets to families regarding HPV and vaccinations in the county health department clinics and at community health fairs. The Central East MCH Nurse partnered with the Office of Oral Health to provide HPV information to 18–19-year-olds, who have a special medical need.

Activity: Partner with TeenHealth MS to conduct focus groups with teens regarding their perceived challenges to healthcare.

MSDH with Teen Health Mississippi, conduct maternal health focus groups focused on engaging Mississippi woman who are a)African American, b)between the ages of 15-44, c)recently pregnant (between 2020 to 2024) about their experiences accessing healthcare before, during and after pregnancy. Twelve focus groups were conducted via zoom, with 107 people participating. They shared several stories and experiences of not receiving care they expected, health care providers who talked at them and not to them, and not feelings understood by healthcare providers and staff.

Strategy: Collaborate on health promotion activities, health observances and other outreach/engagement strategies to increase awareness of adolescent health issues and preventive care and importance of medical homes.

Activity: Identify 1 high school or college in each MSDH District to provide education and referral resources about the importance of HPV vaccination.

Pike County Coordinating Nurse(CCN) participated in the Southwest MS Community College, Community Health Fair. The CCN focused on well visit screenings such as blood glucose and blood pressure. She provide information on the family planning and STD program.
Activity: Work with the Office of Communications to promote health observances and activities on the agency website and other media outlets.

Office of Communications posted two Facebook messages.

- Good sexual health habits, quitting smoking, and getting screened for early signs of possible cancer can make a big difference in your risk of cervical cancer. and vaccination against the virus that causes most cervical cancer dramatically reduces your risk if you receive vaccination in your teens. that's powerful prevention. find out more at msdh.ms.gov/cc #healthyWOMEN #healthyms (2,124 reaches)

- Did you know? teen PREGNANCY rates in the US remain high compared to other industrialized nations, with MS ranking among the highest. MSDH is dedicated to supporting young parents and reducing teen PREGNANCY through education and resources. #healthyms #healthcantwait (3,589 reaches)

Strategy: Educate transitioning youths and their families about accessing adult care, healthcare coverage options, health literacy and self-sufficiency skills.

Activity: Encourage parents and caregivers to share decision making responsibilities with their youth and teach them self-sufficiency skills

Through the MS Personal Responsibility Education Program (PREP) adolescents are empowered to make informed, responsible decisions about their health care, including about HPV. PREP partners with school districts and community-based organizations, to ensure that youth have access to reliable health information and enhance the long-term health and wellbeing of youth moving from adolescents to adulthood.

The CYSHCN program provide resources to internal and external partners about importance youth transitioning from pediatric to adult healthcare to ensure independence and development of self-awareness of personal health journey and navigating health systems. CYSHCN program ensures that children/youth enrolled in the CYSHCN program with MSDH, and partners have a SPoC and transition from pediatric to adult healthcare. These discussions begin no later than age 13. This includes information on the impact of diagnosed conditions, health insurance and options for care, availability of resources, e.g., transportation and/or food and assistance with caregivers understanding the importance of allowing the CYSHCN to schedule appointments and discuss diagnosed condition with the healthcare provider.

Priority: Increase Breastfeeding, Healthy Nutrition and Healthy Weight

Objective: By September 30, 2025, increase the percent of adolescents, ages 12-17 years who are physically active at least 60 minutes a day.

Strategy: Identify a School Health Champion at 1 high school or college in each MSDH District.

Activity: 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.

Due to the vacancy within the Office of Adolescent Health, this activity was not addressed.

Strategy: Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase daily physical activity among adolescents ages 12-17.

Activity: Work with Office of Communications to promote health observances and activities on the agency website and other media outlets

The CYSHCN program participated in health fairs and provided resources that encourage physical activity among teens, e.g., Sickle Cell walks.

The Office of Communications promoted physical activity on Facebook. Example:

- Move more, sit less! let's break the sedentary cycle and prioritize physical activity for a healthier lifestyle. whether it's a brisk walk, a workout session, or just stretching, every little bit counts toward better health. get up and get moving today! #tuesdaytip #healthyms (4,324 reaches)

Activity: Collaborate with MDE Offices of School Nutrition and Healthy Schools to provide promotional materials directly into school districts regarding benefits of physical activity among adolescents

Due to the vacancy within the Office of Adolescent Health, this activity was not addressed.

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: Present on best practices to promote daily activity for adolescents in at least one Grand Rounds Sessions during the year.

Due to the vacancy within the Office of Adolescent Health, this activity was not addressed.

Adolescent Health
Application Year FY2026

The following section outlines strategies and activities to be implemented between 10/1/2025-9/30/2026 to meet the objectives and show improvement on the measures related to adolescent health:

Priority: Improve Adolescent Health

Objective: *By September 30, 2030, increase access to timely, health, developmental, and behavioral health screenings performed among 13–20-year-olds in CHDs annually by 5%. (Baseline: 102)*

Strategy: Provide training and professional development to adolescents, school staff, partners, and providers to educate on adolescent health factors.

Activities:

(1) Partner with internal and external partners, school districts, and local health providers to educate adolescents, ages 13-20, on the available resources, benefits, transition, and health care coverage options.

(2) Collaborate with internal and external partners, school districts, and local health departments to host activities and community events focused on HPV vaccinations, mental health, teen pregnancy prevention, bullying, rape and sexual assault prevention, suicide, and other factors that negatively impact adolescent health.

Objective: *By September 30, 2030, reduce youth suicide attempts by 5% (baseline to target*

Objective: *By September 30, 2030, increase youth access to mental health resources by 5% (from BASELINE TBD to TARGET TBD).*

Strategy: Launch a Youth Mental Health Awareness campaign focused on mental health care.

Activities:

(3) Conduct presentations on suicide prevention awareness.

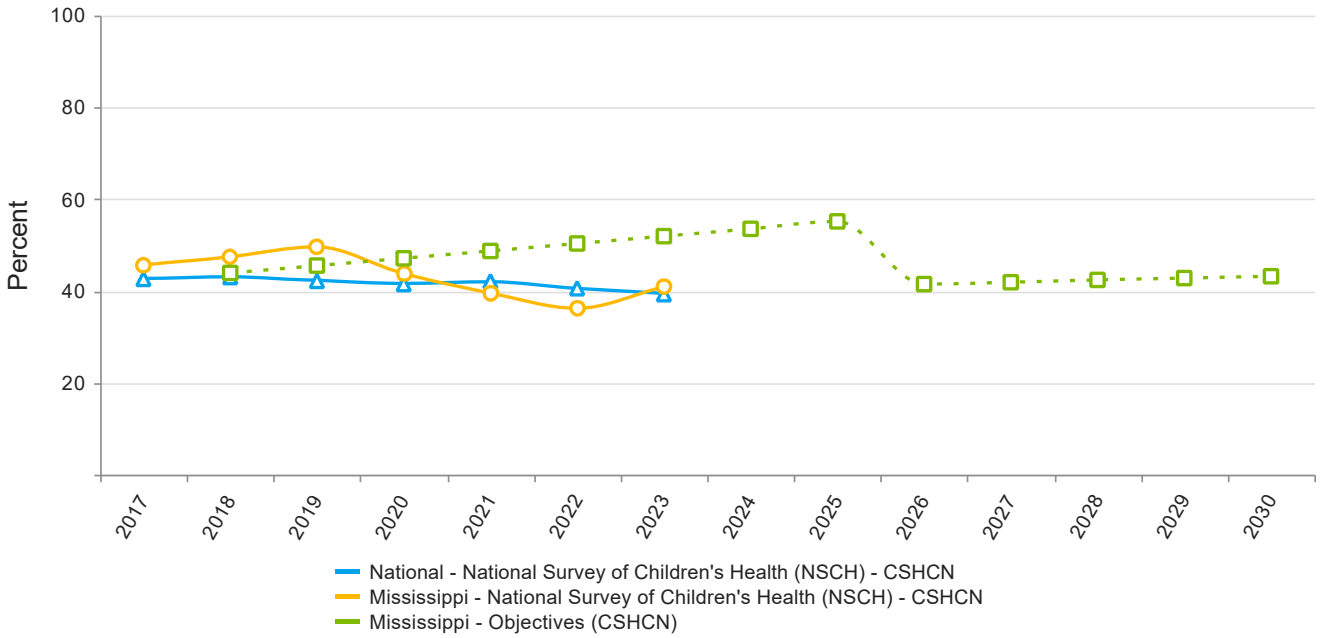
(4) Collaborate with community partners to increase the awareness of youth mental health care and suicide prevention awareness.

(5) Collaborate with the MSDH Office of Communications to create a social media campaign regarding the Youth Mental Health Awareness.

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 - MH Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	47.1	48.7	50.3	51.9	53.5
Annual Indicator	51.4	46.2	43.2	40.8	41.1
Numerator	82,086	72,719	68,226	64,583	86,541
Denominator	159,664	157,506	157,885	158,168	210,648
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	41.5	41.9	42.4	42.8	43.2

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:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	50	52	54	56	58
Annual Indicator	100	0	30	51	41
Numerator					
Denominator					
Data Source	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and insurance access.

Measure Status:	Active

Baseline data was not available/provided.

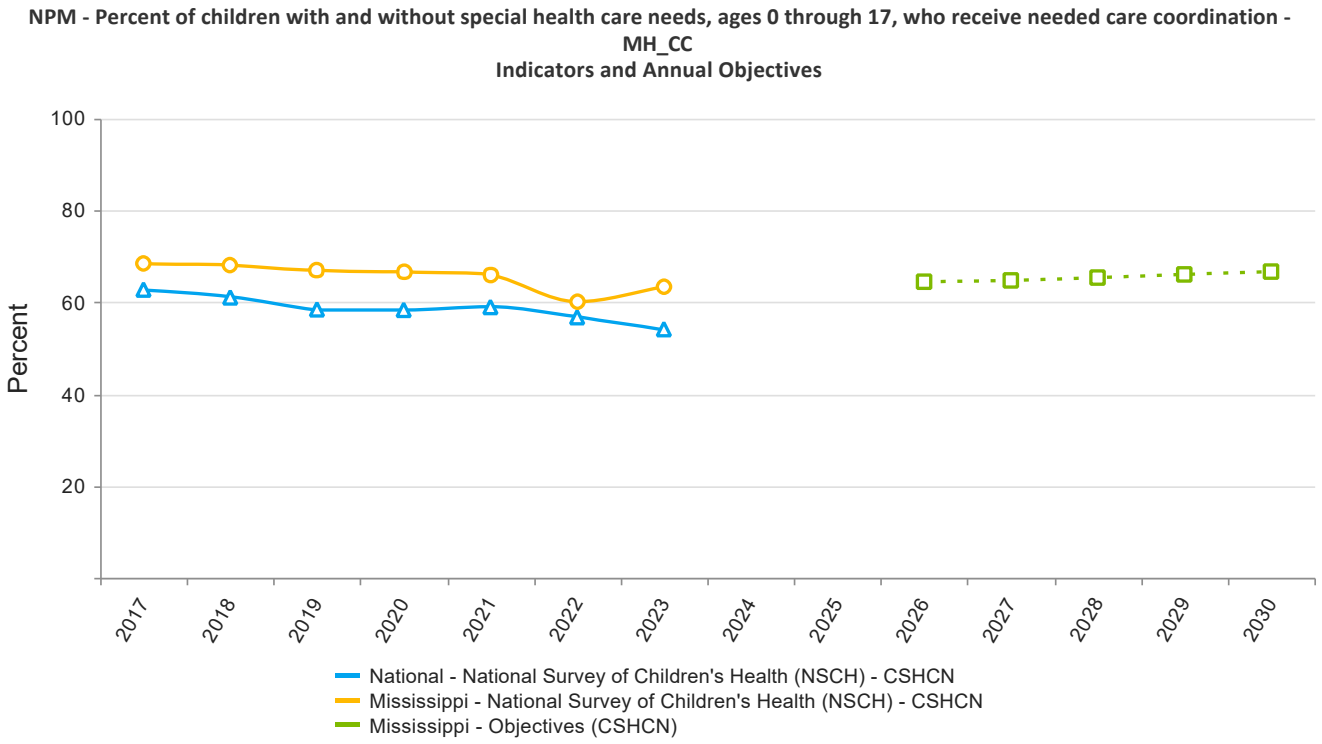
Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	20.0	40.0	60.0	80.0	100.0

ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months old in county health department clinics annually.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	3.3	3.3	3.4	3.4	3.4



NPM - Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination - MH_CC - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2024
Annual Objective	
Annual Indicator	63.4
Numerator	89,882
Denominator	141,746
Data Source	NSCH-CSHCN
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	64.4	64.7	65.3	66.0	66.6

Evidence-Based or –Informed Strategy Measures

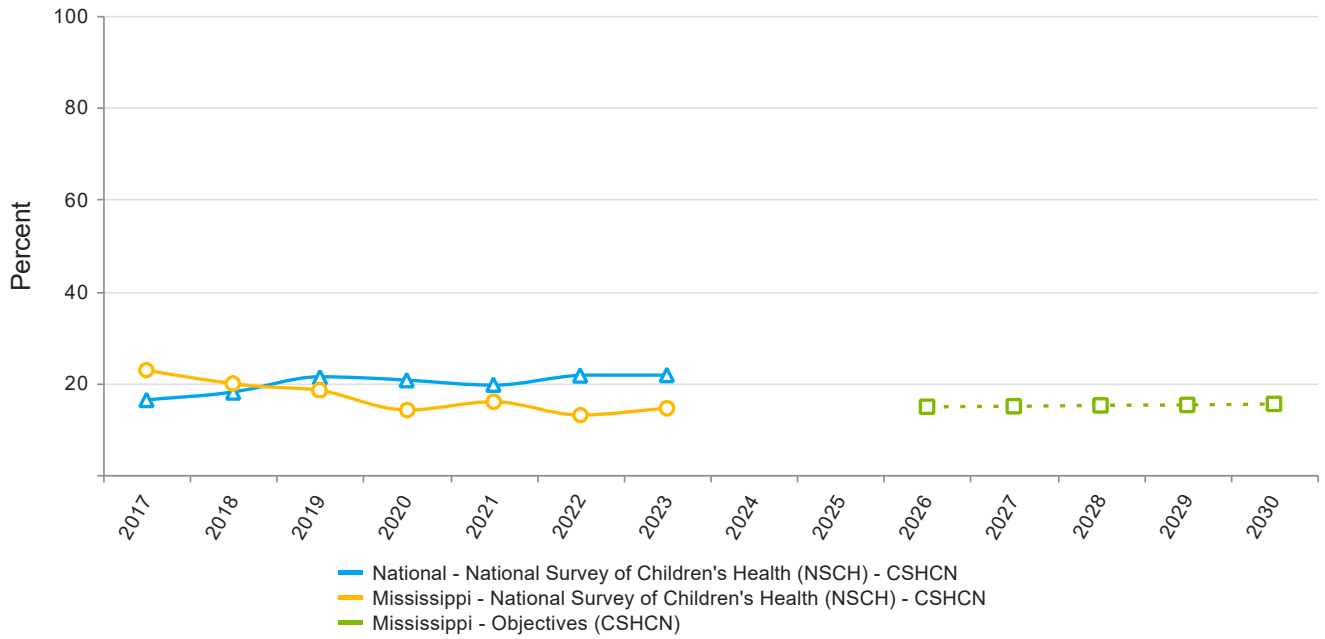
ESM MH_CC.1 - Percent of CYSHCN referrals who accept enrollment into CYSHCN care coordination program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	41.0	43.0	45.0	47.0	49.0

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC
Indicators and Annual Objectives



NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2024
Annual Objective	
Annual Indicator	14.7
Numerator	13,856
Denominator	94,082
Data Source	NSCH-CSHCN
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	14.9	15.0	15.2	15.3	15.5

Evidence-Based or –Informed Strategy Measures

ESM TAHC.1 - Percent of MSDH and external health care professionals/ providers who attend educational opportunities regarding health care transition for CYSHCN.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20.0	25.0	30.0	40.0	55.0

State Action Plan Table

State Action Plan Table (Mississippi) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Ensure a medial homes for CYSHCN	
NPM	
NPM - Medical Home; Medical Home_Care Coordination	
Five-Year Objectives	
By September 30, 2030, the percentage of CYSHCN who receive care coordination services will increase by 5%	
Strategies	
Strategy: Implement standardized population-based strategies to improve care coordination services for children with special health care needs.	
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	Inactive
ESM MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and insurance access.	Active
ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months old in county health department clinics annually.	Active
ESM MH_CC.1 - Percent of CYSHCN referrals who accept enrollment into CYSHCN care coordination program	Active
NOMs	
Children's Health Status	
CSHCN Systems of Care	
Flourishing - Young Child	
Flourishing - Child Adolescent - CSHCN	
Flourishing - Child Adolescent - All	

State Action Plan Table (Mississippi) - Children with Special Health Care Needs - Entry 2

Priority Need

Ensure a medial homes for CYSHCN

NPM

NPM - Transition To Adult Health Care

Five-Year Objectives

By September 30, 2030, the percentage of participating CYSHCN partnering healthcare systems with policies regarding transitioning youth with special health care needs to an adult provider will increase by 10%

Strategies

Strategy: Implement standardized population-based strategies to improve care coordination services for youth transitioning towards adult medical services

ESMs	Status
ESM TAHC.1 - Percent of MSDH and external health care professionals/ providers who attend educational opportunities regarding health care transition for CYSHCN.	Active

NOMs

CSHCN Systems of Care

State Action Plan Table (Mississippi) - Children with Special Health Care Needs - Entry 3

Priority Need

Ensure a medial homes for CYSHCN

NPM

NPM - Medical Home; Medical Home_Care Coordination

Five-Year Objectives

By September 30, 2030, the percentage of Parent Consultants and care coordinators, of a child with special health care needs who can help parents and caregivers navigate a comprehensive system of care (for medical and insurance access), hired by systems participating in the CYSHCN partnership will increase by 10%.

Strategies

Strategy: Increase the number of Parent Consultants and Care Coordinators involved in programs addressing the needs of children and Youth with special health care needs.

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	Inactive
ESM MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and insurance access.	Active
ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months old in county health department clinics annually.	Active
ESM MH_CC.1 - Percent of CYSHCN referrals who accept enrollment into CYSHCN care coordination program	Active

NOMs

Children's Health Status
CSHCN Systems of Care
Flourishing - Young Child
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

2021-2025: State Performance Measures

2021-2025: SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			67	77
Annual Indicator	46.9	40.4	40.8	58.1
Numerator	30	23	20	36
Denominator	64	57	49	62
Data Source	EPIC	EPIC	EPIC	EPIC
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

2021-2025: 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:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			341	375
Annual Indicator	310	272	291	199
Numerator				
Denominator				
Data Source	EPSDT Visits in EPIC	EPSDT Visits in EPIC	EPSDT Visits in EPIC	EPSDT Visits in EPIC
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Final	Final

2021-2025: SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			100	100

State Provided Data				
	2021	2022	2023	2024
Annual Objective			100	100
Annual Indicator	100	93.2	90	84.6
Numerator	60	2,722	72	77
Denominator	60	2,922	80	91
Data Source	Newborn Screening data	MS Newborn screening database and EPIC database	EPIC database	EPIC database
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

2021-2025: 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:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			17.2	18.2
Annual Indicator	16.2	15.4	12.4	15.3
Numerator	8,954	9,208	8,155	12,256
Denominator	55,176	59,681	65,978	80,013
Data Source	National Survey of Children's Health	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	2022-2023
Provisional or Final ?	Final	Final	Final	Final

CYSHCN Domain
Annual Report Year FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023-9/30/2024 to meet the objectives and show improvement on the measures related to CYSHCN:

PRIORITY: Assure Medical Homes for C/YSHCN

Objective: By September 30, 2025, increase the percentage of CYSHCN who receive care coordination services by 10%

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

Activity: Promote use of National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) with internal and external partners and other MCH home visiting programs for effective service delivery

Between October 2023 and September 2024, there were 739 CYSHCN referrals within MSDH. Through partnerships with the FQHCs and University of MS Medical Center, there were 19,661 families served.

The CYSHCN program ensures that every child enrolled receives a SPoC by collaborating with a multidisciplinary team to provide resources and support to complex, special needs children/youth and their families/ caregivers. The team provide appropriate education, resources to match the health literacy level, primary language, and culture of CYSHCN families/caregivers based on the referral and the intake assessment. They establish and implement a shared plan of care, assess transition readiness at age 12, develop transition plans, and emergencies plans in coordination with the CYSHCN, caregivers, and the primary care provider.

Strategy: Provide education to CYSHCN and families on the importance of medical homes, family-centered care, healthcare coverage options, and health literacy

Activity: Conduct monthly meetings with CYSHCN Care Coordinators, Parent Consultants and Specialty clinic partners about healthcare transition education for both CYSHCN and their caregivers.

Through the program, families and CYSHCN receive self-sufficiency training and information to assist with navigating health care system and community. In order to create greater independence and promote self-management skills, CYSHCN and caregivers are encouraged to participate in the development of a shared plan of care. This document assist the CSHCN in the navigation of the healthcare system by connecting/identifying all providers engaging with the CSHCN, locating other resources and supports as needed. Care Coordinators monitor the effectiveness of shared plan of care, observe CYSHCN/caregiver's adherence to shared care plans, and facilitate changes as needed.
The CYSHCN program partnered with the MCH Engagement and Coordination Office, Public Health Social Workers (PHSW), to address the staffing shortages among care coordinators. Through this collaboration, the team developed standard operating procedures and PHSW participate in a weekly meeting with the CYSHCN staff, reviewing standards, caseloads and review challenges for additional resources and support.

Strategy: Work with internal and external partners to increase referrals to home visiting/care coordination programs

Activity: Participate in health fairs and other outreach activities to inform public about home visiting and care coordination programs

The Care Coordinators maintain a CYSHCN/caregiver-centered approach with the CSHCN external partner clinics' multidisciplinary team. The CYSHCN Family Leader provides support to and collaborates with the CYSHCN Parent Consultants in the CYSHCN FQHCs. As a result of the outreach and partnerships with other children/youth supporting entities, an increase opportunity exists to identify CYSHCN within the healthcare system. All families engaged in the CYSHCN systems complete an intake assessment that can aid the family/caregiver with identifying specific needs and concerns.

Through partnerships with other organizations, the CYSHCN program participated in the following community activities to inform the public about the program:

- April 27, 2024: West Point Walk, West Point, MS
- May 21, 2024: EMS Event at Trade Mart
- May 21-23, 2024: MSDH Genetics Newborn Screening & Regional Education & Skills Training Event, Columbus, MS
- June 5, 2024: Health & Wellness Fair, Vicksburg, MS
- June 15, 2024: Springhill's Health Fair, Raymond, MS
- June 24, 2024: Junior Auxiliary of McComb, MS
- June 26, 2024: Community Resource Event, Richland, MS
- August 23-24, 2024: Omega Psi Phi Fraternity State Meeting, Tupelo, MS

Objective: 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

Activity: Share National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) with internal and external partners and other MCH home visiting programs

National Care Coordination Standards are provided to care coordinators to ensure that children enrolled in the program receive a SPoC by collaborating with a multidisciplinary team to provide resources and support to the complex, special needs of children/youth and their families/caregivers. The standards provide care coordinators with 1)Tools that aid them in identifying and assessing transitional needs from pediatric to adult medical care, as well as post-secondary transition planning; 2)Guidelines to address assessing the home & community needs; and 3)Provide the appropriate education, resources to match the health literacy level, primary language, and culture of families/caregivers based on the referral and the intake assessment. This process is reflected in the establishment and implementation of shared plans of care, transitioning plans, and emergency plans in coordination with the CYSHCN, caregivers, and the primary care provider. Care Coordinators routinely update plans and promote adherence to plans to facilitate positive outcomes. They support CYSHCN within the health care system and community. Collaborate with MSDH regional care coordinators to conduct home visits.

Strategy: Educate transitioning youths with special health care needs and their families on accessing adult care, healthcare coverage options, health literacy, and self-sufficiency

Activity: Provide education to young adults on healthcare coverage options and coverage literacy

Activity: Encourage parents and caregivers to share decision making responsibilities with CYSHCN and teach self-sufficiency skills

Care Coordinators ensure that children/youth enrolled in the program with MSDH and partners have a SPoC and transition from pediatric to adult healthcare discussions begin no later than age 13. This includes information regarding the impact of diagnosed conditions, health insurance and options for care, availability of resources, e.g., transportation, food and assistance with caregivers understanding the importance of allowing the CYSHCN to schedule appointments and discuss diagnosed condition with the healthcare provider.

CYSHCN Domain
Application Year FY2026

The following section outlines strategies and activities to be implemented between 10/1/2025-9/30/2026 to meet the objectives and show improvement on the measures related to CYSHCN:

Priority: Ensure a medial homes for CYSHCN

Objective: *By September 30, 2030, the percentage of CYSHCN who receive care coordination services will increase by 5%*

Strategy: Implement standardized population-based strategies to improve care coordination services for children with special health care needs.

Activities:

(1) Collaborate with internal and external stakeholders to operationalize referrals to the program.

(2) Engage and collaborate with internal and external partners to facilitate continuous quality improvement and use of best practices to identify impediments regarding patient enrollment

Objective: *By September 30, 2030, the percentage of participating CYSHCN partnering healthcare systems with policies regarding transitioning youth with special health care needs to an adult provider will increase by 10% (from BASELINE TBD to TARGET TBD).*

Strategy: Implement standardized population-based strategies to improve care coordination services for youth transitioning towards adult medical services

Activities:

(3) Develop a Title V CYSHCN Health Care Transition training to increase the knowledge of CYSHCN Care Coordinators regarding a) the age to begin transitional services; b) what is included in transitional care coordination services; c) development of the transitional care plan; and d) annual review of the transitional care plan.

(4) Establish protocols and policies for transitioning youth with special health care needs to adult care and adulthood.

(5) Implement the Title V CYSHCN Health Care Transition training.

Objective: *By September 30, 2030, the percentage of Parent Consultants and care coordinators, of a child with special health care needs who can help parents and caregivers navigate a comprehensive system of care (for medical and insurance access), hired by systems participating in the CYSHCN partnership will increase by 10%. (from BASELINE TBD to TARGET TBD).*

Strategy: Increase the number of Parent Consultants and Care Coordinators involved in programs addressing the needs of children and Youth with special health care needs.

Activities:

(6) Develop professional development for Parent Consultants to support other families in navigating the comprehensive health care system.

(1) Implement the professional development offering.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Percentage of referrals received by MSDH MCH-serving programs that are on the on-line Universal Referral Form.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5.0	5.0	6.0	6.0	6.0

Evidence-Based or –Informed Strategy Measures

None

SPM 2 - Number of community-based activities attended where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	13.0	14.0	15.0	16.0	17.0

Evidence-Based or –Informed Strategy Measures

None

SPM 3 - Number of social media messages focused on MCH-serving programs per year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	105.0	110.0	115.0	120.0

Evidence-Based or –Informed Strategy Measures

None

SPM 4 - The total number of referrals for social conditions affecting the health of patients being served by the MSDH county health department clinics

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	166.0	167.0	169.0	171.0	172.0

Evidence-Based or –Informed Strategy Measures

None

SPM 5 - Percentage of MSDH MCH-Serving programs that have administered a patient satisfaction survey in the past year to engage the community in program improvement

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	50.0	65.0	75.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Mississippi) - Cross-Cutting/Systems Building - Entry 1	
Priority Need	
Increase access to timely, health, developmental, behavioral health screenings	
SPM	
SPM 4 - The total number of referrals for social conditions affecting the health of patients being served by the MSDH county health department clinics	
Five-Year Objectives	
By September 30, 2030, increase the number of referrals for social conditions affecting maternal, infants, children, adolescents and CYSHCN by 5%. (from BASELINE TBD to TARGET TBD).	
Strategies	
Strategy: Build a responsive infrastructure and workforce to address a range of health-related and social conditions affecting the needs of women, infants, children, adolescents, and CYSHCN identified through developmental and other screening.	
ESMs	Status
No ESMs were created by the State. ESMs are optional for this measure.	

State Action Plan Table (Mississippi) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations

SPM

SPM 5 - Percentage of MSDH MCH-Serving programs that have administered a patient satisfaction survey in the past year to engage the community in program improvement

Five-Year Objectives

By September 30, 2030, completed the published reports 100% per their assigned periodicity.

Strategies

Strategy: Title V will maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Mississippi) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Improve Access to and Utilization of MCH-serving programs and activities available through MSDH

SPM

SPM 3 - Number of social media messages focused on MCH-serving programs per year

Five-Year Objectives

By September 30, 2030, increase the percent of referrals MCH-serving programs receive using the on-line Universal Referral form by 20% (from BASELINE TBD to TARGET TBD). (4% annually)

Strategies

Strategy: Title V will strengthen the relationships with internal and external partners and the community to increase referral to MCH-serving program.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Mississippi) - Cross-Cutting/Systems Building - Entry 4

Priority Need

Improve Access to and Utilization of MCH-serving programs and activities available through MSDH

SPM

SPM 2 - Number of community-based activities attended where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form

Five-Year Objectives

By September 30, 2030, increase the percent of referrals MCH-serving programs receive using the on-line Universal Referral form by 20% (from BASELINE TBD to TARGET TBD). (4% annually)

Strategies

Strategy: Title V will strengthen the relationships with internal and external partners and the community to increase referral to MCH-serving program.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Mississippi) - Cross-Cutting/Systems Building - Entry 5

Priority Need

Improve Access to and Utilization of MCH-serving programs and activities available through MSDH

SPM

SPM 1 - Percentage of referrals received by MSDH MCH-serving programs that are on the on-line Universal Referral Form.

Five-Year Objectives

By September 30, 2030, increase the percent of referrals MCH-serving programs receive using the on-line Universal Referral form by 20% (from BASELINE TBD to TARGET TBD). (4% annually)

Strategies

Strategy: Title V will strengthen the relationships with internal and external partners and the community to increase referral to MCH-serving program.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

2021-2025: State Performance Measures

2021-2025: SPM 19 - Adolescent suicide rate

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			11.3	11
Annual Indicator	11.6	10.8	8.7	6.3
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	Office of Vital Records and Public Health Statisti
Data Source Year	2017-2019	2021	2022	2023
Provisional or Final ?	Final	Provisional	Provisional	Provisional

2021-2025: SPM 20 - Number of MCH programs that have developed a written plan to address health equity

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			3	6
Annual Indicator	1	3	3	4
Numerator				
Denominator				
Data Source	MCH program data	MCH program data	MCH program data	MCH program data
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

Cross Cutting
Annual Report Year FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023 to 9/30/2024 to meet the objectives and shows improvement on the measures to cross cutting issues:

Priority: Improve Access to Mental Health Services Across MCH Populations

Objective: By September 30, 2025, reduce the percentage of suicide attempts among high school students by 1%.

Strategy: Promote, provide, sponsor, or facilitate education, training, and reflective supervision on mental health for MCH workforce, partners, and providers serving MCH populations.

Activity: Identify and share professional development opportunities for supporting the mental health of children, youth, and young adults on the MCH Workforce Development Training Calendar.

The MCH Workforce Development Training Calendar is be reviewed for revisions. To promote awareness of professional development opportunities within MSDH and around the state, the MCH Engagement and Coordination office houses an “opt-in” listserv for professionals. Through this listserv, which has grown to 620 participants internal and external to MSDH, professional receive notifications about different professional development events.

From the summer 2024 MCH Engagement and Coordination Survey, staff indicated the need for free continuing education hours. To meet this need, the MCH Engagement and Coordination Office began a regular monthly “lunch and learn” series for internal MSDH Social Workers, providing free Social Work Continuing Education (SW CE) Hours. Other professions which attend are able to receive a certificate of participation/attendance to submit to their professional board as needed. Starting January 2025, this will be opened to any social workers within Mississippi to participate.

MSDH hosts a monthly “MSDH Grand Rounds” open to all staff (in-person and virtually). The purpose of this monthly meeting is to increase skills capacity and provide information to others about projects occurring in different program areas. Titles include: Using Evaluation Data to Enhance Program Implementation; Cervical Cancer: What You May Not Know: Evaluating Trends in Hypertension Reduction; Loneliness and Depression among adults living on MS Gulf Coast; Informatics and Analytics: Driving Innovation in a Data-Driven World; MS Health Canvas: Painting Progress through Pharmacy Resident Insights on HIV, Tuberculosis and Naloxone; MSDH Data Governance 101; Project Management Tips for Researchers; Community Health Improvement Across the Lifespan.

Once a year the Health Data, Operations and Research and Prevention Health team hosts a “Epidemiology, Evaluation, and Research Meeting” to highlight work by the various staff members. MCH population focused presentations included: Data support for programs within the Bureau of Community and School Health; MS Quitline/Baby & Me; an Overview of the Office of Health Data Research programs and projects with Health Services; Early Hearing Detection and Intervention data; Oral Health data; MS Lead Poisoning Prevention and Healthy Homes Program data; Breast and Cervical Cancer data; Vital Records Reporting on Births, STIs and Mortality; CSTE presentation on Perinatal Periods of Risk.

Activity: 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.

Throughout the 2023-2024 program year, Health Service staff continued participation 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 sections each month across a year. At the completion of the training, successful participants earned the national Infant Family Specialist credential. To build capacity, four MCH staff members, including Early Intervention Service Coordinator Coaches and experienced Master Level 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.

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 in danger of organizational placement.

The statewide MS Making a Plan (MAP) Teams are made up of local community members, who work with children and youth. A Public Health Social Service Director represents the agency on the MAP Team in the Northwest part of the state, covering Tallahatchie, Bolivar, Leflore, Sunflower, and Washington counties. She attended their monthly meetings, providing input regarding health department and local resources. They review cases concerning children and youth (up to age 21 years of age) with serious emotional disturbances/serious mental illnesses, who require support and services from various agencies and providers. The collectives works to identify resources within the community to meet their needs. Other community partners who sit on this MAP Team include but not limited to: Head Start, Mid-State Opportunity, school district members, community center partners, and business members.

Objective: 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 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 (MAM) for a one-stop website and mobile app.

No steps were taken to address this activity during the time period.

HM/HB collaborates with these medical systems and community organizations to ensure timely identification of risks and referrals to HM/HB. HM/HB educates the enrolled families and supports for their care with other institutions.

Health Service programs partner together for early identification of children who may meet criteria for multiple Health Service Programs. Using a universal referral form, programs are able to refer families to internal services. External partners and families may also use the universal referral from to refer to multiple health service programs at one time.

Activity: 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.

Healthy Start participated in the Mujeres unidas, hosted by El Pueblo Organization to establish stronger connections with the Hispanic community.

Various health service programs and county level staff participate in community events in order to promote access to service provided by MSDH.

Outreach by County Level Community Health Workers and nurses:

- 10/11-10/12/2023- Community Health Fair-Mental Health Awareness and Teen Empowerment Summit-Discussed services provided at the CHD (FPW applications and handouts given, BCCP brochure), HPV vaccines, and EPSDT. 100 attended.
- 10/18/2023-Community Health at Columbus Housing Authority-Discussed services provided at the CHD, 75 attended.
- 10/31/2025-Philadelphia Police Department Trick Or Treat –handed out oral care kits and HPV buttons.
- 11/29/2023- Visited 2 clinics in Oktibbeha County-reviewed with staff their services provided at the CHD, immunization schedule, and discussed assisting with family planning waiver applications
- 12/8/2023-Healthy Heart Ambassador Program -Self Monitored Blood Pressure & Nutrition Education in Aberdeen MS- discussed services provided at the CHD; 100 attended
- 1/18/2024- North Forest Housing Complex (Monroe County)-Discussed services provided at CHD (FPW applications and handouts given, BCCP brochure).
- 2/2/2024- Community Counseling Youth (Winston County)-Discussed HPV vaccine and handouts given. Family planning brochures given.
- 3/21/2024- Workshop at Prairie Opportunity in Clay county- Family planning and BCCP brochures given as

well as FP waiver applications- 75 attended

- 7/26/2024-Health Fair at Christian Hill Church- Family planning brochures, HMHB handouts, and BCCP brochures provided; 50 attended.
- 8/22/2024- Health Fair at Sportsplex in Starkville, MS- Family planning and BCCP brochures given; 150 attended
- 9/14/2024- Health Fair in Lowndes County-Family planning, immunization schedule, BCCP brochures given; 200 attended.
- 9/25/2024- Health Fair in Winston County-Family planning, immunization schedule, BCCP brochures given; 100 attended.

Objective: By September 30, 2025, community with health care professionals, service providers and families to address language needs across MCH programs.

Strategy: Use language, images, graphics, and messaging that is responsive to health literacy.

Strategy: Translate program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information.

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 different populations.

Activity: Submit work request to the Office of Communications to ensure all educational materials, guidance, and resources for families are translated.

The MSDH WIC Program, Genetic Services Bureau, and CYSHCN program translated health education materials into Spanish and Vietnamese. HM/HB and Healthy Start programs translated brochures into Spanish.

MSDH staff have access to a language line and interpretation services when addressing the needs of deaf and hard of hearing clients and family members. Healthy Start program partners with the El Pueblo Organization for bilingual community health workers.

Objective: By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities to support providers in implementing appropriate practices in their healthcare settings.

Strategy: Educate MCH workforce, partners, and providers on appropriate practices in healthcare settings.

Activity: In partnership with TeenHealth MS, distribute training for the MCH workforce on teen-friendly care for populations experiencing challenges in health care.

MSDH with Teen Health Mississippi, conduct maternal health focus groups focused on engaging Mississippi woman who are a)African American, b)between the ages of 15-44, c)recently pregnant (between 2020 to 2024) about their experiences accessing healthcare before, during and after pregnancy. Twelve focus groups were conducted via zoom, with 107 people participating. They shared several stories and experiences of not receiving care they expected, health care providers who talked at them and not to them, and not feelings understood by healthcare providers and staff.

Office of Oral Health dental referral program. Dental Lifeline Network.(DLN) DDS program. This program helps individuals with impairments/developmental delays or who are elderly or medically fragile and cannot afford or otherwise access treatment for severe dental conditions. As a result of their ages or impairments/developmental delays, they cannot work and depend on government assistance for health care. During this grant period, DLN received funding as a sub-grantee from a partnership between the Office of Health Equity and the Office of Oral Health to fund a dental coordinator. The results during the fiscal year were 80 people served and generated $179,655 in donated treatment (including $17,367 in laboratory fabrications) by 195 volunteer dentists recruited 34

labs.

Strategy: Conduct PDSA cycles to improve systems, programs, and outcomes, to decrease health care obstacles.

Activity: Analyze program data on enrollments and/or service utilizations to identify areas or populations of need to be addressed collectively through program improvement or development.

Due to staff transitions, this activity went upstream to trainings before implementation. The MSDH Quality Improvement (QI) Office provides a QI process training to all staff to introduce the general benefits and reasoning behind quality improvement, provides the introduction of 11 analytical tools and hands-on collective activities. During the reporting period, 40 staff participated in QI Introduction Training and 33 participated in QI Intermediate Training.

The FP central and regional office teams maintained weekly Zoom meetings to address program challenges, review policy and procedural updates, and focus on quality improvement and service delivery throughout CY2023 and CY2024. The program continues to offer training resources to providers and communities to promote reproductive health, responsible decision-making, and the prevention of unintended pregnancies. Training on FPW eligibility criteria, the application process, and program services remain ongoing, with special attention given to onboarding new staff members.

According to the Joint Committee on Infant Hearing (JCIH) 2019 Position Statement, infants with a neonatal intensive care unit (NICU) stay of more than five days are considered susceptible for hearing loss and should be reported to the Early Hearing Detection and Intervention (EHDI) Program. These infants are at increased risk for auditory complications due to factors such as exposure to ototoxic medications, mechanical ventilation, or other medical complexities. Within this collective, many infants experience NICU stays of 10 days or more, which automatically qualifies them for an evaluation through the Mississippi First Steps Early Intervention Program, regardless of hearing status. Despite this eligibility, not all hospitals were consistently referring these qualifying infants for evaluation.

To address this gap, the EHDI Program launched an informal quality improvement project to ensure that NICU babies with a stay of 10 days or more—who were not being referred by hospitals—were identified and referred directly by EHDI to Mississippi First Steps for early intervention evaluation. As a result of this initiative, between May 1, 2024, and September 30, 2024, EHDI referred 222 NICU infants for evaluation. Many of these babies may not have received timely access to Early Intervention services if not for the proactive efforts of the EHDI Program. This project reflects EHDI's commitment to ensuring that all eligible infants are connected with developmental support services as early as possible to improve their long-term outcomes.

Cross Cutting
Application Year FY2026

The following section outlines strategies and activities to be implemented between 10/1/2025-9/30/2026 to meet the objectives and show improvement on the measures related to cross cutting:

Priority: Improve Access to and Utilization of MCH-serving programs and activities available through MSDH

Objective: *By September 30, 2030, increase the percent of referrals MCH-serving programs receive using the on-line Universal Referral form by 20% (from BASELINE TBD to TARGET TBD). (4% annually)*

Strategy: Title V will strengthen the relationships with internal and external partners and the community to increase referral to MCH-serving program.

Activities:

(1) Create and disseminate to identified internal and external partners a baseline survey regarding the use of the Universal Referral form's.

(2) Collaborate with the Office of Communications to Promote the use of the Universal Referral Form

(3) Promote MCH messaging using social media, MSDH websites and other platforms; related to prevention and health issues for women, infant, adolescent, children and CYSHCN. Topics are to include but not limited to: childhood immunizations, EPSDT, FSEIP, LPPHH, EHDI, car seat safety, child passenger safety, safe sleep, dental health, family planning / reproductive health services, breastfeeding, mental health, health observance months, days, and activities for women, infants, children, adolescents and CYSHCN.

(4) Translate brochures into various languages to meet the changing needs to the MS population.

(5) Identify which Making A Plan (MAP) teams across the state need a representative from MSDH – working to identify a MSDH staff member to take part.

(6) Promote MCH-serving program referrals through community-based activities across the state.

Priority: Maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations

Objective: By September 30, 2030, completed the published reports 100% per their assigned periodicity.

Strategy: Title V will maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations.

Activities:

(1) Address MCH data capacity by increasing data collaborations
   a. Create a data catalog of internal MCH data capacity and disseminate among the various MCH-serving programs
   b. Identify missing MCH data, and identify sources where this data may be available
   c. Begin collaborative conversations with external partners regarding the sharing of MCH data.

(2) Address MCH data capacity through ongoing needs assessment activities
   a. Distribution of a MSDH Title V workforce Health Service survey
   b. Development of survey for external partners regarding their ongoing recommendations for MCH-serving programs.
      B1. Distribution of survey to external partners regarding their ongoing recommendations for MCH-serving programs.
   c. Quality Improvement pilot with the Child Death Review team and coordinator to examine data collection sources and systems to identify areas for improvement in case abstraction.

(3) Address MCH data capacity through program evaluations
   a. Create a patient satisfaction evaluation
   b. Pilot with two different MCH-serving programs (patient satisfaction evaluation)

c. Analyze the data, identify needed changes, and disseminate again in other MCH-serving programs.

Priority: Increase access to timely, health, developmental, behavioral health screenings

Objective: *By September 30, 2030, increase the number of referrals for social conditions affecting maternal, infants, children, adolescents and CYSHCN by 5%. (from BASELINE TBD to TARGET TBD).*

Strategy: Build a responsive infrastructure and workforce to address a range of health-related and social conditions affecting the needs of women, infants, children, adolescents, and CYSHCN identified through developmental and other screening.

Activities:

(1) Operationalize processes and activities for referrals, from MCH-serving programs and CHD regarding social conditions impacting health, for Public Health Social Workers and other social support teams within MSDH to provide services.

(2) Partner with community organizations to address broader health issues affecting maternal/ infant/child/ adolescent well-being.

(3) Partner with community organizations in workshops and community events to promote public health programs and screenings to include but not limited to: childhood immunizations, EPSDT, FSEIP, LPPHH, EHDI, car seat safety, child passenger safety, safe sleep, dental health, family planning / reproductive health services, breastfeeding, and mental health.

(4) Pilot an appointment card to find out if participants in the community event follow up for services.

III.F. Public Input

Public Input

The Mississippi MCH Title V Program has implemented various mechanisms to solicit 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.

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: 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, MCH Block Grant and programs in Mississippi. Take a moment to share your comments, ideas, and concerns with us.” Submissions 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 2024 reporting year, there were 145 hits to the State Title V website. In addition, Health Service Programs provided the following language on their webpage: For more information about the Maternal and Child Health Programs and MCH Block Grant, call 1-800-721-7222.” In reporting year of 2024, the 1-800-721-7222 number received 73 calls.

Through these approached, 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 to restructure, the following technical assistance is desired to strengthen the agency and MCH programs:

MCH Finances

The MSDH Title V/MCH Program has had some difficulty tracking MCH finances and compiling match dollars as these funds are recorded on multiple budgets throughout the agency. Our state accounting system, MAGIC, does provide timely reports on expenditures; however, the system does not currently have coding allowing the sensitive disaggregation funding as needed for new report requirements easily. Further, give 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-matching funds.

General Knowledge of Title V/MCH Block Grant

Over the past few years, the Division of Health Services has had a turnover of staff. With this turnover, knowledge regarding the Title V/MCH Block Grant report and mechanisms have lessened. Our team and MSDH partners needs some fundamental professional development regarding the Title V/MCH Block Grant, NOM, NPM, ESM, types of services (direct, enabling, infrastructure) and use of TVIS.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Division of Medicaid and other MSDH Agreements (Full Document).pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MS Sup Doc 1 - attachment of Regional and Program Maps FY25.doc.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MS_OrgChart_FY26.doc.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Mississippi

	FY 26 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,765,660	
A. Preventive and Primary Care for Children	$ 2,929,698	(30%)
B. Children with Special Health Care Needs	$ 2,929,698	(30%)
C. Title V Administrative Costs	$ 976,566	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,835,962	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,263,759	
5. OTHER FUNDS (Item 18e of SF-424)	$ 6,050,486	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 10,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 7,324,245	
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)	$ 17,089,905	
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)	$ 14,598,724	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 31,688,629	

OTHER FEDERAL FUNDS	FY 26 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)	$ 438,784
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 500,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 4,226,953
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 106,220
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 4,739,894
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 22,190
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 351,005
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)	$ 418,678
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Mississippi ERASE MM Program	$ 495,000

	FY 24 Annual Report Budgeted		FY 24 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,305,490 (FY 24 Federal Award: $ 9,765,660)		$ 9,765,660	
A. Preventive and Primary Care for Children	$ 2,791,647	(30%)	$ 3,187,490	(32.6%)
B. Children with Special Health Care Needs	$ 2,791,647	(30%)	$ 2,968,820	(30.4%)
C. Title V Administrative Costs	$ 930,549	(10%)	$ 887,788	(9.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,513,843		$ 7,044,098	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0		$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,053,440		$ 2,504,193	
5. OTHER FUNDS (Item 18e of SF-424)	$ 5,525,678		$ 4,820,052	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 400,000		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 6,979,118		$ 7,324,245	
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)	$ 16,284,608		$ 17,089,905	
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)	$ 106,139,568		$ 22,886,029	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 122,424,176		$ 39,975,934	

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 300,000	$ 157,413
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 435,947	$ 359,670
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	$ 1,588,366
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 52,446
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 92,418,687	$ 15,593,481
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	$ 3,173,300
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	$ 225,592
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	$ 631,963
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 711,463	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program		$ 217,127
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start		$ 722,152
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program		$ 154,810

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)		$ 9,709
US Department of Education > Office of Special Education Programs > Individual with Disabilities Education Act/American Rescue Plan Act of 2021	$ 2,082,894	$ 0

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Budget amount is based on was awarded prior year	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Budget based on prior year award. These funds are budgeted to MCH Block Grant Child Health Grant # 11625 Internal order 3000038712 B51P	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Budget based on prior year award. These funds are budgeted to MCH Block Grant Child Health Grant # 11626 Internal order 3000038713 C51P	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Budget base on total expenditure budgeted 10% which is administer by our Finance and Accounting Department	
5.	**Field Name:**	**2. Subtotal of Lines 1A-C**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: This total does not include Pregnant Women and All other	
6.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2026**

	Column Name:	**Application Budgeted**
	Field Note: No State funds was budgeted	
7.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: 003S Local County offices Funds This is a cumulative total of all counties each county is responsible for budgeting and spending of their funds generated.	
8.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: 08PS Perinatal Risk Management (Medicaid) reimbursement % 007S Genetic Screening Fees (NewBorn Screening Fees) %	
9.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: 059S EPSTDT Screening & Follow-up Fees	
10.	**Field Name:**	**7. TOTAL STATE MATCH**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Total amount of funds us in matching for the MCH Block from state generated funds	
11.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**

	Field Note: Total amount awarded this grant period	
12.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Total amount expended on grant # 10721 Internal order # 3000035714 MCH Child Health	
13.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Total amount expended on grant # 10722 Internal order # 3000035715 MCH Children w/special Health Care need	
14.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Based on expenditures spent on the 3 programs calculated and charged by Office of Finance and Accounting %10 admin fee	
15.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: No State funds was used	
16.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: These are funds that are generated and expended out in the local county Office 003S Local Funds Grant # 5399 Internal Order # 3000021377 Health Dept also receive funds from each of the local county base on population and appropriation per capital. The combined total for all counties is $5,561,802 these amounts are not used in the formular for our match.	
17.	**Field Name:**	**5. OTHER FUNDS**

	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Funds expended using 007S (Genetic Screening Fees) $3,727,712 and 08PS (Perinatal Risk Management Medicaid) funds $1,627,901. A combined total of 90% to these funds	
18.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: No EPSDT Screening & Follow-up expenditures was used in the matching total	
19.	**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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Mississippi Breast, Cervical, and Other Cancer Control Program Award # NU58DP007129 Budget Period 9/30/2024 thru 6/29/2025 Assistance Listing Number 93.898 068O	
20.	**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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Mississippi Breast, Cervical, and Other Cancer Control Program Award # NU58DP007129 Budget Period 9/30/2024 thru 6/29/2025 Assistance Listing Number 93.898 B68O	
21.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**

	Field Note: Mississippi WISEWOMAN Program Award # NU58DP007661 Budget Period 9/30/2024 thru 9/29/2025 Assistance Listing Number 93.436 296N	
22.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Healthy Start Initiative Award # H49MC52119 Budget Period 9/30/2024 thru 9/29/2025 Assistance Listing Number 93.926 293N	
23.	**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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Maternal, Infant and Early Childhood Home Visiting Grant Program Award # X10MC50310 Budget Period 9/30/2023 thru 9/29/2025 Assistance Listing Number 93.870 282N	
24.	**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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Universal Newborn Hearing Screening and Intervention Award # H61MC00052 Budget period 4/1/2025 thru 3/31/2026 Assistance Listing Number 93.251 055P	
25.	**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:	**2026**

	Column Name:	**Application Budgeted**
	Field Note: Infant, Toddlers & Families (Part C) Award # H181A230034 7/1/2023 - 9/30/2025 Assistance # 84.181A	
26.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Mississippi State System Development Initiative Award # H18MC00027 Budget Period 12/1/2024 thru 11/30/2025 Assistance Listing Number 93.110 005P	
27.	**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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Alliance for Innovation on Maternal Health State Capacity Program Award # A30MC49995 Budget Perion 9/1/2024 thru 8/31/2025 Assistance Listing Number 93.110 298N	
28.	**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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: MS Lead Poisoning Prevention and Healthy Homes Award # NU2EH001427 Budget Period 9/30/2024 thru 9/29/2025 Assistance Listing Number 93.197 077O	

29.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Mississippi ERASE MM Program**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Mississippi ERASE MM Program Award # NU58DP007815 Budget Period 9/30/2024 thru 9/29/2025 Assistance Listing Number 93.946	
30.	**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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 5/30/2025 Mississippi ERASE MMR (212N) Award # NU58DP007815 Assistance Listing Number 93.946 As of 5/30/2025	
31.	**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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 5/30/2025 NCCCP (B68O) Award # NU58DP007129 Assistance # 93.898 As of 5/30/2025	
32.	**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:	**2024**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures as of 5/30/2025 NBCCEDP (068O) Award # NU58DP007129 Assistance # 93.898 As of 5/30/2025	
33.	**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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 5/30/2025 Newborn Screening (055P) Award # H61MC00052 Assistance # 93.251 As of 5/30/2025	
34.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures as of 5/30/2025 WIC Various # Assistance # 10.557 as of 5/30/2025	
35.	**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:	**2024**
	Column Name:	**Annual Report Expended**

	Field Note: Infant & Toddlers/Families (Part C) Award # H181A220334 Budget Period 7/1/2023 - 9/30/2025 Assist # 84.181A RPTG 004P As of 5/30/2025	
36.	**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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: MS Lead Poisoning Prevention and Healthy Homes Award # 5 NUE2EH001427-04 Assistance # 93.197 Budget Period 9/30/2024 thru 9/29/2025 RPTG 007O 11629 As of 5/30/2025	
37.	**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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: MIECHV Award # 6 X10MC50310 Assistance # 93.870 Budget Period 9/30/2023 - 9/29/2025 282N 11540 As of 5/30/2025	
38.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program**
	Fiscal Year:	**2024**

	Column Name:	**Annual Report Expended**
	Field Note: Mississippi WISEWOMEN Program Award # NU58DP007661 Budget Period 9/30/2024 - 9/29/2025 Assistance # 93.436 296N 11716 as of 5/30/2025	
39.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Healthy Start Initiative Award # H49MC52119 Budget Period 9/30/2024 - 9/29/2025 Assistance # 93.926 296N 11417 As of 5/30/2025	
40.	**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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: AIM Award # A30MC49995 Assistance # 93.110 Budget Period 9/1/2024 8/31/2025 298N 11633 As of 5/30/2025	
41.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**

	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: MS State Systems Development Initiative Award # H18MC00027 Budget Period 12/01/2024 - 10/30/2025 Assistance # 93.110 005P 11653 As of 5/30/2025	
42.	**Field Name:**	**Other Federal Funds, US Department of Education > Office of Special Education Programs > Individual with Disabilities Education Act/American Rescue Plan Act of 2021**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Grant no longer available fund expired last year	

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 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 2,929,698	$ 2,721,562
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 2,929,698	$ 3,187,490
4. CSHCN	$ 2,929,698	$ 2,968,820
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 8,789,094	$ 8,877,872

IB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 1,475,787	$ 1,475,787
2. Infants < 1 year	$ 4,329,693	$ 4,329,693
3. Children 1 through 21 Years	$ 697,738	$ 697,738
4. CSHCN	$ 821,027	$ 821,027
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 7,324,245	$ 7,324,245
Federal State MCH Block Grant Partnership Total	$ 16,113,339	$ 16,202,117

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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: 30% Budgeted based on what was awarded for FY24 grant award	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: 30% budget based on what was awarded on FY24 grant award	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Budgeted based on what was awarded on FY24 grant award	
4.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: This is a projection budget based on what is allotted for matching on the FY24 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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: This is a projection budget based on what is allotted for matching on the FY24 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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: This is a projection budget based on what is allotted for matching on the FY24 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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: This is a projection budget based on what is allotted for matching on the FY24 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:**	**IB. Non-Federal MCH Block Grant, Non Federal Total of Individuals Served**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: This is a projection budget based on what is allotted for matching on the FY24 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	
9.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Grant Award # BO4MC52934 Budget Period 10/1/2023 - 9/30/2025 Assistance # 93.994 A51O 10720 B51O 10721 C51O 10722 28% of this award was expended on Women Health	
10.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**

	Field Note: Grant Award # BO4MC52934 Budget Period 10/1/2023 - 9/30/2025 Assistance # 93.994 A51O 10720 B51O 10721 C51O 10722 33% of this award was expended on Child Health	
11.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Grant Award # BO4MC52934 Budget Period 10/1/2023 - 9/30/2025 Assistance # 93.994 A51O 10720 B51O 10721 C51O 10722 30% of this award was expended on Children with special care need	
12.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Local funds 003S Grant # $ 2,504,193 Genetic Screening Fees (007S) grant # 5326 $3,727,712 Perinatal Ris Management (Medicaid) 08PS grant # 5415 $1,465,111 20% of total funds expended was on Pregnant Women	
13.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Local funds 003S Grant # $ 2,504,193 Genetic Screening Fees (007S) grant # 5326 $3,727,712 Perinatal Ris Management (Medicaid) 08PS grant # 5415 $1,465,111 59% of total funds expended was Infant> 1Year	

14.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**

Field Note:
Local funds 003S Grant # $ 2,504,193
Genetic Screening Fees (007S) grant # 5326 $3,727,712
Perinatal Ris Management (Medicaid) 08PS grant # 5415 $1,465,111

10% of total funds expended was on Children 1 through 21 Years

15.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**

Field Note:
Local funds 003S Grant # $ 2,504,193
Genetic Screening Fees (007S) grant # 5326 $3,727,712
Perinatal Ris Management (Medicaid) 08PS grant # 5415 $1,465,111

10% of total funds expended was on 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 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 2,950,178	$ 2,950,178
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,147,307	$ 1,147,307
B. Preventive and Primary Care Services for Children	$ 1,157,719	$ 1,157,719
C. Services for CSHCN	$ 645,152	$ 645,152
2. Enabling Services	$ 2,610,168	$ 2,610,168
3. Public Health Services and Systems	$ 4,205,314	$ 4,205,314
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 Serivices		$ 2,950,178
Direct Services Line 4 Expended Total		$ 2,950,178
Federal Total	$ 9,765,660	$ 9,765,660

IIB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 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	$ 3,110,644	$ 3,110,644
3. Public Health Services and Systems	$ 4,213,601	$ 4,213,601
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	$ 7,324,245	$ 7,324,245

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Budgeted base on what was spent in FY24 direct services	
2.	**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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: based on what was spent in FY24 39% of direct service was on women health	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: based on what was spent in FY24 39% of direct service was on Child health	
4.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: based on what was spent in FY24 22% of direct service was on CSHCN	
5.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Budgeted base on what was spent in FY24 Enabling services	
6.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2026**

	Column Name:	**Application Budgeted**
	Field Note: Budgeted based on what was spent on Public Health Service in FY24 plus 10% admin fee	
7.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: na	
8.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: na	
9.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: na	
10.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: na	
11.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**

	Field Note: Local funds 003S grant # 5321 $1,028,134 Genetic Screening Fees (007S) grant # 5326 $2,824,753 Perinatal Risk Management (Medicaid) 08PS grant # 5415 $3,306,296 42% of funds are budgeted for Enabling Services	
12.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Local funds 003S grant # 5321 $1,028,134 Genetic Screening Fees (007S) grant # 5326 $2,824,753 Perinatal Risk Management (Medicaid) 08PS grant # 5415 $3,306,296 58% of funds are budgeted for Public Health Services & System	
13.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Out of all three MCH Block Grant (A51O, B51O C51O) 30% was for Direct Services	
14.	**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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Out of all three MCH Block Grant (A51O, B51O C51O) 39% of Direct Services was for Women Heath	
15.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Out of all three MCH Block Grant (A51O, B51O C51O) 39% of Direct Services was for Child Health	
16.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**

	Field Note: Out of all three MCH Block Grant (A51O, B51O C51O) 22% of Direct Services was for CYSHCN	
17.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Out of all three MCH Block Grant (A51O, B51O C51O) 27% was for Enabling Services	
18.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Out of all three MCH Block Grant (A51O, B51O C51O) 43% was for Public Health Services and Systems	
19.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Pharmacy**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: na	
20.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Physician/Office Services**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: na	
21.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Hospital Charges (Includes Impatient and Outpatient Services)**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: na	
22.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Dental Care (Does Not Include Orthodontic Services).**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**

	Field Note: na	
23.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Durable Medical Equipment and Supplies.**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: na	
24.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Laboratory Services**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: na	
25.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Local funds 003S grant # 5321 $1,028,134 Genetic Screening Fees (007S) grant # 5326 $2,824,753 Perinatal Risk Management (Medicaid) 08PS grant # 5415 $3,306,296 42% of funds were expended for Enabling Services	
26.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Local funds 003S grant # 5321 $1,028,134 Genetic Screening Fees (007S) grant # 5326 $2,824,753 Perinatal Risk Management (Medicaid) 08PS grant # 5415 $3,306,296 58% of funds were expended for Public Health Services & System	
27.	**Field Name:**	**IIA. - Other - Nursing Serivices**
	Fiscal Year:	**2026**
	Column Name:	**Annual Report Expended**

Field Note:
All services were done by Nurses

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Mississippi

Total Births by Occurrence: 32,443 **Data Source Year: 2024**

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	32,194 (99.2%)	121	87	87 (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	32,194 (99.2%)	1	1	1 (100.0%)
Methylmalonic acidemia with homocystinuria	32,194 (99.2%)	0	0	0 (0%)
Malonic acidemia	32,194 (99.2%)	0	0	0 (0%)
2,4 Dienoyl-CoA reductase deficiency	32,194 (99.2%)	0	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	32,194 (99.2%)	0	0	0 (0%)
2-Methylbutyrylglycinuria	32,194 (99.2%)	0	0	0 (0%)
Argininemia	32,194 (99.2%)	0	0	0 (0%)
Benign hyperphenylalaninemia	32,194 (99.2%)	0	0	0 (0%)
Biopterin defect in cofactor biosynthesis	32,194 (99.2%)	0	0	0 (0%)
Biopterin defect in cofactor regeneration	32,194 (99.2%)	0	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	32,194 (99.2%)	0	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	32,194 (99.2%)	0	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	32,194 (99.2%)	0	0	0 (0%)
Citrullinemia, type II	32,194 (99.2%)	0	0	0 (0%)
Galactoepimerase deficiency	32,194 (99.2%)	1	1	1 (100.0%)
Galactokinase deficiency	32,194 (99.2%)	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	32,194 (99.2%)	0	0	0 (0%)
Hypermethioninemia	32,194 (99.2%)	0	0	0 (0%)
Medium/short-chain L-3-hyrdroxy ACYL-CoA dehydrogenase deficiency	32,194 (99.2%)	0	0	0 (0%)
Medium-chain ketoacyl-CoA thiolase deficiency	32,194 (99.2%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	32,194 (99.2%)	0	0	0 (0%)
T-cell related lymphocyte deficiencies	32,194 (99.2%)	0	0	0 (0%)
Tyrosinemia, type II	32,194 (99.2%)	0	0	0 (0%)
Tyrosinemia, type III	32,194 (99.2%)	0	0	0 (0%)
Various other hemoglobinopathies	32,194 (99.2%)	2	2	2 (100.0%)
3-Methylglutaconic aciduria	32,194 (99.2%)	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 children aged 1 to 21 years when they are transitioned to adult health care. LTCC helps minimize impediments 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:	**2024**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Counts are provisional and may change	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2024**
	Column Name:	**Data Source Year Notes**
	Field Note: The data period is from October 2023 to September 2024	
3.	**Field Name:**	**Expanded Hearing Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	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:	**2024**
	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:	**2024**
	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:	**2024**
	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 2024

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	849	84.8	0.1	5.4	9.7	0.0
2. Infants < 1 Year of Age	2,155	59.0	0.0	6.0	35.0	0.0
3. Children 1 through 21 Years of Age	34,390	41.5	3.0	10.5	43.8	1.2
3a. Children with Special Health Care Needs 0 through 21 years of age^	19,661	11.0	45.7	23.5	1.7	18.1
4. Others	42,264	19.3	0.0	21.1	59.6	0.0
Total	79,658					

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	34,459	Yes	34,459	72.8	25,086	849
2. Infants < 1 Year of Age	33,311	Yes	33,311	24.2	8,061	2,155
3. Children 1 through 21 Years of Age	808,662	Yes	808,662	55.9	452,042	34,390
3a. Children with Special Health Care Needs 0 through 21 years of age^	260,498	Yes	260,498	8.0	20,840	19,661
4. Others	2,096,656	Yes	2,096,656	4.6	96,446	42,264

^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.

5* - CYSHCN number was provided by the program. Since unable to compare categories of children < 1 and children 1-21, CYSHCN is considered a totally separate category and not a subset. Not sure if the system will allow that.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2024**
	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:	**2024**
	Field Note: The number of infants included is infants who received genetic consult due to newborn screening and infants enrolled in Healthy Moms/Healthy Babies, along with EPSDT, immunization, TB diagnostic, single/other services, and COVID-19, as recorded in EPIC. It also includes infants enrolled in Early Intervention with an IFSP as recorded in MITI, the Infants in the Lead program from the Healthy Home Lead Prevention database system, and the oral health program data from dental screening as recorded in EPIC.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: The number of children, one through twenty-one, comes from the number of children documented in the EPIC database and referrals for early intervention services over the age of 1 documented in MITI and the Lead database, and Oral health dental screening from EPIC	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2024**
	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:	**2024**
	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 visit from the EPIC database and the Breast and Cervical Cancer Program database.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2024**
	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	

EPIC.

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2024**
	Field Note: The number of infants served by Title V comes from the unduplicated number of infants in newborn screening surveillance as documented in EPIC, infants screened from the Lead program as documented in the Lead database, Early Intervention Outreach as documented in MITI, and Oral screening, as documented in EPIC.	
3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	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. As well as Early intervention screening and oral health.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: The CYSHCN program only documents enabling services within specialty clinics, MSDH Care Coordinators, and CYSHCN Cares II Cohorts. The program could not document its reach for children not participating in these systems. The percentage served was 7.6%. To clarify and meet validation requirements, the percentage was rounded up to 8%.	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2024**
	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, and webinar participants (topics including parenting, intimate partner violence, and human trafficking), and participants in Title X family planning services and Oral health 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 2024

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	33,836	17,248	13,172	2,329	243	417	9	371	47
Title V Served	849	305	385	23	1	2	1	5	127
Eligible for Title XIX	18,115	6,705	10,097	813	207	73	0	220	0
2. Total Infants in State	33,827	17,248	13,172	2,329	241	414	9	371	43
Title V Served	3,198	950	1,231	154	14	23	2	31	793
Eligible for Title XIX	18,267	9,314	7,113	1,258	130	224	5	200	23

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Data from vital statistics and included number of deliveries to pregnant women who were served by Title V are included in Columns B-I.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2024**
	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:	**2024**
	Column Name:	**Total**
	Field Note: Data from the Mississippi Division of Medicaid	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Data from vital statistics	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2024**
	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:	**2024**
	Column Name:	**Total**
	Field Note: Data from the Mississippi Division of Medicaid	

Form 7
Title V Program Workforce

State: Mississippi

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	146
1a. Total Number of FTEs (State Level)	27
1b. Total Number of FTEs (Local Level)	119
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	7.50
3. Total Number of FTEs eliminated in the past 12 months	0
4. Total Number of Current Vacant FTEs	9
4a. Total Number of Vacant MCH Epidemiology FTEs	3
5. Total Number of FTEs onboarded in the past 12 months	4

B. Training Needs (Optional)	
1	Training in Tableau, ArcGIS, SQL, and SAS
2	Training regarding MCH Block Grant / Title V 101 for new staff in leadership positions
3	
4	

Form Notes for Form 7:

None

Field Level Notes for Form 7:

Form 7 Field Level Notes Table

1.	**Field Name:**	**Total Number of FTEs**
	Field Note: This number was obtained from a year cumulation of all staff hired and reviewed by MSDH reporting code for Title V funds.	
2.	**Field Name:**	**Total Number of FTEs eliminated in the past 12 months**
	Field Note: Our state systems do not allow coding for this type of disaggregation of FTEs.	
3.	**Field Name:**	**Total Number of Current Vacant FTEs**
	Field Note: Our systems do not allow for disaggregation for this type of information. 9 was placed because we are aware of three vacancies.	
4.	**Field Name:**	**Total Number of Vacant MCH Epidemiology FTEs**
	Field Note: Our system does not disaggregate data for this purpose. The three is provided by the Office of Health Data & Research, Director	
5.	**Field Name:**	**Total Number of FTEs onboarded in the past 12 months**
	Field Note: Our systems do not disaggregate information to break this down. 4 was because we are aware of two new hires.	
6.	**Field Name:**	**Training Needs Line 2**
	Field Note: Have completed the technical assistance request of the grant narrative with the same request.	

Form 8
State MCH and CSHCN Directors Contact Information

State: Mississippi

1. Title V Maternal and Child Health (MCH) Director	
Name	Danielle Seale, MSW, LCSW
Title	Title V Maternal and Child Health (MCH) Block Grant Director (interim)
Address 1	570 East Woodrow Wilson
Address 2	
City/State/Zip	Jackson / MS / 39216
Telephone	(601) 576-7477
Extension	
Email	Danielle.Seale@msdh.ms.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Valecia Davis, MA
Title	CYSHCN Director
Address 1	570 East Woodrow Wilson
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, Office of Health Data and Research
Address 1	570 East 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 Priority Needs – Needs Assessment Year

State: Mississippi

Application Year 2026

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Improve Maternal Health Outcomes	New
2.	Reduce Infant Mortality	New
3.	Improve Adolescent Health	New
4.	Increase access to timely, health, developmental, behavioral health screenings	New
5.	Ensure a medial homes for CYSHCN	New
6.	Improve Access to and Utilization of MCH-serving programs and activities available through MSDH	New
7.	Maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Mississippi

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	73.7	4.8	243	32,967
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 - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2023	39.7	4.7	70	176,399
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 - Teen birth rate, ages 15 through 19, per 1,000 females - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	24.9	0.5	2,596	104,221
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 low birth weight deliveries (<2,500 grams) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	12.5 %	0.2 %	4,290	34,448
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 gestation) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	15.0 %	0.2 %	5,151	34,441
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 - Stillbirth rate per 1,000 live births plus fetal deaths - SB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	9.1	0.5	320	34,995
2021	10.0	0.5	355	35,511
2020	10.6	0.6	380	35,853
2019	9.4	0.5	348	36,984
2018	10.5	0.5	391	37,391
2017	11.1	0.5	418	37,775
2016	10.4	0.5	399	38,327
2015	9.0	0.5	350	38,744
2014	10.0	0.5	391	39,127
2013	8.9	0.5	345	38,979
2012	9.4	0.5	367	39,036
2011	9.9	0.5	399	40,259
2010	10.2	0.5	414	40,450
2009	9.2	0.5	399	43,300

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SB - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	8.0	0.5	279	34,810
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 - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	9.1	0.5	316	34,675
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 - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.3	0.4	184	34,675
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 - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	3.8	0.3	132	34,675
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 - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	253.8	27.1	88	34,675
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 - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	242.2	26.5	84	34,675
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 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	3.1	0.3	104	33,151
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 children meeting the criteria developed for school readiness - SR

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	61.7 %	4.2 %	62,086	100,553

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 SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	13.1 %	1.3 %	85,193	649,459
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 - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	27.9	2.9	90	322,792
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 - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	72.5	4.2	294	405,313
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 - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021-2023	27.3	2.1	170	623,038
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 10 through 19 per 100,000 - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	6.5	0.7	79	1,218,530
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 - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	24.7	1.4	301	1,218,530
2020_2022	22.9	1.4	278	1,215,900
2019_2021	19.7	1.3	240	1,219,909
2018_2020	17.6	1.2	215	1,223,175
2017_2019	15.0	1.1	185	1,232,060
2016_2018	13.7	1.1	169	1,235,964
2015_2017	10.1	0.9	124	1,233,197
2014_2016	9.9	0.9	122	1,233,692
2013_2015	8.9	0.9	110	1,236,667
2012_2014	8.6	0.8	107	1,247,145
2011_2013	7.4	0.8	93	1,262,033
2010_2012	7.9	0.8	101	1,280,389
2009_2011	8.5	0.8	110	1,295,320
2008_2010	10.3	0.9	135	1,307,014
2007_2009	10.7	0.9	141	1,313,844

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Firearm - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	100.9	5.3	359	355,868
2021	114.8	5.6	416	362,338
2020	141.9	6.2	524	369,308
2019	125.2	5.8	467	372,855
2018	116.5	5.6	441	378,444
2017	110.7	5.4	426	384,989
2016	127.1	5.7	499	392,537
2015	136.9	6.8	410	299,598
2014	132.0	5.7	533	403,649
2013	143.2	5.9	585	408,542
2011	218.2	7.3	904	414,352
2010	178.8	6.6	745	416,628

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Child - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	178.9	6.7	722	403,623
2021	215.1	7.3	881	409,594
2020	234.2	7.6	943	402,683
2019	202.4	7.1	825	407,632
2018	186.7	6.7	771	412,860
2017	209.7	7.1	863	411,568
2016	204.4	7.1	841	411,536
2015	211.7	8.3	651	307,570
2014	189.5	6.8	781	412,063
2013	193.2	6.8	801	414,511
2011	301.4	8.4	1,287	426,951
2010	258.3	7.7	1,118	432,867

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	50.5 %	2.2 %	259,745	514,455
2022	46.6 %	2.2 %	241,618	518,379
2021	51.7 %	2.3 %	267,920	518,215
2020	55.2 %	1.9 %	289,067	523,849
2019	50.0 %	2.1 %	264,241	528,365
2018	49.8 %	2.0 %	264,140	530,447
2017	51.3 %	2.6 %	273,025	532,368
2017	51.3 %	2.6 %	273,025	532,368
2016	54.4 %	2.2 %	291,202	535,305
2015	53.8 %	2.2 %	287,910	534,931
2014	52.5 %	2.5 %	282,125	537,570
2013	54.0 %	1.9 %	289,671	536,635
2012	53.1 %	1.9 %	285,460	537,349

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM WHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	85.8 %	1.4 %	583,485	680,218
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 6 through 17, who are obese (BMI at or above the 95th percentile) - 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: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	25.0 %	2.1 %	109,936	439,987
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 women who experience postpartum depressive symptoms - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	17.1 %	1.8 %	5,094	29,855
2022	19.4 %	2.4 %	6,061	31,276
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 women who experience postpartum anxiety symptoms - PPA

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	31.6 %	2.2 %	9,438	29,844

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 PPA - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	11.0 %	1.9 %	24,489	223,018
2021_2022	9.6 %	1.6 %	21,907	228,644
2020_2021	14.5 %	2.3 %	33,828	232,768
2019_2020	12.7 %	2.2 %	29,986	236,922
2018_2019	11.4 %	2.1 %	28,085	246,395
2017_2018	14.1 %	2.8 %	35,912	253,898
2016_2017	13.3 %	2.9 %	33,253	250,596

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 BCD - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	19.5 %	2.4 %	49,330	252,992
2021_2022	18.2 %	2.3 %	45,559	249,890
2020_2021	14.2 %	1.8 %	34,319	241,506
2019_2020	12.4 %	1.7 %	29,931	240,986
2018_2019	12.9 %	2.3 %	31,197	242,043
2017_2018	14.4 %	2.5 %	34,837	241,853
2016_2017	14.6 %	2.6 %	35,512	243,311

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 ADA - 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 - SOC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	12.9 %	1.8 %	27,217	210,648
2021_2022	11.9 %	1.7 %	24,260	203,775
2020_2021	14.6 %	2.2 %	29,499	201,783
2019_2020	16.3 %	2.3 %	33,330	204,401
2018_2019	16.1 %	2.3 %	33,713	209,954
2017_2018	14.6 %	2.6 %	32,224	220,136
2016_2017	14.7 %	2.5 %	33,508	227,671

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 6 months through 5, who are flourishing - FL-YC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	80.8 %	2.7 %	154,053	190,755
2021_2022	77.9 %	2.7 %	152,016	195,058
2020_2021	81.8 %	2.4 %	157,758	192,806
2019_2020	82.2 %	2.8 %	158,728	193,180
2018_2019	84.3 %	2.9 %	163,444	193,855

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 FL-YC - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA

Data Source: National Survey of Children's Health (NSCH)-CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	45.0 %	3.6 %	74,296	165,274
2021_2022	47.4 %	3.4 %	75,393	159,197
2020_2021	45.0 %	3.3 %	74,731	166,189
2019_2020	46.0 %	3.4 %	75,832	164,818
2018_2019	47.7 %	3.6 %	83,359	174,833

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 FL-CA - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent

Data Source: National Survey of Children's Health (NSCH)-All Children

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	62.0 %	2.1 %	291,383	470,331
2021_2022	64.1 %	2.0 %	302,579	471,901
2020_2021	61.8 %	1.9 %	291,626	471,674
2019_2020	64.6 %	1.9 %	308,995	478,278
2018_2019	63.7 %	2.2 %	312,607	490,596

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 FL-Child Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	22.8 %	1.6 %	150,941	662,405
2021_2022	24.7 %	1.6 %	165,896	672,124
2020_2021	22.3 %	1.4 %	149,905	673,534
2019_2020	22.9 %	1.5 %	155,957	680,057
2018_2019	22.5 %	1.6 %	155,369	689,442
2017_2018	22.3 %	1.8 %	155,686	696,900
2016_2017	25.5 %	1.9 %	179,272	702,514

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 ACE - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Mississippi

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	88.1	88.1
Numerator	27,351	26,402
Denominator	31,060	29,977
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	89.0	89.9	90.8	91.7	92.6

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	73.6	69.7
Numerator	20,009	18,327
Denominator	27,196	26,287
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	70.3	71.1	71.8	72.5	73.3

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who were screened for depression or anxiety following a recent live birth - MHS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	73.5
Numerator	21,691
Denominator	29,516
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	74.2	75.0	75.7	76.5	77.3

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who are using a most or moderately effective contraceptive following a recent live birth - CU

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	60.7
Numerator	17,432
Denominator	28,722
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	61.3	61.9	62.6	63.2	63.8

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

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

State Provided Data	
	2024
Annual Objective	
Annual Indicator	2.1
Numerator	711
Denominator	33,525
Data Source	CDC Wonder
Data Source Year	2023 - 24
Provisional or Final ?	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	2.1	2.1	2.0	2.0	2.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	80.9	83.3
Annual Indicator	69.8	67.1
Numerator	23,756	22,734
Denominator	34,054	33,867
Data Source	NVSS	NVSS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	67.8	68.5	69.1	69.8	70.5

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	16.1	16.9
Annual Indicator	23.0	18.3
Numerator	19,896	16,718
Denominator	86,365	91,499
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	18.5	18.7	18.9	19.0	19.2

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants placed to sleep on their backs - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	68.2	68.9	69.6	70.3	71
Annual Indicator	69.4	64.3	70.7	70.7	61.7
Numerator	22,384	20,451	21,727	21,727	16,487
Denominator	32,256	31,790	30,728	30,728	26,713
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	62.3	62.9	63.6	64.2	64.8

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	66.2	67.5	68.9	70.3	71.7
Annual Indicator	34.4	32.7	30.7	30.7	18.6
Numerator	10,964	10,154	9,166	9,166	5,259
Denominator	31,829	31,010	29,840	29,840	28,328
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	18.8	19.0	19.2	19.4	19.6

Field Level Notes for Form 10 NPMs:

None

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	47.9	50.3	52.8	55.4	58.2
Annual Indicator	41.3	42.4	41.9	41.9	65.7
Numerator	12,948	13,078	12,497	12,497	18,870
Denominator	31,323	30,870	29,808	29,808	28,723
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	66.4	67.0	67.9	68.6	69.2

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	81.4
Numerator	23,570
Denominator	28,961
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	82.2	83.0	83.9	84.7	85.6

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who had a dental visit during pregnancy - PDV-Pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	37.7	39.6	41.6	43.7	45.9
Annual Indicator	31.6	32.1	35.3	35.3	29.4
Numerator	10,696	10,493	11,307	11,307	9,112
Denominator	33,881	32,729	31,993	31,993	31,015
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		39.6	41.6	43.7	45.9
Annual Indicator	31.6	32.1	35.3		
Numerator	10,696	10,493	11,307		
Denominator	33,881	32,729	31,993		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2019	2020	2021		
Provisional or Final ?	Final	Final	Final		

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	29.7	30.0	30.3	30.6	30.9

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 - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	81.4	82.2	83	83.8	84.6
Annual Indicator	77.1	75.0	72.0	72.1	72.8
Numerator	500,754	484,100	468,061	474,563	471,424
Denominator	649,719	645,270	650,503	658,109	647,786
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	73.5	74.3	75.0	75.8	76.5

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 - AWV

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	80	80.6	81.2	82	82.8
Annual Indicator	66.2	65.1	60.5	61.6	64.5
Numerator	155,497	155,882	145,341	148,228	158,015
Denominator	234,939	239,310	240,226	240,436	244,893
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	65.2	65.8	66.5	67.1	67.8

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	76.8
Numerator	40,575
Denominator	52,825
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	77.6	78.3	79.1	79.9	80.7

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 - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	47.1	48.7	50.3	51.9	53.5
Annual Indicator	51.4	46.2	43.2	40.8	41.1
Numerator	82,086	72,719	68,226	64,583	86,541
Denominator	159,664	157,506	157,885	158,168	210,648
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	41.5	41.9	42.4	42.8	43.2

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 - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	42.7	43.8
Numerator	293,703	298,389
Denominator	687,740	681,154
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	44.2	44.7	45.1	45.6	46.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination - MH_CC - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2024
Annual Objective	
Annual Indicator	63.4
Numerator	89,882
Denominator	141,746
Data Source	NSCH-CSHCN
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	64.4	64.7	65.3	66.0	66.6

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2024
Annual Objective	
Annual Indicator	14.7
Numerator	13,856
Denominator	94,082
Data Source	NSCH-CSHCN
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	14.9	15.0	15.2	15.3	15.5

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

State: Mississippi

2021-2025: NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	20.5	23.5	24.3	25.2	26.5
Annual Indicator	28.0	31.5	34.1	30.9	25.1
Numerator	19,663	25,115	28,605	25,435	21,422
Denominator	70,109	79,686	83,842	82,348	85,290
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	78.5	79.7	80.9	82.1	82.9
Annual Indicator	75.4	77.5	74.7	77.3	79.0
Numerator	390,297	403,215	379,846	389,062	394,552
Denominator	517,720	520,497	508,347	503,084	499,169
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day - PA-Adolescent

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			20.4	18.8	17.2
Annual Indicator	23.4	23.4	25.5	25.5	21.7
Numerator	29,043	29,043	31,054	31,054	25,177
Denominator	123,981	123,981	121,794	121,794	116,160
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2019	2019	2021	2021	2023

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			20.4	18.8	17.2
Annual Indicator	16.7	20.6	20.5	14.0	13.3
Numerator	38,663	48,356	48,374	34,225	33,131
Denominator	231,717	234,684	235,476	243,942	249,624
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Mississippi

SPM 1 - Percentage of referrals received by MSDH MCH-serving programs that are on the on-line Universal Referral Form.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5.0	5.0	6.0	6.0	6.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Number of community-based activities attended where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	13.0	14.0	15.0	16.0	17.0

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Number of social media messages focused on MCH-serving programs per year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	105.0	110.0	115.0	120.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - The total number of referrals for social conditions affecting the health of patients being served by the MSDH county health department clinics

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	166.0	167.0	169.0	171.0	172.0

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Percentage of MSDH MCH-Serving programs that have administered a patient satisfaction survey in the past year to engage the community in program improvement

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	50.0	65.0	75.0

Field Level Notes for Form 10 SPMs:

None

SPM 6 - Percentage of individuals who have been identified as having sickle cell trait and/ or disease by the Genetic program who were referred to the Lead poisoning prevention program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.1	25.5	25.8	26.0	26.3

Field Level Notes for Form 10 SPMs:

None

SPM 7 - Percentage of First Step Early Intervention Program referrals who get an Individualized Family Service Plan

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	44.0	44.0	44.0	45.0	45.0

Field Level Notes for Form 10 SPMs:

None

SPM 8 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for screened (passed and not passed) before 6 months of age.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	91.8	92.7	93.7	94.6	95.5

Field Level Notes for Form 10 SPMs:

None

SPM 9 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for diagnosis with permanent hearing loss: before 3 months of age.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	46.1	46.6	47.0	47.5	48.0

Field Level Notes for Form 10 SPMs:

None

SPM 10 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for babies referred to Part C EI: before 6 months of age

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	33.6	34.0	34.3	34.7	35.0

Field Level Notes for Form 10 SPMs:

None

SPM 11 - Percent of Mississippi newborns screened (Newborn Screening program)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

None

SPM 12 - Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth. (Newborn Screening Program)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	92.9	93.9	94.8	95.7	96.7

Field Level Notes for Form 10 SPMs:

None

SPM 13 - Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth with an abnormal result. (Newborn Screening)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	92.9	93.9	94.8	95.7	96.7

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age

Measure Status:	**Inactive - Completed**				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			3.9	4	4.1
Annual Indicator		3.8	5	11.7	7.9
Numerator		5,554	7,297	16,977	12,937
Denominator		144,844	146,681	145,661	164,715
Data Source		Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: SPM 10 - Percent of severe maternal morbidity events related to hypertension

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			2.2	2.1
Annual Indicator	3.5	3.4	3.9	4.2
Numerator	1,114	1,075	1,192	1,258
Denominator	32,010	31,331	30,637	30,291
Data Source	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data	Mississippi Hospital Discharge Data
Data Source Year	2022	2023	2024	2025
Provisional or Final ?	Final	Provisional	Final	Final

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.

2021-2025: SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			11.2	10.7
Annual Indicator	11.7	7.1	18.4	28.4
Numerator	5,221	2,995	7,342	10,397
Denominator	44,528	42,144	39,888	36,668
Data Source	WIC Spirit database	WIC Spirit database	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: SPM 12 - Percent of women who are enrolled in WIC and initiate breastfeeding

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			51	51.5
Annual Indicator	49.3	54	55.9	53.9
Numerator		11,007	21,547	20,635
Denominator		20,401	38,512	38,306
Data Source	WIC Spirit database	WIC Spirit database	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

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.

2021-2025: SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			67	77
Annual Indicator	46.9	40.4	40.8	58.1
Numerator	30	23	20	36
Denominator	64	57	49	62
Data Source	EPIC	EPIC	EPIC	EPIC
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

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.

2021-2025: 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:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			341	375
Annual Indicator	310	272	291	199
Numerator				
Denominator				
Data Source	EPSDT Visits in EPIC	EPSDT Visits in EPIC	EPSDT Visits in EPIC	EPSDT Visits in EPIC
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Final	Final

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	

2021-2025: SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			100	100
Annual Indicator	100	93.2	90	84.6
Numerator	60	2,722	72	77
Denominator	60	2,922	80	91
Data Source	Newborn Screening data	MS Newborn screening database and EPIC database	EPIC database	EPIC database
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

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 the timeliness of referral to a tertiary center are not yet available. However, we have data on the timeliness of screening.	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data for this measure regarding the timeliness of referral to a tertiary center are not yet available. However, we have data on the timeliness of screening.	

2021-2025: SPM 16 - Nulliparous, term singleton, vertex (NTSV) cesarean rate

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			28.5	25.7
Annual Indicator	31.7	30.5	30.3	30.1
Numerator	3,304	3,300	3,367	3,242
Denominator	10,439	10,830	11,096	10,776
Data Source	Mississippi Hospital Discharge Data	NTSV from Vital Records	NTSV from Vital Records	NTSV from Vital Records
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: SPM 17 - Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			78.5	79
Annual Indicator	75.6	77.9	77.3	82.6
Numerator	67,008	56,332	73,729	89,443
Denominator	88,608	72,327	95,345	108,331
Data Source	MS BRFSS	MS BRFSS	MS BRFSS	MS BRFSS
Data Source Year	2021	2019 2021	2021 2022	2022-2023
Provisional or Final ?	Final	Provisional	Provisional	Provisional

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).

2021-2025: 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:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			17.2	18.2
Annual Indicator	16.2	15.4	12.4	15.3
Numerator	8,954	9,208	8,155	12,256
Denominator	55,176	59,681	65,978	80,013
Data Source	National Survey of Children's Health	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	2022-2023
Provisional or Final ?	Final	Final	Final	Final

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	

2021-2025: SPM 19 - Adolescent suicide rate

Measure Status:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			11.3	11
Annual Indicator	11.6	10.8	8.7	6.3
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	Office of Vital Records and Public Health Statisti
Data Source Year	2017-2019	2021	2022	2023
Provisional or Final ?	Final	Provisional	Provisional	Provisional

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	

2021-2025: SPM 20 - Number of MCH programs that have developed a written plan to address health equity

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			3	6
Annual Indicator	1	3	3	4
Numerator				
Denominator				
Data Source	MCH program data	MCH program data	MCH program data	MCH program data
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

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.	

2021-2025: SPM 21 - Percent of children with and without special healthcare needs who have a medical home

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			46.5	46.7
Annual Indicator	46.2	43.2	40.8	41.1
Numerator	72,719	68,226	64,583	86,541
Denominator	157,506	157,885	158,168	210,647
Data Source	National Survey of Childrens Health	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	2022-2023
Provisional or Final ?	Final	Final	Final	Final

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 PPV.1 - Percent of mothers enrolled in home visiting programs who received a postpartum visit with a healthcare providers within 84 days of delivery.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	45.0	60.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM MHS.1 - Percent of pregnant and postpartum women screened positive for depression and are referred for appropriate follow-up care and support.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	45.0	60.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM MHS.2 - Percent of pregnant and postpartum women screened for substance use disorder who receive appropriate follow-up care and support.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	45.0	55.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM CU.1 - Percent of females seen in the MSDH county health departments for family planning services who are screened for and accept the Family Planning Waiver.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25.0	35.0	45.0	55.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM RAC.1 - Number of Child Death Review and Fetal Infant Mortality Review recommendations implemented annually (Risk Appropriate Perinatal Care)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	3.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	5	6	24	26	28
Annual Indicator	21	22	25	29	30
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Provisional	Final	Final

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	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 30 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 BF.2 - Number of Child Death Review and Fetal Infant Mortality Review recommendations implemented annually (Breastfeeding)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	3.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	20,450	20,700	21,000	21,250	21,500
Annual Indicator	14,880	9,560	11,863	13,950	13,601
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	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

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.	
5.	**Field Name:**	**2024**
	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 SS.2 - Number of cribs distributed to participants of MCH-serving programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	200.0	300.0	400.0	500.0

Field Level Notes for Form 10 ESMs:

None

ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education through the collaborative with WIC

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective	650	700	750	800	850
Annual Indicator	347	0	1,000	1,000	5,135
Numerator					
Denominator					
Data Source	MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health - REDCAP	MSDH Office of Oral Health - REDCAP	MSDH Office of Oral Health - REDCAP
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	5,186.0	5,238.0	5,291.0	5,344.0	5,397.0

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.	
4.	**Field Name:**	**2024**
	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.	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The actual annual objective is 5,186 but due to data ranges for this objective, 1,000 was indicated for 2026.	
6.	**Field Name:**	**2027**
	Column Name:	**Annual Objective**
	Field Note: The actual annual objective is 5,238 but due to data ranges for this objective, 1,000 was indicated for 2027.	
7.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**
	Field Note: The actual annual objective is 5,29 but due to data ranges for this objective, 1,000 was indicated for 2028.	
8.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**
	Field Note: The actual annual objective is 5,344 but due to data ranges for this objective, 1,000 was indicated for 2029.	
9.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**
	Field Note: The actual annual objective is 5,395 but due to data ranges for this objective, 1,000 was indicated for 2030.	

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

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	2,000	3,000	4,000	100	150
Annual Indicator	903	0	29	38	2
Numerator					
Denominator					
Data Source	Office of Oral Health	Office of Oral Health	EPIC	EPIC	MSDH Office of Oral Health
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

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.	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Total unduplicated encounters 0-3 = 84 (WIC participants) All patient families were called by dental team members, and reached 84; of this number, 1 has a dental home; 58 have no ability to leave voicemail; 2 successfully achieved care for dental referral; 3 forgot their appointment.	

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

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	2,000	3,000	4,000	450	500
Annual Indicator	976	424	20	3	17
Numerator					
Denominator					
Data Source	EPIC	EPIC	EPIC	EPIC	MSDH Office of Oral Health
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

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:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	65	70	75	20	25
Annual Indicator	2	8	14	6	35
Numerator					
Denominator					
Data Source	Office of Oral Health	Office of Oral Health	MSDH Office of Oral Health REDCAP	MSDH Office of Oral Health REDCAP	MSDH Office of Oral Health REDCAP
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

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.

ESM PDV-Child.4 - Number of referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	150.0	200.0	250.0	300.0

Field Level Notes for Form 10 ESMs:

None

ESM AWV.1 - 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:	Inactive - Completed			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			100	100
Annual Indicator	100	100	100	82
Numerator				
Denominator				
Data Source	MSDH County Health Department information	MSDH County Health Department information	MSDH County Health Department information	MSDH County Health Department information
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Provisional	Provisional	Final	Final

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 AWV.2 - Percentage of adolescents ages 13-17 who received all recommended doses of the human papillomavirus (HPV) vaccine

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	38.8	39.2	39.6	40.0	40.4

Field Level Notes for Form 10 ESMs:

None

ESM AWV.3 - Percent of adolescents, ages 12-17, with an EPSDT medical visit and screening in the MSDH county Health Departments

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	0.7	0.7	0.7	0.7	0.7

Field Level Notes for Form 10 ESMs:

None

ESM MHT.1 - Number of presentations surrounding suicide awareness for youths

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	27.0	28.0	29.0	30.0	32.0

Field Level Notes for Form 10 ESMs:

None

ESM MHT.2 - Percent of community partners in a collaboration addressing youth mental health care and suicide prevention awareness.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	30.0	40.0	50.0	60.0	70.0

Field Level Notes for Form 10 ESMs:

None

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:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	50	52	54	56	58
Annual Indicator	100	0	30	51	41
Numerator					
Denominator					
Data Source	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and insurance access.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20.0	40.0	60.0	80.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months old in county health department clinics annually.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	3.3	3.3	3.4	3.4	3.4

Field Level Notes for Form 10 ESMs:

None

ESM MH_CC.1 - Percent of CYSHCN referrals who accept enrollment into CYSHCN care coordination program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	41.0	43.0	45.0	47.0	49.0

Field Level Notes for Form 10 ESMs:

None

ESM TAHC.1 - Percent of MSDH and external health care professionals/ providers who attend educational opportunities regarding health care transition for CYSHCN.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20.0	25.0	30.0	40.0	55.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM DS.1 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

Measure Status:	**Inactive - Completed**			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			20	30
Annual Indicator	0	1,162	2,928	2,033
Numerator				
Denominator				
Data Source	Early Intervention Child Find Log	Early Intervention Child Find Log	Early Intervention Child Find Log	Early Intervention Child Find Log
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Provisional	Final	Final

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

2021-2025: ESM WWV.1 - 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**	**2024**
Annual Objective			100	125
Annual Indicator	641	56	113	73
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	MS Quitline provider and Baby and Me Tobacco Free
Data Source Year	2022	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final

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 the 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.

4.	**Field Name:**	**2024**
	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 the 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.

2021-2025: 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**	**2024**
Annual Objective			22	23	24
Annual Indicator	20.6		20.5	14	13.3
Numerator	48,356		48,374	34,225	33,131
Denominator	234,684		235,476	243,941	249,624
Data Source	National Survey of Childrens Health		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	2022-2023
Provisional or Final ?	Final		Final	Final	Final

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.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Mississippi

SPM 1 - Percentage of referrals received by MSDH MCH-serving programs that are on the on-line Universal Referral Form.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the percent of referrals received by MSDH MCH-serving programs that are on the on-line Universal Referral Form.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of referrals received by MSDH MCH-serving programs on the on-line Universal Referral Form **Denominator:** # of all referrals received by MSDH MCH-serving programs
Healthy People 2030 Objective:	By September 30, 2030, increase the percent of referrals MSDH MCH-serving programs receive using the on-line Universal Referral form by 20% (from BASELINE TBD to TARGET TBD). (4% annually)
Data Sources and Data Issues:	Redcap and MSDH MCH-serving program databases where referral are collected and stored. (EPIC, self-referral and provider referral).
Significance:	The MCH-serving programs are working to enhance and increase use of the Universal Referral form in order to improve and expand services provided. The Universal Referral form allows for participants and/or providers to select multiple programs within MSDH for services, instead of paper forms which are individualized to a program. Use of this form will increase access to services.

SPM 2 - Number of community-based activities attended where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the number of outreach activities where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** # of community-based activities attended where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form **Denominator:**
Data Sources and Data Issues:	counts from MCH-serving programs of the number of community activities they participated in and provided education about the MSDH MCH program electronic Universal Referral Form
Significance:	Community outreach is an important part of providing health education and knowledge to the community about public health and MCH-serving programs. It is a way to learn about what is occurring within the community, what are the community needs, and identify ways to collaborate. It also provides the community with knowledge about current and new programs offered at their local county health department.

SPM 3 - Number of social media messages focused on MCH-serving programs per year
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase the awareness of MCH-serving programs with a regular and robust social media presence.
Definition:	**Unit Type:** Count **Unit Number:** 120 **Numerator:** # of social media messaging focused on MCH-serving programs per year. **Denominator:**
Data Sources and Data Issues:	Office of Communications collects the data for all social media platforms
Significance:	Social media supports brand awareness, visibility and reach. It is a way to engage residents who may or may not know about the various MCH-serving programs.

SPM 4 - The total number of referrals for social conditions affecting the health of patients being served by the MSDH county health department clinics
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase the number of referrals for social conditions affecting maternal, infants, children, adolescents and CYSHCN who are being served by the MSDH county health department clinics
Definition:	**Unit Type:** Count **Unit Number:** 2,000 **Numerator:** The total number of referrals for social conditions affecting the health of patients being served by the MSDH county health department clinics **Denominator:**
Healthy People 2030 Objective:	By September 30, 2030, increase the number of referrals for social conditions affecting maternal, infants, children, adolescents and CYSHCN by 5%. (from BASELINE TBD to TARGET TBD).
Data Sources and Data Issues:	county health departments; EPIC; Public Health Social Worker's internal database.
Significance:	The purpose is to operationalize the processes and activities for referrals for social conditions affecting maternal, infants, children, adolescents and CYSHCN with the development of policies, procedures, and data collection.

SPM 5 - Percentage of MSDH MCH-Serving programs that have administered a patient satisfaction survey in the past year to engage the community in program improvement
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the percent of MSDH MCH-serving programs that have administered a patient satisfaction survey in the past year to engage the community in program improvement
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MSDH MCH-Serving programs that administered a patient satisfaction survey in the past year to engage the community in program improvement **Denominator:** Total number of MSDH MCH-serving programs
Data Sources and Data Issues:	Shared Health Service Teams Folder database storing the developed patient satisfaction surveys
Significance:	The development of the patient surveys is part of the next 5-year needs assessment and for consumer engagement.

SPM 6 - Percentage of individuals who have been identified as having sickle cell trait and/ or disease by the Genetic program who were referred to the Lead poisoning prevention program
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	The goal is to increase referrals of individuals with sickle cell trait and/ or disease from the Genetic Newborn Screening program to the Lead Poisoning Prevention Program
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of individuals who have been identified as having sickle cell trait and/ or disease by the Genetic program who were referred to the Lead poisoning prevention program. **Denominator:** The total number of individuals in the Lead Poisoning Prevention and Healthy Homes program
Data Sources and Data Issues:	HLLPPS and Lead databases
Significance:	Being able to identify and increase referrals from the Genetics Program, of individuals with sickle cell trait and/ or disease, will allow for care coordination and follow-up by the Lead Poisoning Prevention and Healthy Homes program. They have the ability to work with families to identify the source of the lead, and work to eliminate the source with the goal of reducing and/or eliminating the exposure of lead to children. At this point, there is no baseline on this data. This is a new activity. Initial activities are to build the infrastructure for the referrals then obtain baseline data to build upon.

SPM 7 - Percentage of First Step Early Intervention Program referrals who get an Individualized Family Service Plan
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	The goal is to increase the number of FSEIP referrals who get the Individualized Family Service Plan (IFSP)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of FSEIP referrals who get an IFSP **Denominator:** Number of FSEIP referrals
Data Sources and Data Issues:	MITI (using the fiscal year to pull the data (FY 24 - October 1, 2023 to September 30, 2024, referrals (4,651); IFSP (2,004)
Significance:	Child Find activities educate the communities, providers and families about the First Steps Early Intervention program. They are one of the ways the programs outreaches to increase referrals and, ultimately, enrollments into the program.

SPM 8 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for screened (passed and not passed) before 6 months of age.
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% for screened (passed and not passed) before 6 months of age.</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>Total babies screened (passed and not passed) before 6 months of age.</td></tr>
<tr><td>Denominator:</td><td>Total occurrent births according to vital records</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>EHDI database</td></tr>
<tr><td>Significance:</td><td>The EHDI works to educate communities, providers, and families regarding the importance of the recommended standards of a screening for hearing loss before the infant reaches 1 month of age, a diagnostic evaluation before the infant reaches 3 months of age, and if there is any hearing loss, enrollment into an early intervention program before the infant reaches 6 months of age. With early detection, the infant and family can identify problems before they become too severe.

Calendar year 2023 percentage for screenings: 90.9%
Numerator: Total babies screened (passed and not passed) before 6 months of age.
Denominator: Total occurrent births according to vital records</td></tr>
</table>

SPM 9 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for diagnosis with permanent hearing loss: before 3 months of age.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% for diagnosis with permanent hearing loss: before 3 months of age.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of babies diagnosed with permanent hearing loss: before 3 months of age **Denominator:** Total number of babies with permanent hearing loss
Data Sources and Data Issues:	EHDI database
Significance:	The EHDI works to educate communities, providers, and families regarding the importance of the recommended standards of a screening for hearing loss before the infant reaches 1 month of age, a diagnostic evaluation before the infant reaches 3 months of age, and if there is any hearing loss, enrollment into an early intervention program before the infant reaches 6 months of age. With early detection, the infant and family can identify problems before they become too severe. Calendar year 2023 percentage for diagnostic: 45.65% Numerator: Total number of babies diagnosed with permanent hearing loss: before 3 months of age Denominator: Total number of babies with permanent hearing loss

SPM 10 - Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for babies referred to Part C EI: before 6 months of age
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% for babies referred to Part C EI: before 6 months of age
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of babies referred to Part C EI: before 6 months of age **Denominator:** Total number of babies referred to Part C EI
Data Sources and Data Issues:	EHDI database
Significance:	The EHDI works to educate communities, providers, and families regarding the importance of the recommended standards of a screening for hearing loss before the infant reaches 1 month of age, a diagnostic evaluation before the infant reaches 3 months of age, and if there is any hearing loss, enrollment into an early intervention program before the infant reaches 6 months of age. With early detection, the infant and family can identify problems before they become too severe. Calendar year 2023 percentage for enrollment into EHDI by 6 months: 33.3% Numerator: Total number of babies referred to Part C EI: before 6 months of age Denominator: Total number of babies referred to Part C EI

SPM 11 - Percent of Mississippi newborns screened (Newborn Screening program)
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the number of Mississippi newborns screened (Newborn Screening program)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of Mississippi newborns screened. **Denominator:** Total number of Mississippi newborns (total occurrence births)
Data Sources and Data Issues:	Vital records, EPIC, Revvity
Significance:	Newborn screening identifies health conditions early in an infant's life, to provide timely newborn screening and better care coordination. This early detection provides the infant, and their family, access to specialists and timely treatments. Newborn Screening Programs | MCHB and Newborn-Screening-Education-Best-Practice-Framework.pdf

SPM 12 - Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth. (Newborn Screening Program)
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the number of Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth. (Newborn Screening Program)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of Mississippi newborns who received a newborn screening during 24-48 hours after birth. **Denominator:** Total number of Mississippi newborns screened.
Data Sources and Data Issues:	Vital records, EPIC, Revvity
Significance:	Newborn screening identifies health conditions early in an infant's life, to provide timely newborn screening and better care coordination. This early detection provides the infant, and their family, access to specialists and timely treatments. Newborn Screening Programs | MCHB and Newborn-Screening-Education-Best-Practice-Framework.pdf

SPM 13 - Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth with an abnormal result. (Newborn Screening)
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the number of Mississippi newborns who received a newborn screening during 24-48 hours after birth with an abnormal result. (Newborn Screening)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of Mississippi newborns who received a newborn screening during 24-48 hours after birth with a newborn screening abnormal result. **Denominator:** Total number of newborns with a newborn screening abnormal result.
Data Sources and Data Issues:	Vital records, EPIC, Revvity
Significance:	Newborn screening identifies health conditions early in an infant's life, to provide timely newborn screening and better care coordination. This early detection provides the infant, and their family, access to specialists and timely treatments. Newborn Screening Programs | MCHB and Newborn-Screening-Education-Best-Practice-Framework.pdf

Form 10
State Performance Measure (SPM) Detail Sheets (2021-2025 Needs Assessment Cycle)

2021-2025: 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

Measure Status:	Inactive - Completed
Goal:	Increase the proportion of children on Medicaid aged 12 and 24 months that have a reported blood lead screening
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Mississippi children on Medicaid aged 12 and 24 months that have a reported blood lead screening is **Denominator:** Number of Mississippi children on Medicaid aged 12 and 24 months is
Data Sources and Data Issues:	MSDH Lead Program data and Division of Medicaid data
Significance:	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.

2021-2025: SPM 10 - Percent of severe maternal morbidity events related to hypertension
Population Domain(s) – Women/Maternal Health

Measure Status:	Inactive - Completed
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.

2021-2025: 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:	Inactive - Completed
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.

2021-2025: SPM 12 - Percent of women who are enrolled in WIC and initiate breastfeeding
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Inactive - Completed
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

2021-2025: 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:	Inactive - Completed
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
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.

2021-2025: 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:	Inactive - Completed
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:**
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.

2021-2025: 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:	Inactive - Completed
Goal:	to increase timely screening and referral of newborns and infants diagnosed with a genetic or metabolic condition
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 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. **Denominator:** Infants born in Mississippi who are diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel
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.

2021-2025: SPM 16 - Nulliparous, term singleton, vertex (NTSV) cesarean rate
Population Domain(s) – Women/Maternal Health

Measure Status:	Inactive - Completed
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
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.

2021-2025: 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:	Inactive - Completed
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
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.

2021-2025: 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

<table>
<tr><td>Measure Status:</td><td>Inactive - Completed</td></tr>
<tr><td>Goal:</td><td>Increase the percent of children with special health care needs who have received services necessary for transition to adult health care</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 children with special health care needs who have received services necessary for transition to adult health care (12-17 years)</td></tr>
<tr><td>Denominator:</td><td>Total number of children with special health care needs (12-17 years)</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2021-2025: SPM 19 - Adolescent suicide rate
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - Completed
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.

2021-2025: 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:	Inactive - Completed
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

2021-2025: SPM 21 - Percent of children with and without special healthcare needs who have a medical home
Population Domain(s) – Child Health

Measure Status:	Inactive - Completed
Goal:	to assure that all children with and without special healthcare have a medical home
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>children, 0-17 years, with and without special healthcare needs who have a medical home</td></tr><tr><td>**Denominator:**</td><td>all children, 0-17 years, in Mississippi with special healthcare needs</td></tr></table>
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 PPV.1 - Percent of mothers enrolled in home visiting programs who received a postpartum visit with a healthcare providers within 84 days of delivery.
NPM – 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 - PPV

Measure Status:	Active
Goal:	80% of postpartum mothers participating in case management/home visiting programs receive a postpartum visit with a healthcare provider within 84 days of delivery.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of all unduplicated postpartum women served across the following programs (HM/HB, MIECHV, Healthy Start, and Time4Mom) who received a postpartum visit within 84 days of delivery. **Denominator:** Total number of all unduplicated postpartum women served across the following programs (HM/HB, MIECHV, Healthy Start, and Time4Mom)
Data Sources and Data Issues:	HM/HB – EPIC Time4Mom – EPIC / internal data tracking Healthy Start - EPIC / internal data tracking MIECHV - PAT / internal data tracking
Evidence-based/informed strategy:	Evidence based / informed strategy 1. Home visiting aligns with Patient Navigation 2. www.mchevidence.org/tools/strategies/details.php?postpartum-visit.04 3. It directly relates to NPM as having education, postpartum support, and coordination as a core component of service delivery will assure more women have a postpartum visit.
Significance:	t is important to provide support to women for accessing needed medical services while pregnant and postpartum. The more women enrolled in support programs, the greater likelihood they will access a postpartum visit with their provider as encouraging one and assisting to schedule/coordinate is a direct component of service delivery. • Measures quantity of effect • Tells us if anyone is better off having been served through a program

ESM MHS.1 - Percent of pregnant and postpartum women screened positive for depression and are referred for appropriate follow-up care and support.
NPM – Percent of women who were screened for depression or anxiety following a recent live birth - MHS

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>80% of pregnant and postpartum women are referred for services following a positive screening for depression.</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>Total number of all unduplicated pregnant and postpartum women served across the following programs (HM/HB, MIECHV, Healthy Start, and Time4Mom) who screened positive for depression and were referred for services.</td></tr>
<tr><td>Denominator:</td><td>Total number of all unduplicated pregnant and postpartum women served across the following programs (HM/HB, MIECHV, Healthy Start, and Time4Mom) who screened positive for depression.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>HM/HB – EPIC
Time4Mom – EPIC / internal data tracking
Healthy Start - EPIC / internal data tracking
MIECHV - PAT / internal data tracking</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Evidence-based/informed strategy:
• Home visiting, aligns with Patient Navigation, and aligns with Universal Screening.
• WWW.mchevidence.org/documents/accelerators/Postpartum-mental-health-screening-evidence-accelerator.pdf
• It directly related to NPM as having education, postpartum support and coordination as a core component of service delivery will assure more women have a mental health screening.</td></tr>
<tr><td>Significance:</td><td>Significance: It is important to provide support to women for accessing needed mental health services while pregnant and postpartum. The more women enrolled in support programs, the greater likelihood they will receive a postpartum mental health screening.
1. Measures quality of effect.
2. Tells us if anyone is better off having been served through a program.</td></tr>
</table>

ESM MHS.2 - Percent of pregnant and postpartum women screened for substance use disorder who receive appropriate follow-up care and support.
NPM – Percent of women who were screened for depression or anxiety following a recent live birth - MHS

Measure Status:	Active
Goal:	80% of pregnant and postpartum women are referred for services following a positive screening for substance use disorder.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of all unduplicated pregnant and postpartum women served across the following programs (HM/HB, MIECHV, Healthy Start, and Time4Mom) who screened positive for substance use disorder and were referred for services. **Denominator:** Total number of all unduplicated pregnant and postpartum women served across the following programs (HM/HB, MIECHV, Healthy Start, and Time4Mom) who screened positive for substance use disorder.
Data Sources and Data Issues:	HM/HB – EPIC Time4Mom – EPIC / internal data tracking Healthy Start - EPIC / internal data tracking MIECHV - PAT / internal data tracking
Evidence-based/informed strategy:	Evidence based / informed strategy: • Home visiting, aligns with Patient Navigation, and aligns with Universal Screening. • WWW.mchevidence.org/documents/accelerators/Postpartum-mental-health-screening-evidence-accelerator.pdf • It directly related to NPM as having education, postpartum support and coordination as a core component of service delivery will assure more women have a mental health screening.
Significance:	It is important to provide support to women for accessing needed mental health services while pregnant and postpartum. The more women enrolled in support programs, the greater likelihood they will receive a postpartum mental health screening. • Measures quality of effect. • Tells us if anyone is better off having been served through a program

ESM CU.1 - Percent of females seen in the MSDH county health departments for family planning services who are screened for and accept the Family Planning Waiver.
NPM – Percent of women who are using a most or moderately effective contraceptive following a recent live birth - CU

Measure Status:	Active
Goal:	increase the percent of females seen in the MSDH county health departments for family planning services who are screened for and accept the Family Planning Waiver by 5%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of females seen in the MSDH county health departments for family planning services who are screened for and accept the Family Planning Waiver. **Denominator:** Total number of females seen in the MSDH county health departments for family planning services.
Data Sources and Data Issues:	Epic, electronic health record; Family Planning Waiver Users counts
Evidence-based/informed strategy:	Evidence- based / informed strategy: 1. Reducing financial impediments for women in need of postpartum contraception 2. www.mchevidence.org/tools/strategies/details.php?postpartum-contraception-05 3. It directly relates to NPM as it measures the uptake of postpartum contraception following a live birth.
Significance:	It is important to connect reproductive age women with resources to help them access contraception to both reduce unintended pregnancy and increase birth spacing. • Measures quantity of effort • Tells us what we did and how much of it we did – to assure we are maximizing outreach efforts for informing eligible women about Family Planning Waiver and assisting them to enroll through the health department clinics.

ESM RAC.1 - Number of Child Death Review and Fetal Infant Mortality Review recommendations implemented annually (Risk Appropriate Perinatal Care)
NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

Measure Status:	Active
Goal:	Implement 3 or more recommendations that are provided from the Child Death Review and FIMRs across the state directed towards reducing infant deaths.
Definition:	**Unit Type:** Count **Unit Number:** 3 **Numerator:** Total number of recommendations implemented **Denominator:**
Data Sources and Data Issues:	MIHB internal tracking
Evidence-based/informed strategy:	Evidence-based / Informed strategy: 1. No similar strategy found in the established evidence for this NPM. 2. No similar strategy found in Innovation Hub. 3. Data and recommendations from FIMRs and Child Death Reviews can inform providers and systems of care on the need for targeted interventions to reduce infant mortality.
Significance:	Significance: Data and recommendations from FIMRs and CDRs inform programming that is targeted at various systems of care levels. 1. Measures quantity oof effort 2. Tells us how much of something was done.

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 infants breastfed exclusively through 6 months - BF

Measure Status:	Inactive - Completed
Goal:	Increase the percent of births occurring in birthing hospitals designated as Baby Friendly
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of birthing hospitals in the state designated as Baby Friendly **Denominator:**
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 BF.2 - Number of Child Death Review and Fetal Infant Mortality Review recommendations implemented annually (Breastfeeding)
NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Active
Goal:	Implement 3 or more recommendations that are provided from the Child Death Review and FIMRs across the state directed towards reducing infant deaths.
Definition:	**Unit Type:** Count **Unit Number:** 3 **Numerator:** Total number of recommendations implemented **Denominator:**
Data Sources and Data Issues:	MIHB internal tracking
Evidence-based/informed strategy:	Evidence-based / Informed strategy: 1. No similar strategy found in the established evidence for this NPM. 2. No similar strategy found in Innovation Hub. 3. Data and recommendations from Fetal Infant Mortality Reviews and Child Death Reviews can inform providers and systems of care on the need for targeted interventions to reduce infant mortality.
Significance:	Data and recommendations from FIMRs and CDRs inform programming that is targeted at various systems of care levels. 1. Measures quantity oof effort 2. Tells us how much of something was done.

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 - SS

Measure Status:	Inactive - Completed
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
Evidence-based/informed strategy:	https://www.mchevidence.org/tools/measures/safe-sleep.php
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 SS.2 - Number of cribs distributed to participants of MCH-serving programs
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 - SS

Measure Status:	Active
Goal:	Distribute 500 cribs to infants in need through MSDH and Title V MCH serving programs.
Definition:	**Unit Type:** Count **Unit Number:** 500 **Numerator:** Total number of cribs distributed by MSDH and Title V MCH serving programs. **Denominator:**
Data Sources and Data Issues:	MIHB internal tracking
Evidence-based/informed strategy:	Evidence Based/informed strategy: 1. Aligns with the Community Based Distribution of Cribs and Safe Sleep Education 2. www.mchevidence.org/tools/strategies/details.php?safe-sleep-08 3. Studies show that crib distribution and safe sleep education programs have positive effects on increasing mother's knowledge and utilization of safe sleep practices.
Significance:	Sleep related deaths and accidents are a leading cause of infant death in MS. Many infants who die due to sleep related injuries were not on an approved sleep surface. 1. Measures quantity oof effort 2. Tells us how much of something was done.

ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education through the collaborative with WIC
NPM – Percent of women who had a dental visit during pregnancy - PDV-Pregnancy

Measure Status:	Active
Goal:	Increase the number of pregnant and postpartum women who received oral health education through the collaborative with WIC by 2% annually
Definition:	**Unit Type:** Count **Unit Number:** 9,999 **Numerator:** Number of pregnant and postpartum women who received oral health education through the collaborative with WIC **Denominator:**
Data Sources and Data Issues:	internal data collection of Oral Health (REDCap and SPIRIT for WIC) (baseline 3686)
Evidence-based/informed strategy:	Evidence- based / informed strategy: 1. Oral Health Care During Pregnancy | OHRC 2. Talking to Pregnant Women about Oral Health | Oral Health | CDC 3. Pregnancy and Oral Health - AMCHP 4. Improving Oral Health Outcomes for Pregnant Women and Infants by Educating Home Visitors - AMCHP
Significance:	Oral health is a part of health and well-being for pregnant women. Providing education to women regarding the importance of oral health during pregnancy may support preventing carries. • Measures quality of effect. • Tells us if anyone is better off having been served through a program.

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 - PDV-Child

Measure Status:	Inactive - Completed
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 nurse
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child

Measure Status:	Inactive - Completed
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:** 1,000 **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 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.
Evidence-based/informed strategy:	While we are using our EPIC system to capture data on the number of ESPDT 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 on follow up with these participants to share these data.
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 - PDV-Child

Measure Status:	Inactive - Completed
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

ESM PDV-Child.4 - Number of referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses.
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child

Measure Status:	Active
Goal:	Increase Number of referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses.
Definition:	**Unit Type:** Count **Unit Number:** 300 **Numerator:** Number of referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses. **Denominator:**
Data Sources and Data Issues:	EPIC
Evidence-based/informed strategy:	Evidence based / informed strategy 1. Provide education to nurses 2. MCH-npm-combined-summary-and-detail-overview.pdf 3. Bright Futures screening table
Significance:	According to the Recommendations for Preventive Pediatric Health Care, by the American Academy of Pediatrics, children at age 6 begin to lose their baby teeth. It is important to address losing baby teeth and how to care for adult teeth.

ESM AWV.1 - 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 - AWV

Measure Status:	Inactive - Completed
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 AWV.2 - Percentage of adolescents ages 13-17 who received all recommended doses of the human papillomavirus (HPV) vaccine
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Active
Goal:	Increase the percentage of adolescents, ages 13-17, who received all recommended doses of the human papillomavirus (HPV) vaccine by 5%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents ages 13-17 who received all recommended doses of the human papillomavirus (HPV) vaccine **Denominator:** Total number of adolescents aged 13 - 17
Data Sources and Data Issues:	America's Health Rankings
Evidence-based/informed strategy:	Implementing provider reminder and recall systems is an evidence-based approach recommended by the Community Guide and the CDC. Adolescents often miss completing the HPV vaccine series due to a lack of follow-up, missed opportunities during visits, and limited parental awareness. Reminder and recall systems help providers identify patients who are overdue for vaccines and engage families to complete the series.
Significance:	Measuring the percentage of adolescents ages 13–17 who received all recommended doses of the HPV vaccine is significant for several public health and programmatic reasons: • Indicator of Cancer Prevention • Tracks Progress Toward National Goals • Identifies Gaps • Evaluate Effectiveness of Immunization Programs • Public Health Impact on Herd Immunity • Cost-Effectiveness

ESM AWV.3 - Percent of adolescents, ages 12-17, with an EPSDT medical visit and screening in the MSDH county Health Departments
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Active
Goal:	Increase the number of EPSDT screenings, which include the depression screening performed among adolescents ages 12-17 in county health department clinics annually.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents, ages 12-17, with an EPSDT medical visit and screening in the MSDH county Health Departments **Denominator:** Total Number of adolescent-aged 12 – 17 who had a medical visit in the MSDH county Health Departments
Data Sources and Data Issues:	EPIC
Evidence-based/informed strategy:	Evidence based / informed strategy • Bright Futures • EPSDT_state_profile_mississippi.pdf. • Medicaid is Vital to Mississippi_s Children.pdf • BF_Adol_Priorities_Screens.pptx
Significance:	EPSDT developmental screenings for adolescents ages 11-20 address not only physical screenings such as height/weight, body mass index, blood pressure, vision and hearing, but also mental health screenings such as psychosocial/behavioral assessment, tobacco, alcohol, and drug use assessments, depression screenings. Early identification and interventions are important in identifying developmental conditions. • Measures quality of effect. • Tells us if anyone is better off having been served through a program.

ESM MHT.1 - Number of presentations surrounding suicide awareness for youths
NPM – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT

Measure Status:	Active
Goal:	Increase presentations surrounding suicide awareness by 5% to address youth access to mental health resources and reduce youth suicide attempts.
Definition:	**Unit Type:** Count **Unit Number:** 32 **Numerator:** Number of presentations surrounding suicide awareness for youths **Denominator:**
Data Sources and Data Issues:	Data collection by Community Health Advancement (baseline 25)
Evidence-based/informed strategy:	Evidence- based / informed strategy: • MCHbest. Mental Health Treatment. | MCH Evidence • Mark Haddad, Vanessa Pinfold, Tamsin Ford, Brendan Walsh, Andre Tylee, The effect of a training programme on school nurses' knowledge, attitudes, and depression recognition skills: The QUEST cluster randomised controlled trial, International Journal of Nursing Studies, Volume 83, 2018, Pages 1-10, ISSN 0020-7489, https://doi.org/10.1016/j.ijnurstu.2018.04.004. • Adolescent Health Current Initiatives -
Significance:	Suicide awareness presentations promote an understanding, reduce stigma and provide skills for teachers, school counselors, health care providers, and peers to intervene effectively. Suicide awareness presentations provide open communication for peers to speak up, for teens to understand the warning signs, and normalizes the signs for help as a strength and not a weakness. • Measures quality of effect. • Tells us if anyone is better off having been served through a program.

ESM MHT.2 - Percent of community partners in a collaboration addressing youth mental health care and suicide prevention awareness.
NPM – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT

Measure Status:	Active
Goal:	Increase the number of community partners to address youth access to mental health resources and reduce youth suicide attempts by 5%
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of community partners in a collaboration addressing youth mental health care and suicide prevention awareness. **Denominator:** Number of community partners invited to join in the collaboration to address youth mental health care and suicide prevention awareness.
Data Sources and Data Issues:	Data collection by Community Health Advancement
Evidence-based/informed strategy:	Evidence- based / informed strategy: • MCHbest. Mental Health Treatment. | MCH Evidence • Mark Haddad, Vanessa Pinfold, Tamsin Ford, Brendan Walsh, Andre Tylee, The effect of a training programme on school nurses' knowledge, attitudes, and depression recognition skills: The QUEST cluster randomised controlled trial, International Journal of Nursing Studies, Volume 83, 2018, Pages 1-10, ISSN 0020-7489, https://doi.org/10.1016/j.ijnurstu.2018.04.004. • Adolescent Health Current Initiatives -
Significance:	Community partners understand the specific factors affecting their communities. They have the trusted relationships with different populations and are able to reach more people, who may not traditionally engage with the county health departments. Each community partners brings unique resources to the table, strengthening the collaborative efforts to address youth mental health care and suicide prevention awareness. • Measures quality of effect. • Tells us if anyone is better off having been served through a program

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 - MH

Measure Status:	Inactive - Completed
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 MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and insurance access.
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of Parent Consultants and Care Coordinators of CYSHCN who are able to assist parents and caregivers in navigating a comprehensive system of care for medical and insurance access by 2% annually.</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 Parent Consultants and Care Coordinators in the CYSHCN program who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and insurance access</td></tr>
<tr><td>Denominator:</td><td>Number of Parent Consultants and Care Coordinators in the CYSHCN program</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Internal data collection by CYSHCN program leadership staff</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Evidence based / informed strategy:
1. Medical Home Portal - AMCHP
2. MCH Navigator: https://www.pcpcc.org/webinar/practical-approaches-enhance-communication-and-coordinated-care-pcmh</td></tr>
<tr><td>Significance:</td><td>Significance: For children and youth with special health care needs, and their families, having a medical home helps facilitate partnership between the provider, the family and the CYSHCN. When a CYSHCN has identified medical providers, they are more likely to meet have improved quality of life.
• Measures quality of effect.
• Tells us if anyone is better off having been served through a program.</td></tr>
</table>

ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months old in county health department clinics annually.
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Active
Goal:	Increase the number of EPSDT screenings performed among children 0-36 months old in county health department clinics annually.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of EPSDT screenings performed among children 0-36 months old in county health department clinics **Denominator:** Total number of children 0-36 months old seen in county health department clinics
Data Sources and Data Issues:	EPIC
Evidence-based/informed strategy:	Evidence based / informed strategy Per the American Academy of Pediatrics, a medical home is an approach to providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff and families. It goes on further to state that a medical home extends past the clinical practice to include specialty care, and anyone providing services to children. https://publications.aap.org/pediatrics/article/133/5/e1451/32796/Patient-and-Family-Centered-Care-Coordination-A?autologincheck=redirected • Bright Futures • CDC's "Learn the Signs, Act Early • npm_6_developmental_screening_evidence_review_brief_april_2018.pdf • Flower KB, Massie S, Janies K, Bassewitz JB, Coker TR, Gillespie RJ, Macias MM, Whitaker TM, Zubler J, Steinberg D, DeStigter L, Earls MF. Increasing Early Childhood Screening in Primary Care Through a Quality Improvement Collaborative. Pediatrics. 2020 Sep;146(3):e20192328. doi: 10.1542/peds.2019-2328. Epub 2020 Aug 7. PMID: 32769199.
Significance:	EPSDT developmental screenings are routinely completed visits among this age range in county health departments. EPSDT visits play an important role in establishing medical homes for children. Early identification and interventions are important in identifying developmental conditions for referrals to specialists, community services, and creates an opportunity for the child to be connected with a consistent source for care. Collection of this data will allow the Title V MCH programs to track the percentage of children receiving an EPSDT developmental screenings. • Measures quality of effect. • Tells us if anyone is better off having been served through a program.

ESM MH_CC.1 - Percent of CYSHCN referrals who accept enrollment into CYSHCN care coordination program
NPM – Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination - MH_CC

Measure Status:	Active
Goal:	Increase the percentage of CYSHCN referrals who accept enrollment into CYSHCN care coordination program by 2% annually
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CYSHCN referrals who accept enrollment into CYSHCN care coordination program **Denominator:** Total Number of CYSHCN referrals
Data Sources and Data Issues:	MSDH CYSHCN: EPIC; External Partners; internal CYSHCN database
Evidence-based/informed strategy:	Evidence based / informed strategy 1. National Care Coordination Standards for Children and Youth with Special Health Care Needs - NASHP 2. care-coordination-report-v5.pdf 3. Medical Home Care Coordination Resources
Significance:	Care coordination is important for CYSHCN because they often require services from multiple providers, agencies, and systems. Care Coordination helps to reduce fragmented care. • Measures quality of effect. • Tells us if anyone is better off having been served through the care coordination program.

ESM TAHC.1 - Percent of MSDH and external health care professionals/ providers who attend educational opportunities regarding health care transition for CYSHCN.
NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

Measure Status:	Active
Goal:	Increase the percent of MSDH and external health care professionals/ providers who attend educational opportunities regarding health care transition for CYSHCN.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MSDH and external health care professionals/ providers who attend educational opportunities regarding health care transition for CYSHCN. **Denominator:** Total number of MSDH and external health care professionals/ providers invited
Data Sources and Data Issues:	Internal data collection by CYSHCN leadership
Evidence-based/informed strategy:	Evidence based / informed strategy 1. MCH Navigator: Transition to Adult Health Care for Youth with Special Health Care Needs 2. Medical Home Portal - AMCHP
Significance:	For children and youth with special health care needs, and their families, having a medical home helps facilitate partnership between the provider, the family, and the CYSHCN. Providers need to be knowledgeable about the important steps needed to occur starting around age 13 for a CYSHCN, and continued until they transition, at age 21. • Measures the quality of effect. • Tells us if anyone is better off having been served through a program.

Form 10

Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM DS.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring
2021-2025: NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

<table>
<tr><td>Measure Status:</td><td>Inactive - Completed</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>

2021-2025: ESM WWV.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - 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.

2021-2025: ESM PA-Adolescent.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide
2021-2025: NPM – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day - 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 impediments 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.

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 2024

	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:

Other Data Source(s) (Optional) Field Notes:

Data Source Name:	**9) BRFSS**
	Field Note: Provide data about women and men of reproductive age
Data Source Name:	**10) YRBSS**
	Field Note: Provide data about adolescent risk and protective factors
Data Source Name:	**11) NSCH**
	Field Note: Provides the child's data using a Mississippi sub-sample
Data Source Name:	**12) EPIC**
	Field Note: Provides health encounter data for many programs
Data Source Name:	**13) HHLPSS**
	Field Note: This is the state's Lead Poisoning Prevention database
Data Source Name:	**14) CATALYST**
	Field Note: This is the database for the breast and cervical cancer prevention program
Data Source Name:	**15) NVSS**
	Field Note: Provides official vital statistics data
Data Source Name:	**16) HPSA Find**
	Field Note: Used to identify health professional shortage areas
Data Source Name:	**17) Mississippi Infant & Toddler Intervention (MITI) Data System**
	Field Note: This is the state's Early Intervention database

Form 12
Part 2 – Products and Publications (Optional)

State: Mississippi

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Products and Publications information has not been provided by the State.