



MISSISSIPPI STATE  
DEPARTMENT OF HEALTH

**2020**

***Title V***

***Maternal and Child Health Services***

***Block Grant***

Comprehensive Needs Assessment

# Table of Contents

<b>Executive Summary</b>	<b>1</b>
<b>Introduction</b>	<b>1</b>
<b>2020 Needs Assessment Process</b>	<b>2</b>
Process	2
Needs Assessment Data Sources and Methods of Collection	3
<b>Findings by MCH Population Domain</b>	<b>6</b>
Women/Maternal Domain	6
Perinatal/Infant Domain	7
Child Domain	9
Adolescent Domain	10
CYSHCN Domain	11
<b>Description of Prioritization Process</b>	<b>13</b>
<b>Final Prioritized List of Needs by Domain</b>	<b>17</b>
<b>Domain Report: Women/Maternal</b>	<b>20</b>
Setting a Baseline for Women's/Maternal Health in Mississippi: A Summary of Federally Available Data	20
Statements of Needs: Women/Maternal Domain	33
Prioritized Statements of Needs: Women/Maternal Domain	37
<b>Domain Report: Perinatal/Infant Domain</b>	<b>38</b>
Setting a Baseline for Perinatal/Infant Health in Mississippi: A Summary of Federally Available Data	38
Statements of Needs: Perinatal/Infant Domain	51
Prioritized Statements of Needs: Perinatal/Infant Domain	55
<b>Domain Report: Child Domain</b>	<b>56</b>
Setting a Baseline for Child Health in Mississippi: A Summary of Federally Available Data	56
Statements of Needs: Child Domain	67
Prioritized Statements of Needs: Child Domain	70
<b>Domain Report: Adolescent Domain</b>	<b>71</b>
Setting a Baseline for Adolescent Health in Mississippi: A Summary of Federally Available Data	71
Statements of Needs: Adolescent Domain	87
Prioritized Statements of Needs: Adolescent Domain	90
<b>Domain Report: CYSHCN Domain</b>	<b>91</b>
Setting a Baseline for CYSHCN Health in Mississippi: A Summary of Federally Available Data	91
Statements of Needs: CYSHCN Domain	99
Prioritized Statements of Needs: CYSHCN Domain	103
<b>Appendix: Socio-Demographics of Focus Group Participants and Survey Respondents</b>	<b>104</b>

# Executive Summary

## I. 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 promoting and improving the health and well-being of the nation's women, adolescents, infants, and children, including children and youth with special health care needs (CYSHCN). 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 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 (<http://www.mchb.hrsa.gov/>).

CYSHCN “have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally” (McPherson et al., 1998). In Mississippi, 23.3% of children and youth ages 0-17 have a special health care need, higher than the national percentage (18.5%). Based on these estimates, 167,120 children and youth in Mississippi have a special health care need ([www.childhealthdata.org/browse/survey](http://www.childhealthdata.org/browse/survey)). CYSHCN and their families often need services from multiple systems – health care, public health, education, mental health, and social services.

The Title V MCH Block Grant Needs Assessment is a systematic process to collect information about the state's public health system and service provision to pregnant women, mothers, infants, children, adolescents, and CYSHCN. The information collected through the needs assessment is used to identify statewide priorities, drive strategic planning, and allocate funds. 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.

## II. 2020 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.

Promoting health equity and reducing health disparities are guiding principles for the MSDH. The agency operationalizes its programs through the lens of health equity as defined in the [Healthy People 2020](#) framework: "...the attainment of the highest level of health for all people." Furthermore, the MSDH recognizes that disparities and inequities are driven by many factors, including social determinants of health such as education, poverty, structural racism, and housing safety and quality. As such, the Title V MCH Needs Assessment included strategies to assure equitable opportunities for participation so that broad stakeholder voices could be heard. These included:

- Fielding paper and mobile-friendly online surveys
- Assuring accessibility of online surveys for screen reading software
- Using translation and interpreter services (surveys and focus groups)
- Partnering with local, trusted organizations for recruitment and awareness efforts
- Facilitating diverse focus groups that included representation based on geography, race, ethnicity, language, income, age, and disability status
- Providing incentives for focus group participation

Health disparities not only affect groups facing inequities but also limit overall improvements in quality of care and the health status for the broader population, resulting in unnecessary costs. Several areas of disparity were identified across all domains. The full domain reports for each population of interest provide more in-depth discussion of identified disparities and inequities. The MSDH is committed to addressing health equity in the processes, policies, and procedures of all MSDH programs.

The needs assessment data collection and prioritization process for each domain is described below.

### A. Process

As part of the 2020 Title V MCH Comprehensive Needs Assessment, the MSDH entered into an agreement with the University of Alabama at Birmingham (UAB) School of Public Health, Department of Health Care Organization and Policy, Applied Evaluation and Assessment Collaborative (AEAC) 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 AEAC 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, and provided final approval for all activities. The AEAC fielded surveys, facilitated focus groups and key informant interviews, performed all analyses, and developed final reports. The AEAC entered into agreements with three community partner organizations to support the needs assessment: The University of Southern Mississippi Institute for Disability Studies, Mississippi Community Education Center, and the Family Resource Center of North Mississippi. These organizations worked with the AEAC to raise awareness of surveys, recruit focus group participants, handle logistics, and provide locations to host focus groups.

## **B. Needs Assessment Data Sources and Methods of Collection**

### ***Overview***

The data described in this report were collected specifically to capture the experiences and perceptions of stakeholders including health care consumers, families, teens/young adults, and providers across the state to bolster the MSDH's knowledge and assist in identifying MCH needs. Information compiled from national surveys, census data, vital statistics, and previous needs assessments were considered by the MSDH and are reported elsewhere. All methods were based on previous instruments, past experiences, best practice in instrument development and data collection, and areas of interest by an internal needs assessment leadership team at the MSDH. Populations for recruitment were also identified by the internal team to ensure complete representation of MCH stakeholders across the state.

### ***Federally Available Data***

The AEAC 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. Values represent the most recently available data retrieved from

<https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures> and <https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures> and the Federally Available Data (FAD) Resource Document (Maternal and Child Health Bureau. Federally Available Data (FAD) Resource Document. July 2, 2020; Rockville, MD: Health Resources and Services Administration. Available at:

<https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures>). For the child and adolescent domains, overall FAD were further stratified directly from the National Survey of Children's Health ([www.childhealthdata.org](http://www.childhealthdata.org)) to represent specific age groups. For the CYSHCN domain, some FAD aligned with this population included both CYSHCN and non-CYSHCN. For these measures, AEAC staff again accessed the original data source (National Survey of Children's Health, [www.childhealthdata.org](http://www.childhealthdata.org)) to stratify the data to limit analyses exclusively to performance for CYSHCN.

### ***Surveys***

*Family Survey* – The MSDH conducted a family survey of Mississippi residents to obtain information regarding Mississippi's capacity and the strengths and weaknesses in the state's health care delivery system. The survey was designed by the AEAC and intended to capture perspectives of Mississippi residents, including women of childbearing age and those who are raising children and youth. The survey was disseminated online in both English and Spanish. Surveys were also available in mobile-friendly layouts and screen reader compliant formats. The online survey was disseminated through the platform Qualtrics. Surveys were marketed by the AEAC and MSDH Title V team to Mississippi residents through flyers, social media postings, email, partnerships with other agencies and health care providers. There were a total of 577 survey respondents.

*Provider Survey* – The MSDH also conducted a survey of primary health care providers for women of childbearing age, children, and youth regarding Mississippi's service capacity and the state's health

care delivery system. The survey was designed by the AEAC and disseminated online through Qualtrics. Surveys were marketed by the AEAC and MSDH Title V team to Mississippi providers through flyers, social media, email, and partnerships with other agencies and health care providers. There were a total of 104 survey respondents representing the specialties of Family Medicine, Obstetrics and Gynecology, Gynecology, and Pediatrics. Multi-specialty providers, mental health providers, and other Allied Health Professionals were also represented in the sample.

*Adolescent Survey* – The MSDH conducted a survey of adolescents and young adults in Mississippi to understand the unique concerns, experiences, and perspectives of this age category. The survey was designed by the AEAC and disseminated online in both English and Spanish. Surveys were also available in mobile-friendly layouts and screen reader compliant formats. The online survey was disseminated through the platform Qualtrics. Surveys were marketed by the AEAC and MSDH Title V team to Mississippi residents between the ages of 13 and 26 through flyers, social media and website postings, email, and partnerships with other agencies and health care providers. There were 58 responses in that age range, though an additional 118 adults responded; adult responses were analyzed with the general family survey data.

*Families of CYSHCN Survey* – The MSDH conducted a family survey of Mississippi residents to obtain information regarding Mississippi’s capacity and the strengths and weaknesses in the state’s health care delivery system. The survey was designed by the AEAC and intended to capture perspectives of families/caregivers of CYSHCN. The survey was disseminated via paper and online formats in both English and Spanish. Surveys were also available in mobile-friendly layouts and screen reader compliant formats. The online survey was disseminated through the platform Qualtrics. The MSDH sent paper surveys to families on the CYSHCN program contact list, and completed surveys were then returned to the AEAC through the MSDH. The MSDH marketed the survey to families/caregivers of CYSHCN through flyers, social media, email, and partnerships with other agencies. Data from the paper surveys were entered into Qualtrics and merged with the online version for final analysis. There were a total of 167 family survey respondents.

*Youth with Special Health Care Needs Survey* – The MSDH also conducted a survey of Mississippi youth and young adults with SHCN between the ages of 13 and 25. The survey was designed by the AEAC and disseminated via paper and online formats in both English and Spanish. Surveys were also available in mobile-friendly layouts and screen reader compliant formats. The online survey was disseminated through the platform Qualtrics. The MSDH sent paper surveys to youth on the CYSHCN program contact list, and completed surveys were then returned to the AEAC through the MSDH. The MSDH marketed the survey to YSHCN through flyers, social media, email, and partnerships with other agencies. Data from the paper surveys were entered into Qualtrics and merged with the online version for final analysis. There were a total of 62 youth survey respondents.

### ***Key Informant Interviews***

Qualitative data collection included semi-structured key informant interviews facilitated with individuals identified by the MSDH as having expert knowledge of one or more MCH populations or about specific issues important to the MCH population in the state. Twenty individuals representing local, state, public, and private groups consented to participate in an interview. Interviews were conducted over the phone by AEAC faculty and staff. The AEAC staff members designed a template for

a consistent notetaking process across all team members facilitating interviews. Notes were compared and data were collated by an AEAC staff member for emerging themes, and subsequent thematic summaries were determined based on data included in the emerging themes. Strengths, barriers, gaps, and areas of need were also identified from all participants and merged to identify cross-agency perceptions. The AEAC team convened to discuss collated data and determine agreement across all team members after completion of the analysis.

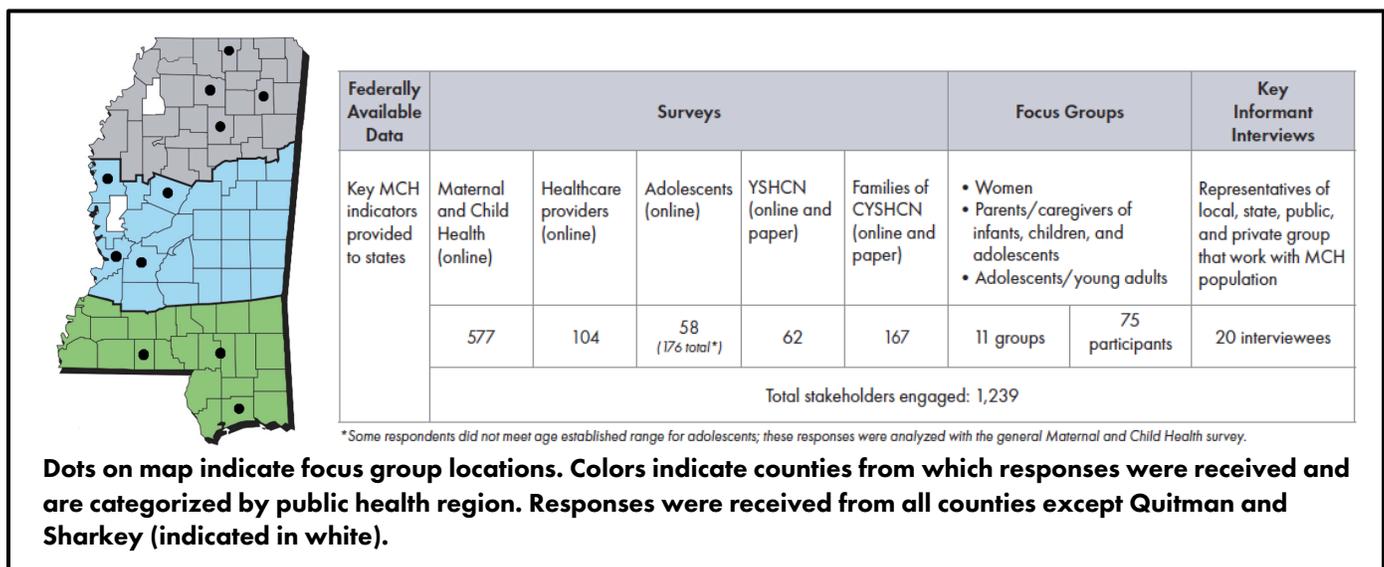
**Focus Groups**

The MSDH and AEAC partnered with The University of Southern Mississippi Institute for Disability Studies, Mississippi Community Education Center, and the Family Resource Center of North Mississippi to recruit focus group participants across the state. Focus groups were facilitated by AEAC staff and faculty with community members across Mississippi. Focus group participants included women; parents/caregivers of infants, children, and adolescents; adolescents/young adults; Spanish speaking families; and families of CYSHCN. A total of 75 participants attended 11 focus groups with at least three groups in each public health region. All focus groups were recorded and professionally transcribed.

Two AEAC staff members, designated as coders, analyzed focus group transcripts using the qualitative data analysis software NVivo. Initial codes were developed from the focus group topic guide. Subsequent updates to the codebook were documented throughout the process. Coders consulted and discussed final themes and sub-themes for intercoder agreement. A document was created describing the final themes and sub-themes identified.

Figure 1 provides an overview of data collected across all methods of the Mississippi 2020 Title V MCH Needs Assessment. A total of 1,239 stakeholders were engaged through surveys, focus groups, and key informant interviews. Socio-demographic characteristics of focus group participants and survey respondents generally matched those for the state. Detailed socio-demographic characteristics of stakeholders who participated in these specific data collection methods are presented in the Appendix.

**Figure 1. Overview of Data for Mississippi 2020 Title V MCH Needs Assessment**



### III. Findings by MCH Population Domain

**Overview**

Consistent with the mixed-methods process outlined above, the information below incorporates both quantitative and qualitative findings. Each of the following sections begins with an overview of the FAD from the HRSA/MCHB Title V Information System. Data presented include NPMs and NOMs reported for Mississippi. Additional state-level data from surveys and reports supplement FAD for some domains. These data are used to set a baseline, quantitative picture of the State. Following the FAD chart in each specific domain are summaries of the major themes drawn from consideration of all data collection strategies. Quantitative and qualitative data led to the development of the need statements that were presented to stakeholders and leadership to choose as the state’s priority needs for the upcoming five-year cycle. These need statements are further described within the full domain report for each population of interest.

Furthermore, in keeping with the processes’ guiding principle of promoting health equity and reducing disparities, several themes were noted across all domains.

- Indicator data show differences in outcomes based on race, ethnicity, socioeconomic status, age, insurance status and type, and urban/rural location.
- Stakeholders expressed differences in access to services, treatment experiences, and perceptions of quality of care based on race, ethnicity, socioeconomic status, marital status, sexual orientation, age, disability status, substance use, insurance status and type, primary language, and geographic location.
- Several areas of disparity were identified across all domains. The full domain reports for each population of interest provide more in-depth discussion of identified disparities and inequities.

**A. Women/Maternal Domain**

Women’s/Maternal Health Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Well-woman visit	61.6%	Worse	Mixed
Low-risk cesarean delivery (first births)	30.8%	Worse	Trending better
Early elective delivery	2.0%	Same	Trending better
Severe maternal morbidity	198.2 per 10,000	Worse	Trending worse
Pregnancy-related mortality	22.1 per 100,000	Worse	Trending worse
Preventive dental visit – during pregnancy	21.2%	Worse	NA
Smoking – during pregnancy	8.9%	Worse	Trending better
Early prenatal care	78.5%	Better	Trending better
Neonatal abstinence syndrome (NAS)	3.0 per 1,000	Better	Trending worse
Teen births	31.0 per 1,000	Worse	Trending better

\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in arears. See page 3 for information on FAD and to access current information.

For the women/maternal domain, six themes were identified following a thorough consideration of all data collection methods.

1. Health and Oral Health Care Access, Cost, and Insurance
2. Health and Wellness
3. Maternal Mortality
4. Mental and Behavioral Health
5. Reproductive and Sexual Health
6. Smoking, Substance, and Alcohol Use

From these themes, the following women/maternal needs were identified:

- Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, disability status, insurance status/type, primary language, sexual orientation, and weight
- Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education
- Lack of or inadequate access to supports for health and wellness, including education, affordable and safe options for physical activity, and healthy foods
- Lack of or inadequate access to comprehensive, family-centered, and culturally competent reproductive and well-woman health care and education, including for women with disabilities
- Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)
- Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services
- Inadequate or lack of comprehensive, affordable health and dental insurance
- High levels of maternal mortality

## B. Perinatal/Infant Health Domain

Perinatal/Infant Health Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Risk-appropriate perinatal care – very low birth weight babies born in hospitals with a Level III+ NICU	81.7%	NA	Trending better
Breastfeeding – ever	63.2%	Worse	Trending better
Breastfeeding – exclusively through 6 months	13.0%	Worse	Trending better
Safe sleep – infant placed on back	56.9%	Worse	Trending slightly better
Neonatal abstinence syndrome (NAS)	3.0 per 1,000	Better	Trending worse
SUID mortality	152.9 per 100,000	Worse	Mixed
Infant mortality	8.7 per 1,000	Worse	Trending better
Preterm birth	13.6%	Worse	About the same
Low birth weight	11.6%	Worse	About the same
Early elective delivery	2.0%	Same	Trending better

\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in arrears. See page 3 for information on FAD and to access current information.

For the perinatal/infant health domain, eight themes were identified following a thorough consideration of all data collection methods.

1. Breastfeeding
2. Health and Oral Health Care Access, Cost, and Insurance
3. Infant Mortality
4. Mental Health
5. Reproductive Health
6. Safe Sleep Education
7. Smoking, Substance, and Alcohol Use
8. Young and New Parents

From these themes, the following perinatal/infant health needs were identified:

- Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, disability status, insurance status/type, primary language, sexual orientation, and weight
- Lack of or inadequate access to comprehensive reproductive health care
- Inequitable access to health resources (including delivery hospitals) based on race/ethnicity, socioeconomic status, geographic location, and education
- Lack of supports for pregnant and parenting teens and young/new parents
- High levels of infant mortality (and associated factors of preterm birth and low birth weight)

- High levels and worsening trends of sleep-related/SUID deaths
- Lack of or inadequate access to breastfeeding supports
- Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)
- Inadequate or lack of comprehensive, affordable health and dental insurance
- Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services

### C. Child Health Domain

Child Health Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Developmental screening – child (9-35 months)	18.6%	Worse	Trending slightly better
Physical activity – child (6-11 years) (4-6 days per week)	20.6%	Worse	Trending slightly better
Preventive dental visit – child (6-11 years)	86.1%	Worse	About the same
Household smoking – child (0-5 years)	20.3%	Worse	Trending better
Household smoking – child (6-11 years)	21.0%	Worse	Trending better
Child mortality	29.9 per 100,000	Worse	Trending better
Obesity (2-4 years)	14.5%	About the same	Trending slightly better
Child vaccination – child (19-35 months)	68.7%	About the same	Trending better
Hospitalization for non-fatal injury – child (0-9 years)	127.1 per 100,000	About the same	Trending better

\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in arears. See page 3 for information on FAD and to access current information.

For the child health domain, six themes were identified following a thorough consideration of all data collection methods.

1. Pediatric Workforce Shortage
2. Health and Wellness
3. Mental and Behavioral Health
4. Oral Health Care Access and Cost
5. Smoking, Substance, and Alcohol Use
6. Developmental and Health Screenings

From these themes, the following child needs were identified:

- Lack of awareness of healthy nutrition guidelines and portion sizes
- Lack of or inadequate access to mental health services that are comprehensive and age-appropriate
- Lack of or inadequate access to affordable and safe options for physical activity
- Lack of timely, appropriate, and consistent health and developmental screenings
- Limited access to affordable oral health care and insurance
- Lack of comprehensive, family-centered, and culturally competent health care
- Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education
- Lack of or inadequate smoking, alcohol, and substance use prevention education

#### D. Adolescent Health Domain

Adolescent Health Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Physical activity (every day)	27.8%	Worse	Trending slightly worse
Bullying (victimization)	24.3%	Worse	Trending worse
Adolescent well-visit	77.0%	Slightly worse	Trending better
Preventive dental visit – adolescent	88.9%	Better	About the same
Adolescent mortality	48.4 per 100,000	Worse	Trending better
Adolescent motor vehicle death	28.0 per 100,000	Worse	Trending better
Adolescent suicide	9.6 per 100,000	Slightly better	Mixed
HPV vaccination	49.6%	Worse	Trending better
Obesity (10-17 years)	19.2%	Worse	Trending worse
Household smoking (12-17 years)	21.2%	Worse	Trending slightly worse
Hospitalization for non-fatal injury (10-19 years)	204.4 per 100,000	Better	Trending better
Teen births	31.0 per 1,000	Worse	Trending better

\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in areas. See page 3 for information on FAD and to access current information.

For the adolescent domain, eight themes were identified following a thorough consideration of all data collection methods.

1. Health and Wellness
2. Healthy Relationships
3. Mental and Behavioral Health
4. Oral Health Care Access, Cost, and Insurance
5. Pregnant and Parenting Teens

- 6. Reproductive and Sexual Health
- 7. Smoking, Substance, and Alcohol Use
- 8. Supports for Transitioning to Adulthood

From these themes, the following adolescent needs were identified:

- Lack of or inadequate access to affordable and safe options for physical activity, exercise, and recreation
- Inadequate and insufficient health and sexual health education
- Lack of or inadequate access to comprehensive reproductive health care, including for adolescents with disabilities
- Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education
- Lack of or inadequate access to mental health services that are comprehensive and age-appropriate
- Lack of supports for pregnant and parenting teens
- Inadequate or insufficient preparation, information, and resources to support transition to adulthood (life skills, job preparedness)
- Limited access to adult role models and mentors
- Inadequate or lack of comprehensive, affordable health and oral health care and insurance
- Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education
- Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, insurance status/type, sexual orientation, and gender identity

**E. Children and Youth with Special Health Care Needs (CYSHCN) Domain**

CYSHCN Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Medical home	46.9%	Better	Trending better
Transition**	22.3%	Slightly better	Trending slightly worse
Adequate insurance	68.1%	Better	Trending slightly better
CSHCN systems of care (received all components of a well-functioning system: family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition)	15.6%	About the same	No change

\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in arears. See page 3 for information on FAD and to access current information.

\*\*Data may be unreliable due to small sample

For the CYSHCN domain, seven themes were identified following a thorough consideration of all data collection methods.

1. Access to Care
2. Adult Based Care
3. Community Inclusion and Integration
4. Coordination of Care
5. Education and Information
6. Family Stress and Support
7. Special Education

From these themes, the following CYSHCN needs were identified:

- Lack of or inadequate supports for transition to all aspects of adulthood
- Inadequate insurance, including cost and benefit coverage issues
- Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain
- Lack of or inadequate access to coordinated, comprehensive care
- Lack of or inadequate support for family/caregiver wellbeing
- Inadequate support for caregivers navigating the system of care
- Lack of or inadequate access to CYSHCN-specific health education
- Insufficient special education services
- Youth with SHCN are not meeting guidelines for physical activity and nutrition
- Lack of provider workforce that is knowledgeable about CYSHCN, especially in rural areas and for adult services
- Lack of or inadequate accessibility and accommodation supports, including physical environment, interpreter services, and materials
- Lack of or inadequate access to timely assessments and appropriate referral

## IV. Description of Prioritization Process

Final selection of priority needs was conducted in a two-phase process. It was a priority of the MSDH to include broad stakeholder input on the developed need statements prior to making any decisions. Following stakeholder input, MSDH senior leadership was informed by stakeholder opinions while incorporating their knowledge of agency capacity and other feasibility considerations. Due to the COVID-19 pandemic, both prioritization phases were conducted virtually.

### Phase 1: Stakeholder Input

In July 2020, the MSDH convened domain-specific virtual meetings of key constituents and consumers to serve as an advisory committee and to assist with the prioritization of identified MCH needs. Participants received an introductory module to view before the virtual meetings. This module included an overview of Title V and the needs assessment requirement, as well as a presentation of the specific processes used for the 2020 needs assessment. Three synchronous, virtual meetings took place over a one-week period. In two of the meetings, two population domains were discussed and their priorities ranked. In the final meeting, one population domain was discussed and priorities ranked. In each virtual meeting, the list of needs associated with a domain was presented with the relevant FAD and summaries of the qualitative data. Following presentations and discussion, virtual meeting participants rated each need using the live polling feature in Zoom.

There was impressive stakeholder participation and engagement in the virtual meetings, especially considering the personal and professional challenges of responding to the pandemic. The total number of virtual meeting participants for each day were:

Day 1 – Women and Perinatal Domains = 39

Day 2 – Child and Adolescent Domains = 28

Day 3 – CYSHCN Domain = 20

### *Process to Obtain Need Rankings*

Virtual meeting participants individually rated each need according to two separate criteria:

1. *Importance/Impact for community based on data*
2. *Feasibility*

Individual ratings for criteria scores were summed and then averaged to yield a total score for each need. Total scores were used to assign rank order for needs. Below is a description and chart showing the specific considerations for each of the three criteria:

1. *Importance/Impact for community based on data*: How important is this issue or need based on what you have heard from the data presentation? What is the extent of impact for the MCH population if this issue or need were addressed?

Rating Scale for Importance/Impact

1 = Low Importance/ Impact	2 = Low-Medium Importance/ Impact	3 = Medium Importance/ Impact	4 = Medium-High Importance/ Impact	5 = High Importance/ Impact
-------------------------------------	--	--	---	--------------------------------------

2. *Feasibility*: How feasible is it to address this need? Are there existing solutions, political will, and resources available?

Rating Scale for Feasibility

1 = No/Low Feasibility	2 = Low-Medium Feasibility	3 = Medium Feasibility	4 = Medium-High Feasibility	5 = High Feasibility
------------------------------	----------------------------------	------------------------------	-----------------------------------	----------------------------

## Phase 2: Leadership Rating and Final Decisions

Following the rating and final rankings that the broader stakeholders completed at the July 2020 meetings, the AEAC designed an online survey to distribute to MSDH senior leadership to reach consensus on the final priority needs identified in the 2020 Needs Assessment Process. Following a discussion of the process, senior leadership team members individually completed the survey. Support documents were provided to participants and included domain-specific summary data booklets, FAD, prioritization criteria, and the ranked lists of needs produced by the stakeholder meetings. A total of 11 senior leadership team members participated in the final phase of prioritization.

Below are the criteria, special considerations for ranking, and ranking system.

1. *Aligns with other priorities and initiatives in organization and/or state*
2. *Feasibility*
3. *Measure/Method to assess*
4. *Opportunities to collaborate with other national, state, and/or community partners*
5. *Health/outcome equity and disparities*

Individual prioritization took place in two steps:

1. Selection of top three priority needs by domain: Participants first chose the highest priority need for a domain, informed by the support documents and the prioritization criteria. Participants then selected two additional high priority needs. This process was repeated for each population domain.

2. Selection of five additional needs: The highest priority needs for each domain produced a list of five priority needs, satisfying the requirement that each domain be represented by at least one priority need on the final list. The two additional high priority needs selected for each domain formed a list from which participants could select five additional needs to complete the final list.

After all participants completed the survey, the following formula was used to calculate a score for each need: **number of votes for highest priority + number of votes for the next highest priority + ranked top three at stakeholder meeting** (1 = yes, 0 = no).

Below is a description and chart showing the specific considerations for each of the five criteria:

1. *Aligns with other priorities and initiatives in organization and/or state*: The extent to which the need aligns with other priorities/initiatives in the state and/or the MSDH

Rating Scale for Alignment

1 = Low Alignment	2 = Moderate Alignment	3 = High Alignment
----------------------	---------------------------	-----------------------

2. *Feasibility*: The extent to which addressing the need is feasible based on cost, expertise, time, resources, political will, and existence of evidence-based solutions

Rating Scale for Feasibility

1 = Low Feasibility	2 = Moderate Feasibility	3 = High Feasibility
------------------------	-----------------------------	-------------------------

3. *Measure/Method to assess*: The extent to which data and/or measurement strategy exists (or willingness/ability to develop exists) to monitor progress on addressing the need

Rating Scale for Measure

1 = No measure exists and agency not willing or unable to develop	2 = Measure doesn't exist, but agency is willing and able to develop	3 = Measure exists
--	---	-----------------------

4. *Opportunities to collaborate with other national, state, and/or community partners:* The extent to which addressing this need offers opportunities to collaborate with others at national, state, and/or community levels

Rating Scale for Collaboration

1 = Low Potential for Collaboration	2 = Moderate Potential for Collaboration	3 = High Potential for Collaboration
---	--	--

5. *Health/outcome equity and disparities:* The extent to which the need is associated with inequitable attainment of highest level of health-related outcomes; the extent of disparities in outcome for some population groups

Rating Scale for Equity

1 = No/minimal inequity or disparity exists	2 = Moderate inequity or disparity exists	3 = Significant equity or disparity exists
---	---	--

## V. Final Prioritized List of Needs by Domain

At the conclusion of Phase 2, the following prioritized lists were produced for each domain.

### A. Women/Maternal Domain

Rank	Need
1	High levels of maternal mortality
2	Lack of or inadequate access to comprehensive, family-centered, and culturally competent reproductive and well-woman health care and education, including for women with disabilities
3	Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, disability status, insurance status/type, primary language, sexual orientation, and weight
4	Lack of or inadequate access to supports for health and wellness including education, affordable and safe options for physical activity, and healthy foods
5	Inequitable access to health resources (including delivery hospitals) based on race/ethnicity, socioeconomic status, geographic location, and education
6 (tied)	Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)
6 (tied)	Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services
7	Lack of or inadequate comprehensive, affordable health and oral health insurance

### B. Perinatal/Infant Domain

Rank	Need
1	High levels of infant mortality (and associated factors of preterm birth and low birth weight)
2	High levels and worsening trends of sleep-related deaths/SUID
3	Lack of supports for pregnant and parenting teens and young/new parents
4 (tied)	Inequitable access to health resources (including delivery hospitals) based on race/ethnicity, socioeconomic status, geographic location, and education
4 (tied)	Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, insurance status/type, and primary language
4 (tied)	Inadequate or lack of comprehensive, affordable health and oral health insurance
5	Lack of or inadequate access to comprehensive reproductive health care
6 (tied)	Lack of or inadequate access to breastfeeding supports
6 (tied)	Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)
6 (tied)	Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services

### C. Child Domain

Rank	Need
1 (tied)	Lack of comprehensive, family-centered, and culturally-competent health care
1 (tied)	Lack of timely, appropriate, and consistent health and developmental screenings
2	Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education
3 (tied)	Lack of or inadequate access to affordable and safe options for physical activity
3 (tied)	Lack of or inadequate access to mental health services that are comprehensive and age-appropriate
4	Lack of awareness of healthy nutrition guidelines and portion sizes
5 (tied)	Lack of or inadequate smoking, alcohol, and substance use prevention education
5 (tied)	Limited access to affordable oral health care and insurance

### D. Adolescent Domain

Rank	Need
1	Inadequate or insufficient preparation, information, and resources to support transition to adulthood (life skills, job preparedness)
2	Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education
3	Lack of or inadequate access to comprehensive reproductive health care, including for adolescents with disabilities
4	Limited access to adult role models and mentors
5 (tied)	Inadequate and insufficient health and sexual health education
5 (tied)	Lack of or inadequate access to mental health services that are comprehensive and age-appropriate
6	Lack of or inadequate substance abuse treatment (smoking, alcohol, drugs) and prevention education
7 (tied)	Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, insurance status/type, sexual orientation, and gender identity
7 (tied)	Lack of or inadequate access to affordable and safe options for physical activity, exercise, and recreation
8 (tied)	Lack of supports for pregnant and parenting teens
8 (tied)	Inadequate or lack of comprehensive, affordable health and oral health care and insurance

## E. CYSHCN Domain

Rank	Need
1	Lack of or inadequate access to coordinated, comprehensive care
2	Lack of or inadequate supports for transition to all aspects of adulthood
3 (tied)	Inadequate support for caregivers navigating the system of care
3 (tied)	Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain
3 (tied)	Lack of provider workforce that is knowledgeable about CYSHCN, especially in rural areas and for adult services
4	Lack of or inadequate access to timely assessments and appropriate referral
5 (tied)	Lack of or inadequate support for family/caregiver wellbeing
5 (tied)	Inadequate insurance, including cost and benefit coverage issues
6 (tied)	Insufficient special education services
6 (tied)	Lack of or inadequate access to CYSHCN-specific health education
7 (tied)	Lack of or inadequate accessibility and accommodation supports, including physical environment, interpreter services, and materials
7 (tied)	Youth with SHCN are not meeting guidelines for physical activity and nutrition

**MSDH 2020 Title V Maternal and Child Health Services Block Grant  
Comprehensive Needs Assessment**  
*Domain Report: Women/Maternal*

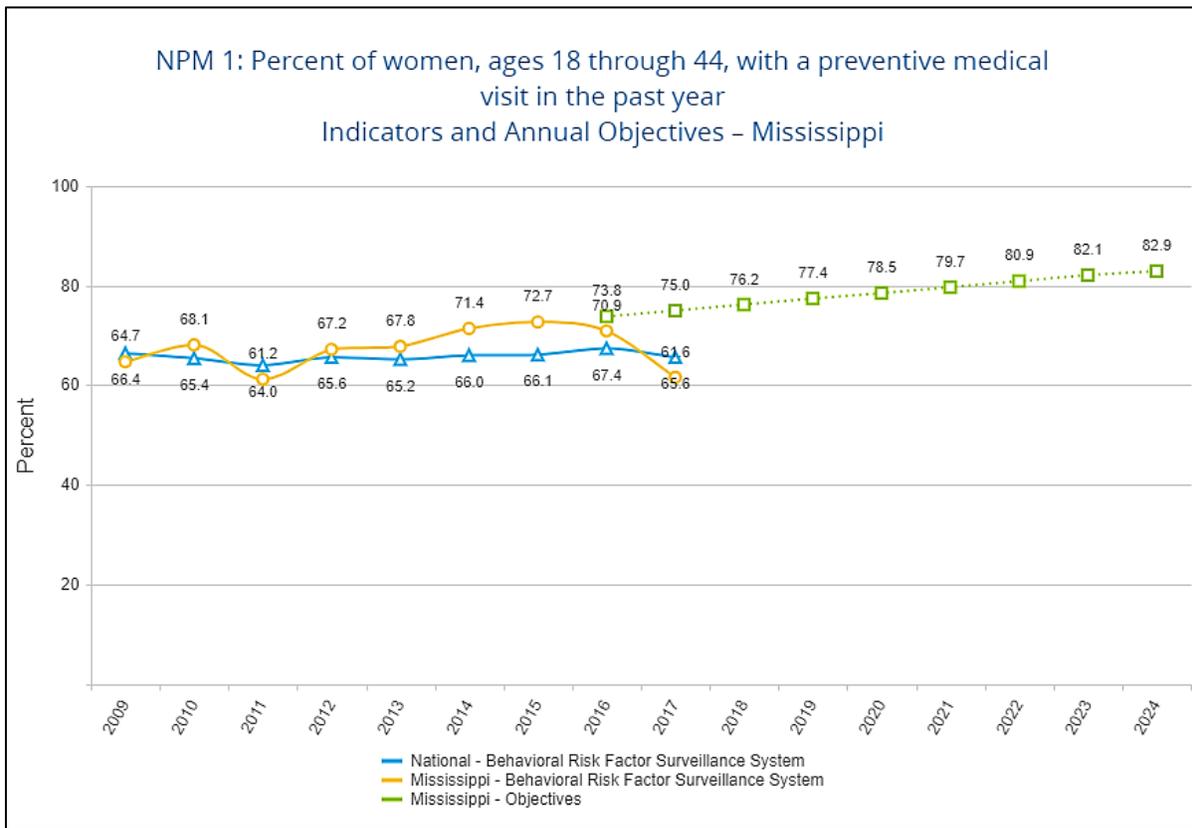
**I. Setting a Baseline for Women’s/Maternal Health in Mississippi: A  
Summary of Federally Available Data**

Each state is provided with a set of indicators that cover all Title V domains. These indicators are tied to the National Performance Measures and National Outcome Measures on which states have chosen to focus. The table below summarizes all of the indicators that are associated with women’s/maternal health for Mississippi.

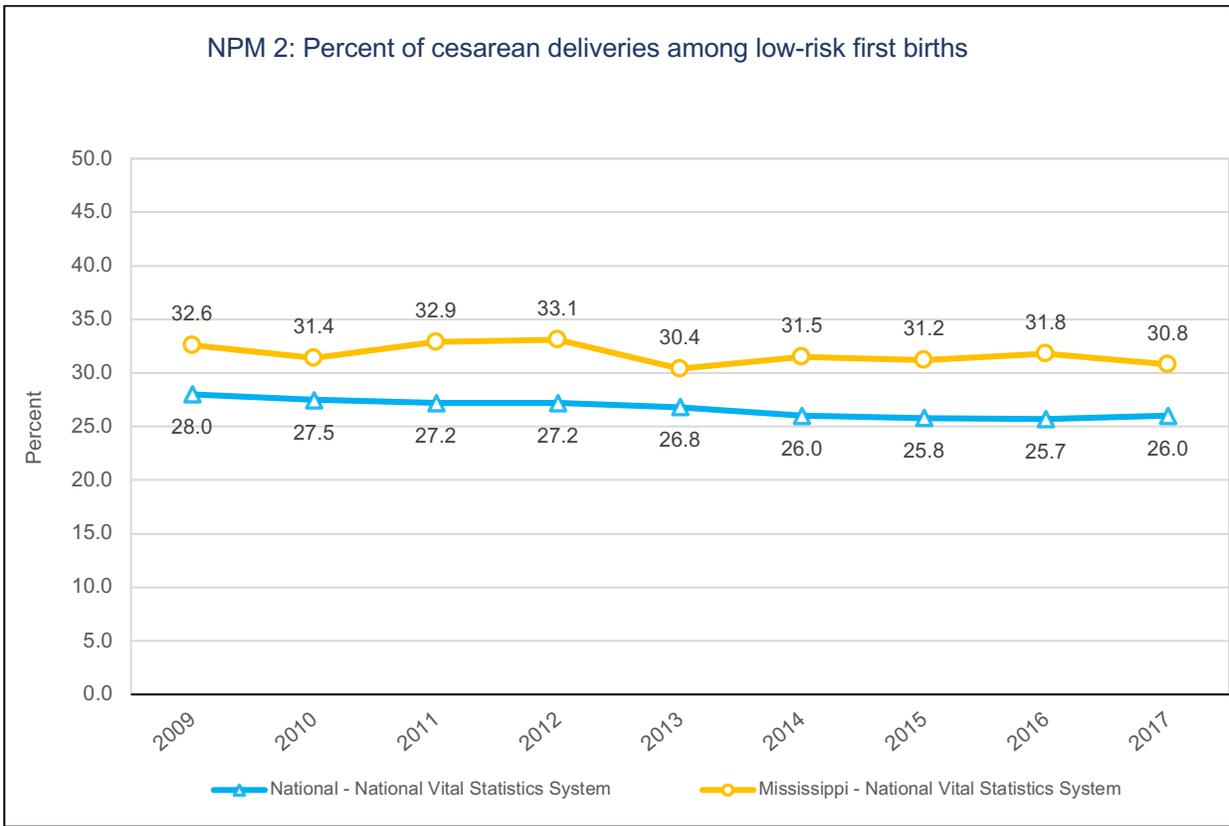
Women’s/Maternal Health Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Well-woman visit	61.6%	Worse	Mixed
Low-risk cesarean delivery (first births)	30.8%	Worse	Trending better
Early elective delivery	2.0%	Same	Trending better
Severe maternal morbidity	198.2 per 10,000	Worse	Trending worse
Pregnancy-related mortality	22.1 per 100,000	Worse	Trending worse
Preventive dental visit – during pregnancy	21.2%	Worse	NA
Smoking – during pregnancy	8.9%	Worse	Trending better
Early prenatal care	78.5%	Better	Trending better
Neonatal abstinence syndrome (NAS)	3.0 per 1,000	Better	Trending worse
Teen births	31.0 per 1,000	Worse	Trending better

\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in arears. See page 3 for information on FAD and to access current information.

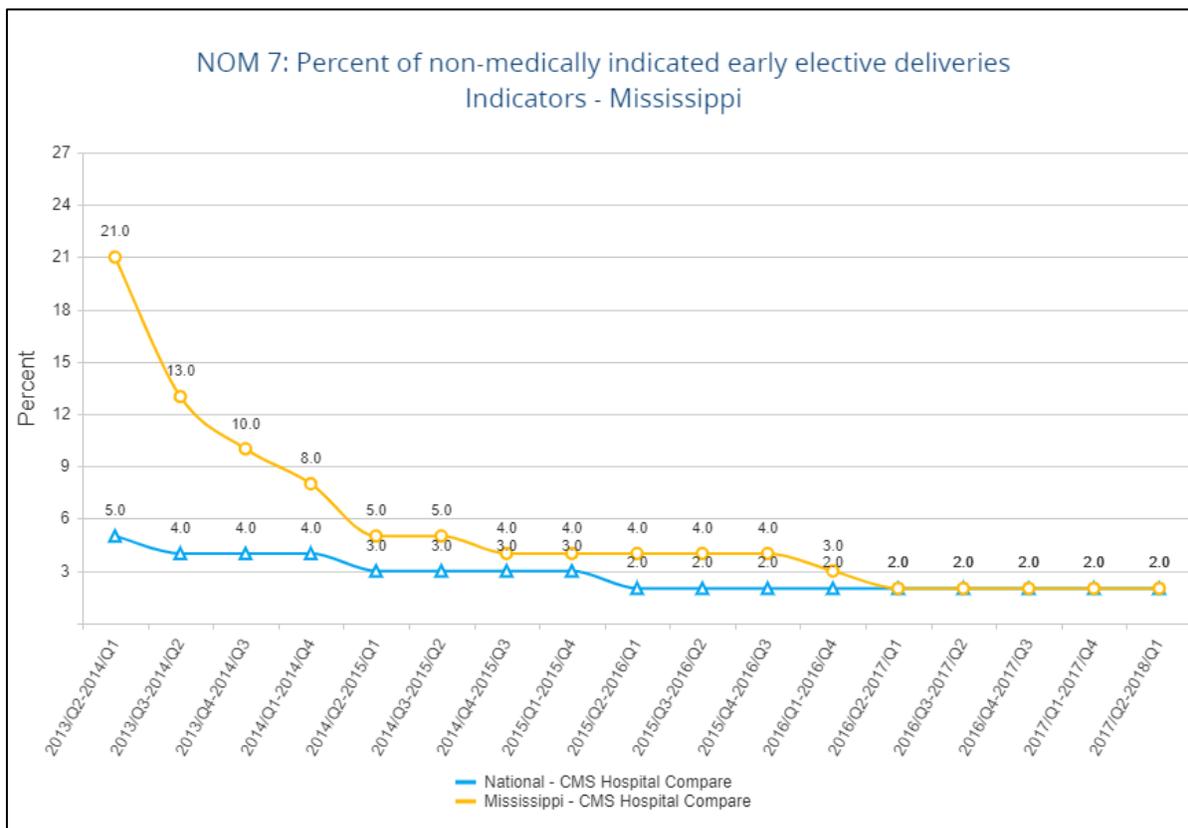
Consistent with the guiding principle of promoting health equity and reducing disparities, several areas of disparity were noted across all domains in both the Federally Available Data (FAD) and qualitative findings. For this domain, indicator data show differences in outcomes based on race, ethnicity, socioeconomic status, education, and insurance status and type. Furthermore, these inequities are driven by many factors, including social determinants of health like education, poverty, structural racism, and housing safety and quality. Notable disparities in sentinel indicators are presented below. The following charts present the above data in a more detailed format and, where available, across time to show comparisons to national indicators and trends.



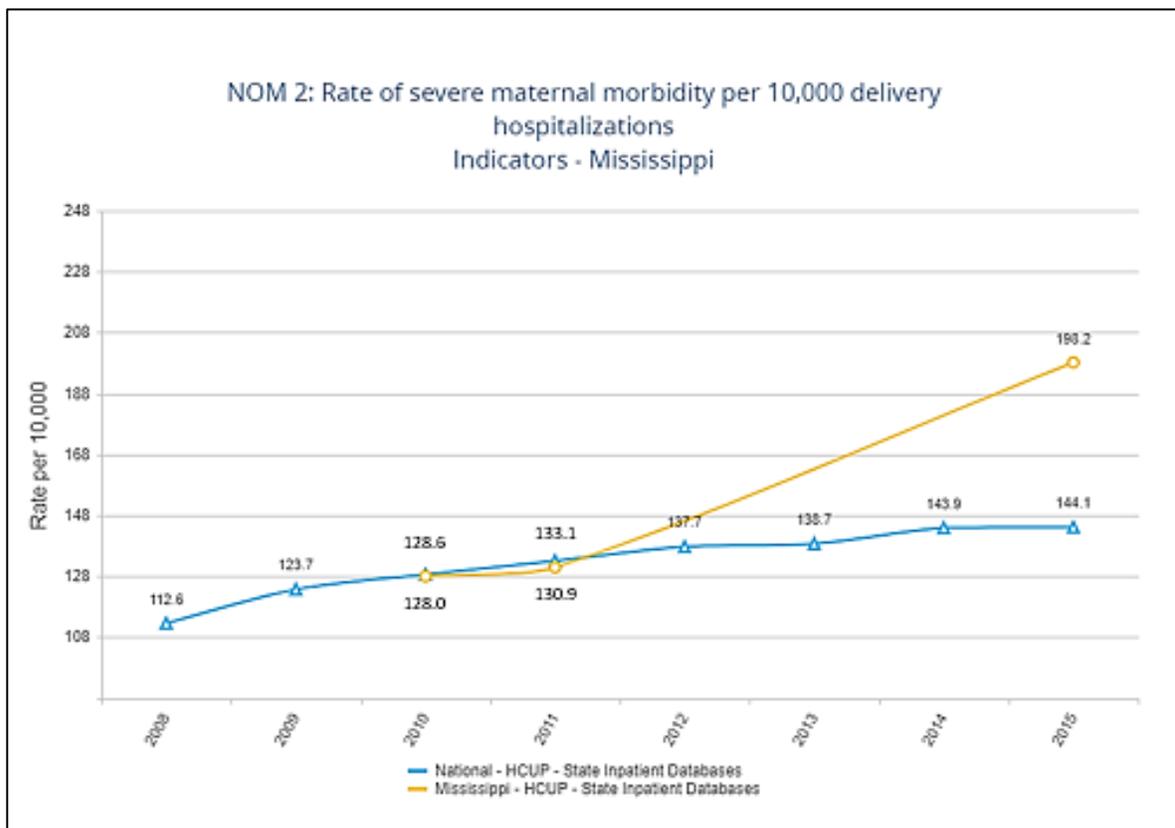
The above data, from the Behavioral Risk Factor Surveillance System, compare Mississippi and the U.S. on NPM 1 (Percent of women, ages 18 through 44, with a preventive medical visit in the past year) between 2009 and 2017. In Mississippi, the percent has fluctuated over time with a steady increase from 2011 to 2015 before declining in 2016 and 2017. The percentage decreased from 64.7% in 2009 to 61.6% in 2017. Nationally, the percent has fluctuated slightly but stayed relatively consistent from 2009 to 2017. In 2010 and from 2012 - 2016, Mississippi reported higher percentages than the U.S., though the state reported a percentage lower than the nation in 2017. The green data points indicate the objectives for coming years.



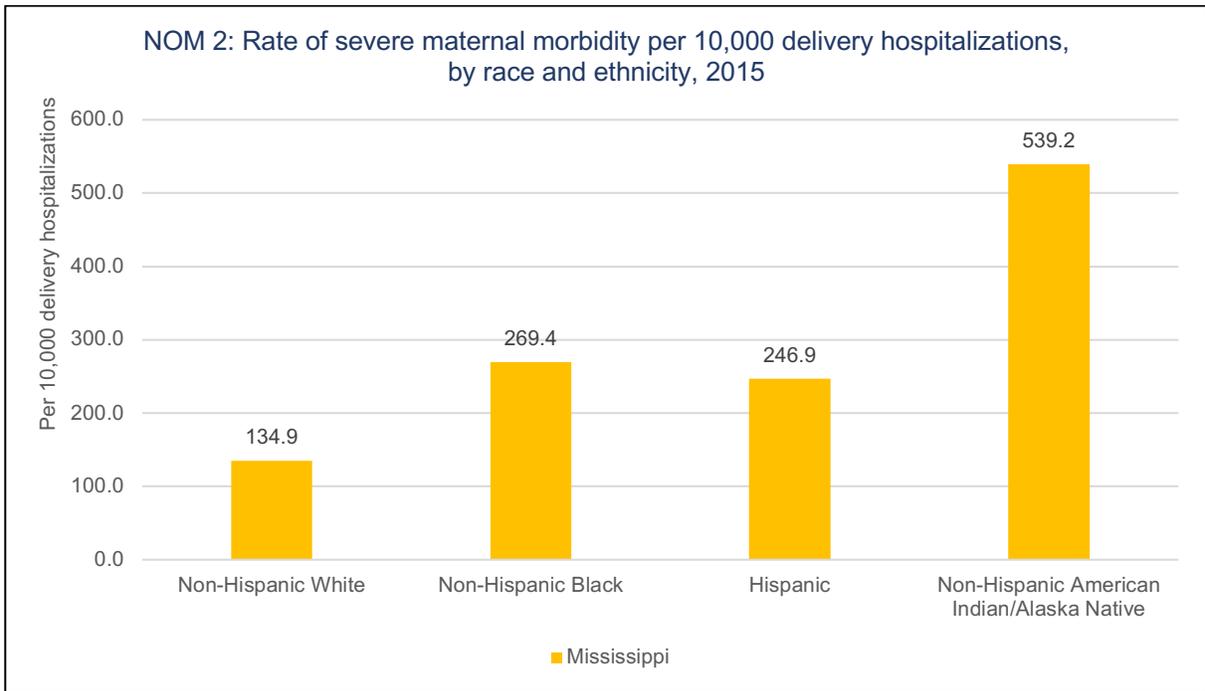
The above data, from the National Vital Statistics System, compare Mississippi and the U.S. on NPM 2 (Percent of cesarean deliveries among low-risk first births) between 2009 and 2017. For both Mississippi and the U.S., the percent has decreased slightly over this period of time. Mississippi consistently reports a slightly higher percent than the nation. Individuals with private insurance exhibit a higher percentage of cesarean deliveries compared to those with Medicaid, other public insurance, and no insurance coverage. Individuals who identify as Native American/Alaskan Natives demonstrated a higher percentage compared with individuals who identify as non-Hispanic white, non-Hispanic black, Hispanic, Asian, or multiple race.



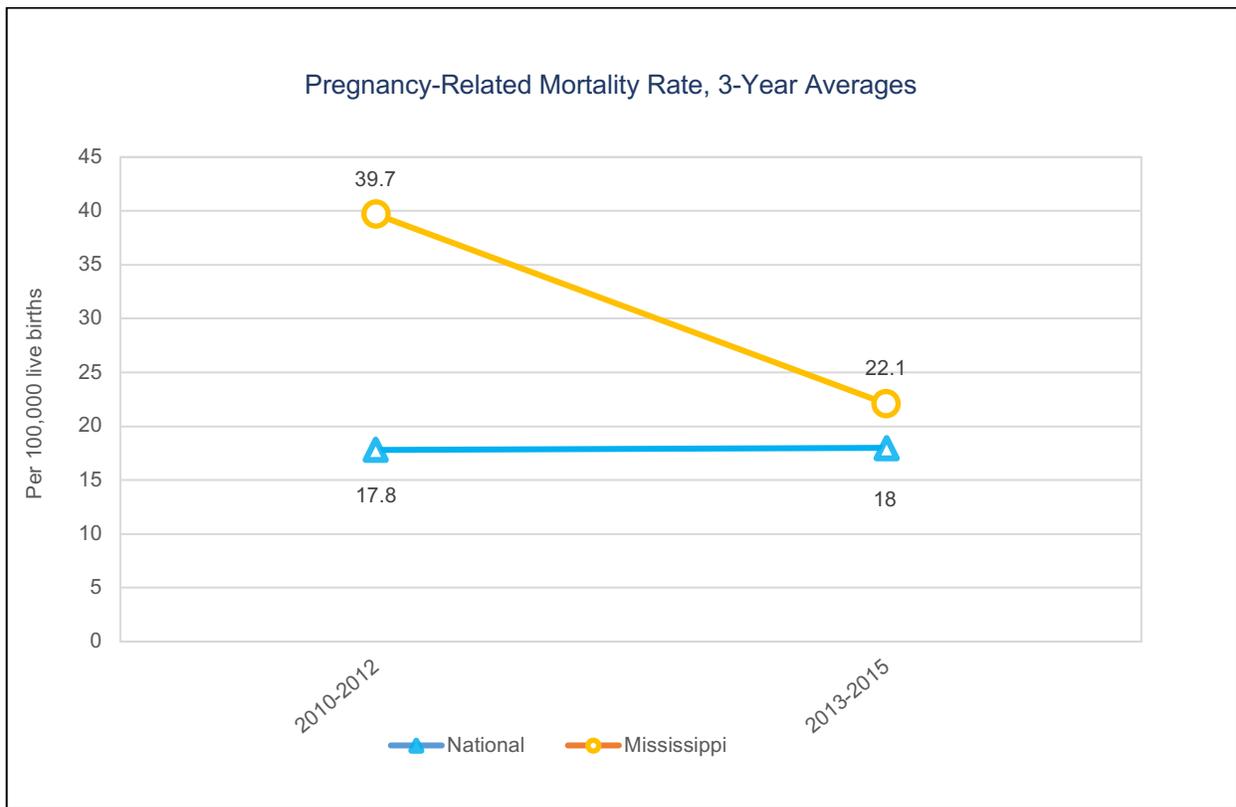
The above data, from CMS Hospital Compare, display Mississippi and the U.S. performance on NOM 7 (Percent of non-medically indicated early elective deliveries) between 2013 (Q2) and 2018 (Q1). Since the spring of 2013, Mississippi's percent has decreased significantly. From the second quarter of 2016 through the end of 2017, the Mississippi and national percentages remained steady at 2.0%.



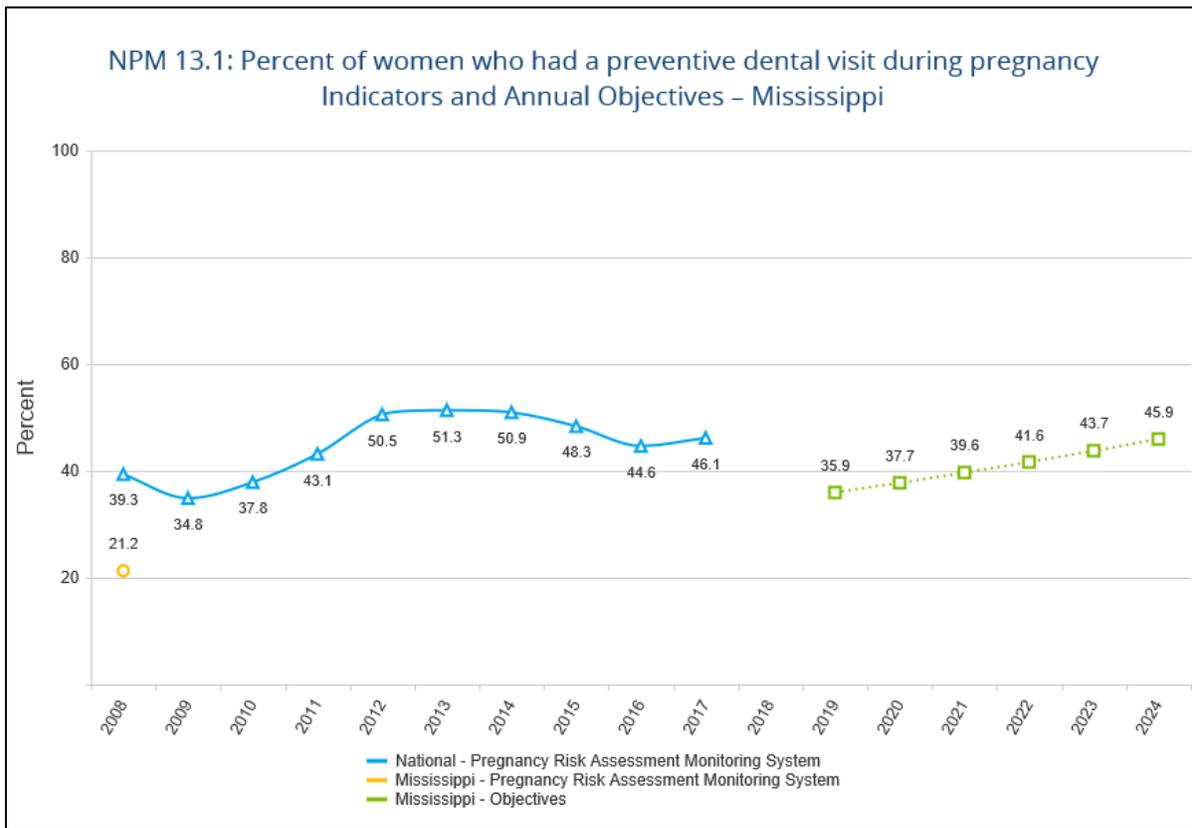
The above data, from the Healthcare Cost and Utilization Project – State Inpatient Databases, compare Mississippi and the U.S. on NOM 2 (Rate of severe maternal morbidity per 10,000 delivery hospitalizations). Mississippi began reporting in 2010. In 2010 and 2011, Mississippi reported percentages slightly lower than the national percentages. However, in 2015, Mississippi’s percentages increased significantly. The national percentage has increased gradually over time. Individuals without health insurance have a higher rate of severe maternal morbidity than those with private insurance, Medicaid or other public insurance.



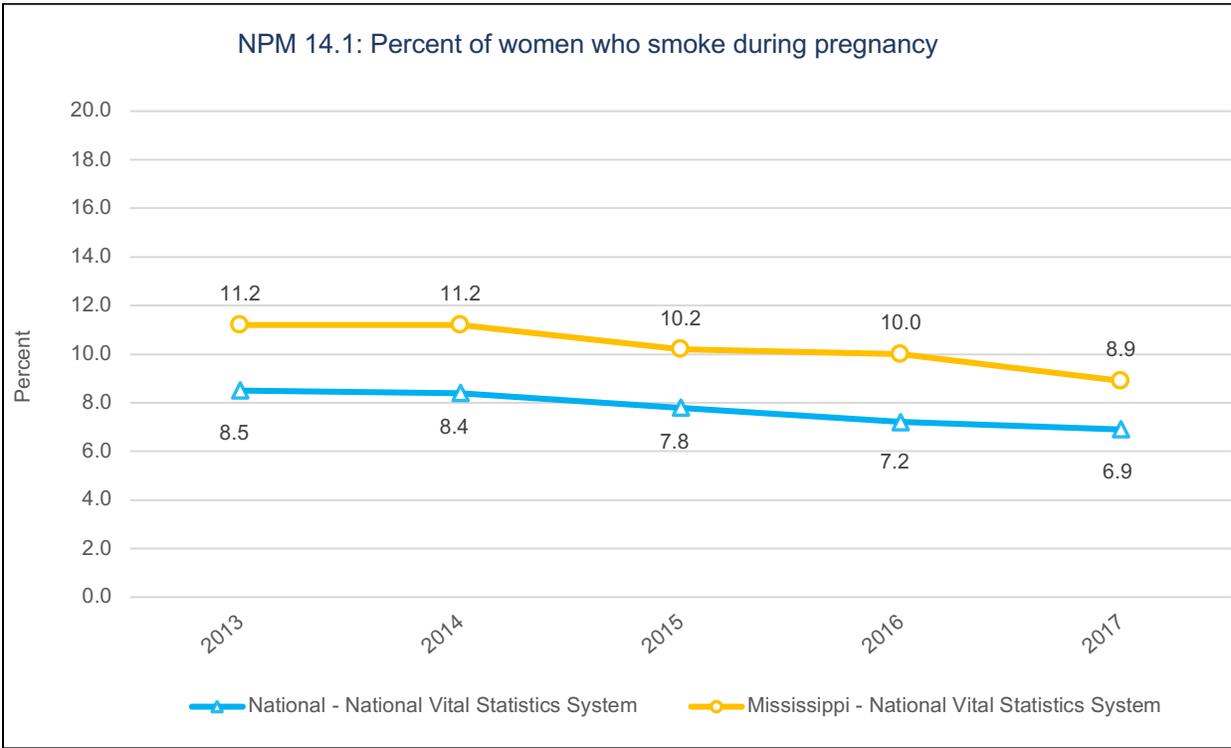
This chart presents the disparities in the rate of severe maternal morbidity by race and ethnicity. Individuals who identify as non-Hispanic American Indian/Alaska Native have the highest rate of severe maternal morbidity while individuals who identify as non-Hispanic white have the lowest rate.



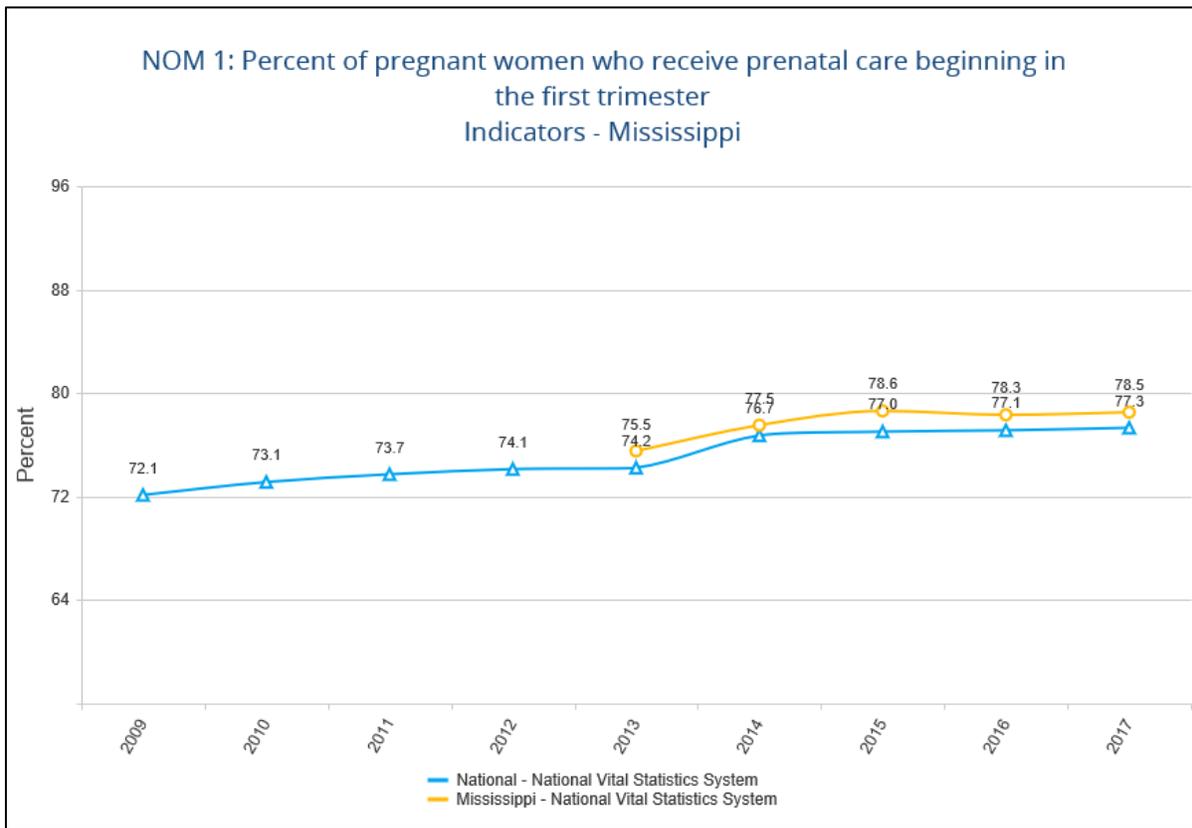
At the time of Title V Information System (TVIS) entry in 2019, FAD data were not reportable for maternal mortality due to significant quality concerns with death certificate data within the National Vital Statistics System (NVSS). The above data, from the 2011-2012 Mississippi Pregnancy-Related Maternal Mortality Report and 2013-2016 Mississippi Maternal Mortality Report, compare Mississippi and the U.S. on the rate of pregnancy-related mortality. Mississippi’s pregnancy-related mortality rate has declined significantly between the two reporting periods while the national rate has remained relatively stable.



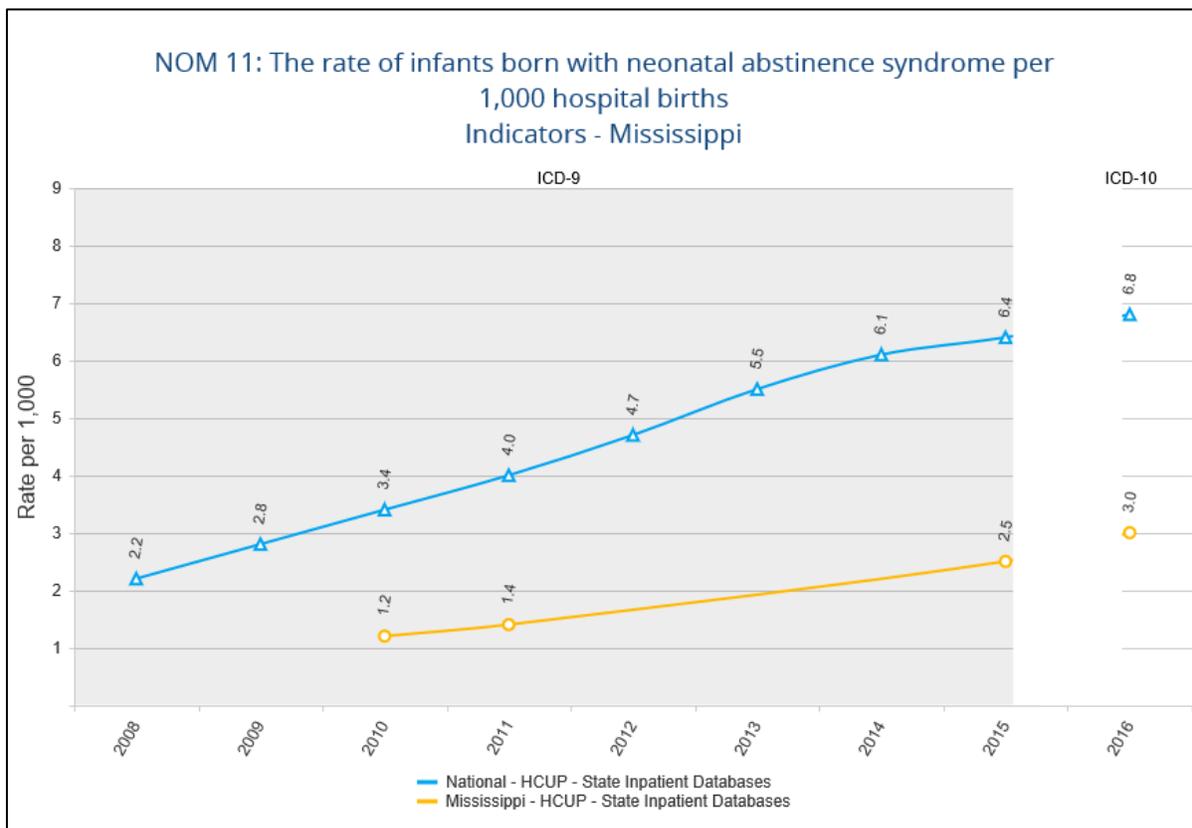
The above data, from the Pregnancy Risk Assessment Monitoring System, compare Mississippi and the U.S. on NPM 13.1 (Percent of women who had a preventive dental visit during pregnancy) in 2008. (PRAMS data is reported to the Centers for Disease Control and Prevention annually, but only appears in the national dataset if the preset Response Rate Threshold for the year was met by the state.) Mississippi's percent was lower than the national percent in 2008. The U.S. percent increased between 2009 and 2013, declining slightly in recent years. The green data points indicate Mississippi's objectives for coming years.



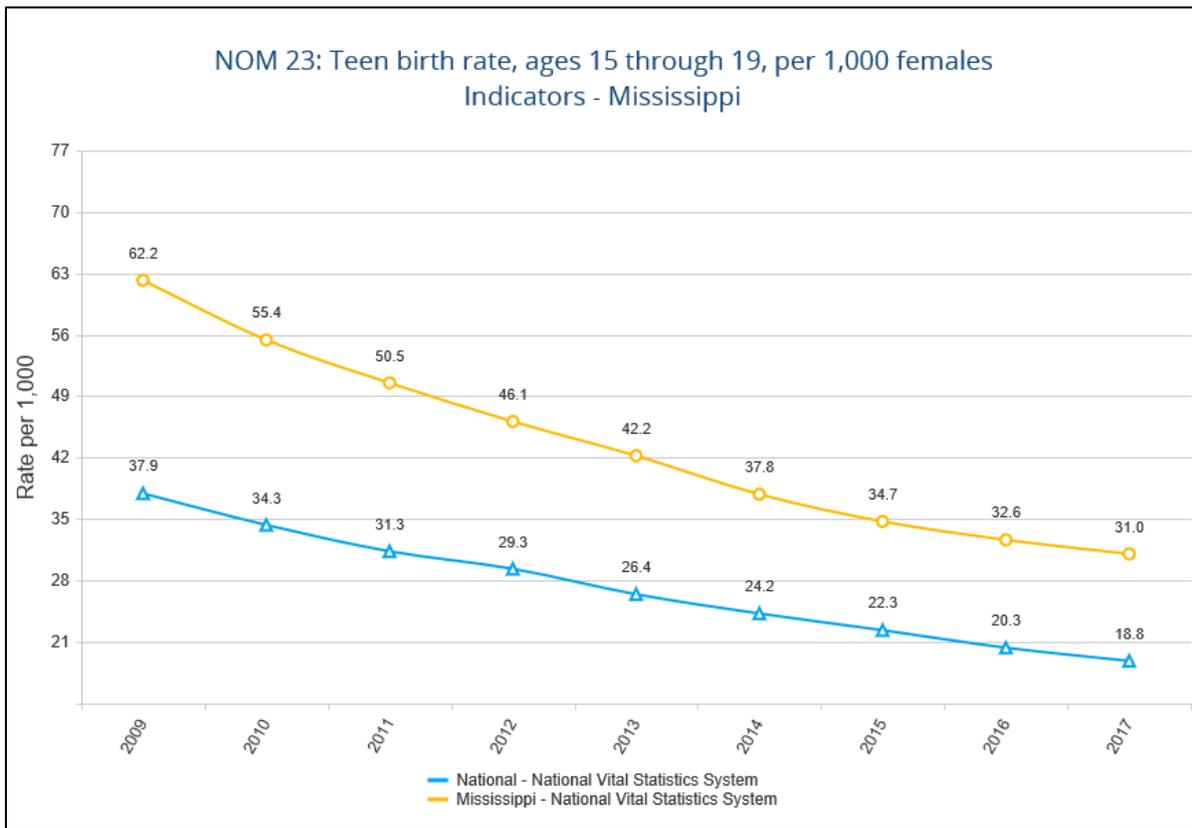
The above data, from the National Vital Statistics System, compare Mississippi and the U.S. on NPM 14.1 (Percent of women who smoke during pregnancy) between 2013 and 2017. Both the Mississippi and national data demonstrate a slightly declining trend. Mississippi reported data slightly higher than the national data. A higher percentage of women covered by Medicaid smoked during pregnancy, as compared to women with private insurance, other public insurance, or no insurance. Higher percentages of women who identify as non-Hispanic white and non-Hispanic multiple race smoke during pregnancy compared with women who identify as non-Hispanic black, Hispanic, and Native American/Alaska Native.



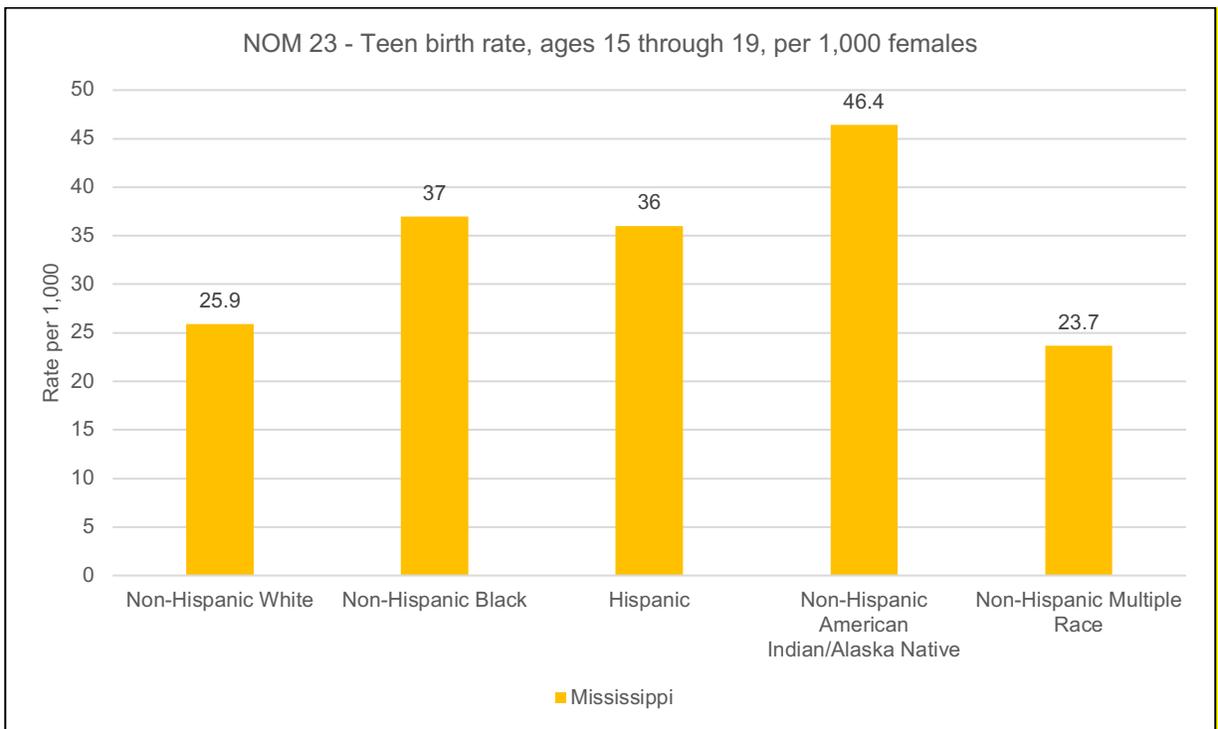
The above data, from the National Vital Statistics System, compare Mississippi and the U.S. on NOM 1 (Percent of pregnant women who receive prenatal care beginning in the first trimester) between 2009 and 2017. Mississippi's percent is higher than the U.S., although the state only reported data from 2014 to 2017. Both the nation's and Mississippi's percentages have increased steadily over time. A lower percentage of women who identify as Hispanic received prenatal care in the first trimester compared with women who identify as non-Hispanic white or non-Hispanic black. A lower percentage of women who were uninsured received early prenatal care compared to those with private insurance, Medicaid, and other public insurance.



The above data, from the Healthcare Cost and Utilization Project – State Inpatient Databases, compare Mississippi and the U.S. on NOM 11 (The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births). Mississippi consistently reports rates lower than the national rates. Both Mississippi’s and the national rates have steadily increased over time. Individuals covered by Medicaid reported a higher rate of infants born with neonatal abstinence syndrome compared to those with private insurance. Individuals who identify as non-Hispanic white exhibited a higher rate than those who identify as non-Hispanic black.



The above data, from the National Vital Statistics System, compare Mississippi and the U.S. on NOM 23 (Teen birth rate, ages 15 through 19, per 1,000 females) between 2009 and 2017. Mississippi's rates have been consistently higher than the national rate; however, both Mississippi and the U.S. have seen large decreases in the teen birth rate since 2009.



This chart presents the disparities in the teen birth rate by race and ethnicity according to the most recent National Vital Statistics System data (2017). Teens who identify as American Indian/Alaska Native exhibited the highest birth rate in the state (46.4 per 1,000). Teens who identify as Non-Hispanic multiple race reported the lowest birth rate (23.7 per 1,000).

**II. Statements of Needs: Women/Maternal Domain**

In an effort to gain more detailed information about community experiences, preferences, concerns, and perceptions, a series of focus groups, key informant interviews, and surveys were conducted in late 2019. Focus group transcripts, key informant interview notes, and survey responses were analyzed to identify common themes across data collection methods and broad stakeholder populations. A more detailed description of the data analysis may be found on pages 3-5 of the executive summary. These themes were then considered along with the FAD and other state quantitative data to guide the development of need statements.

Based on both quantitative and qualitative data, eight statements describing areas of need in the women/maternal domain were developed and presented to community stakeholders and agency leadership for discussion and prioritization. These are described below, along with the method that yielded the supporting evidence for each need. There is similarity for some needs across those identified in other domains.

**Legend for Data Collection Method and Abbreviation**

Data Collection Method	Abbreviation
Federally Available Data	F
Focus Groups	G
Key Informant Interviews	K
Surveys	S

1. **Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education (*identified in the following Data Collection Methods: G, K*)**
  - a. Barriers to health care and health maintenance include:
    - i. socioeconomic status
    - ii. education
    - iii. neighborhood crime and safety
    - iv. relationships
    - v. childcare
    - vi. policies and politics
    - vii. literacy
    - viii. equitable educational opportunities
  - b. Health care workforce shortages limit access to care within a reasonable distance, especially for specialty care.
  - c. Quality of care may be poor, especially in rural areas. Provider education is needed on evidence-based care, cultural competence, and resources available in the community.
  - d. Restrictions in scope of practice for advanced practice providers further limits access to care.
  - e. Lack of transportation, lack of awareness of available resources, and fragmented systems of care are barriers to accessing care.

2. **Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, disability status, insurance status/type, primary language, sexual orientation, and weight (*identified in the following Data Collection Methods: G, K*)**
  - a. Individuals may receive poor quality care because of their socioeconomic and insurance statuses.
  - b. Health care providers may not listen to and include patients in decision-making.
  - c. The health care system may not be not patient- or family-centered.
  - d. Spanish speaking/Latinx communities experience language-related barriers to care:
    - i. inaccurate translation of paperwork
    - ii. poor quality of interpretation
  - e. The quality of care available for individuals, including children, who are undocumented was perceived to be poor.
3. **Lack of or inadequate access to supports for health and wellness, including education, affordable and safe options for physical activity, and healthy foods (*identified in the following Data Collection Methods: G, K, S*)**
  - a. Individuals want to be physically active but many do not have access to safe, affordable spaces for physical activity.
  - b. Nearly 79% of family survey respondents reported exercising 30 minutes per day for fewer than 5 days per week.
  - c. Nearly 25% of family survey respondents reported no days of exercise at all.
  - d. Healthy, affordable food options may be difficult to access. Fast food options are inexpensive and convenient.
  - e. Adults are not meeting healthy nutrition guidelines.
    - i. Nearly 62% of family survey respondents reported only eating 1-2 servings of fruits or vegetables per day.
    - ii. Nearly 47% of family survey respondents reported drinking four or fewer cups of water per day.
  - f. The general population is in need of health education and improved health literacy to increase preventive behaviors.
  - g. Overeating may be a coping mechanism for unaddressed mental health needs.
4. **Lack of or inadequate access to comprehensive, family-centered, and culturally competent reproductive and well-woman health care and education, including for women with disabilities (*identified in the following Data Collection Methods: F, G, K, S*)**
  - a. Public insurance may not cover all necessary exams and tests, both during pregnancy and for general reproductive health.
  - b. Women would like to have their reproductive choices respected by their providers. They are not confident they receive accurate information from providers, especially regarding C-sections and family planning.
  - c. Women were aware of various birth control options available to them but wanted to receive more information about the benefits and risks of each type.
  - d. Women would like to access tubal ligations more easily.
  - e. When a specific type of birth control does not meet a woman's needs it can be difficult to try another when public insurance lapses.

- f. Survey respondents were less aware that the health department could provide longer-acting and more reliable birth control methods, such as IUDs, implants, patches, rings, and injections, than they were of the provision of condoms and oral contraceptives.
  - g. Women would like more reproductive health education covering safe sex, communicating with partners, sexually transmitted infections, healthy pregnancies, what to expect during labor and birth, and postpartum mental health.
  - h. Health education should be culturally sensitive and tailored to the Spanish speaking/Latinx community. For example, prenatal care should incorporate trusted female community partners to maximize utilization.
- 5. Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum) (*identified in the following Data Collection Methods: G, K*)**
- a. There is a shortage of mental health service providers across the state. Mental health services may be unavailable to those who are uninsured, underinsured, or are covered by Medicaid, especially in rural communities.
  - b. Emergency psychiatric care may be available in some communities, but non-urgent and preventive mental health services are not.
  - c. Domestic violence is a significant concern in many communities. Available services may not protect victims from their abusers.
  - d. Postpartum depression and anxiety are common. Stigma surrounding mental health and fear of having children taken by the Mississippi Department of Child Protective Services may prevent individuals from seeking care when they need it.
  - e. The Spanish speaking/Latinx population may experience stigma around mental health. Education on seeking treatment for mental health and postpartum depression is important.
  - f. The Spanish speaking/Latinx population may not have access to any mental health providers, especially in rural areas, due to the language barrier.
- 6. Lack of or inadequate substance abuse treatment (smoking, alcohol, drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services (*identified in the following Data Collection Methods: F, G, K, S*)**
- a. Rehabilitation is difficult to access for individuals with limited resources. There is a need for community support groups, especially for those in recovery.
  - b. Individuals suffering from addiction and those in recovery may receive low quality care due to provider bias.
  - c. Substance use may be a coping mechanism for stress and other untreated mental health needs.
  - d. Tobacco products and illicit drugs, including opioids, are widely accessible and available to adults and adolescents.
  - e. Opioid use is not perceived as being a significant issue in Mississippi.
- 7. Inadequate or lack of comprehensive, affordable health and oral health insurance (*identified in the following Data Collection Methods: G, S*)**
- a. Fourteen percent (14%) of survey respondents reported that they or someone in their house did not have health insurance; the most common reason stated for not having health insurance was that it is too expensive.
  - b. Many people earn too much money from their jobs to qualify for Medicaid but not enough to afford insurance or the out-of-pocket costs of care.

- c. Oral health care is unavailable or limited in many communities, requiring stakeholders to travel long distances to access care. Stakeholders may have limited options because many providers do not accept public dental insurance.
  - d. The out-of-pocket costs of oral health services are cost-prohibitive for many families. Providers often require multiple visits to address an oral health need.
  - e. Over 30% of survey respondents reported that they or someone in their house did not have oral health insurance.
- 8. High levels of maternal mortality (*identified in the following Data Collection Methods: F, G, K, S*)**
- a. Focus and investment on prevention is important to address maternal mortality, including women having access to care before and between pregnancies to manage chronic conditions and become educated on adopting positive health behaviors that affect health outcomes.
  - b. Social determinants of health were reported as the predominant underlying causes of maternal mortality. This includes:
    - i. housing insecurity
    - ii. low level of adult health literacy
    - iii. educational attainment
    - iv. unemployment/underemployment
    - v. poverty
    - vi. food insecurity
  - c. Women experience high levels of stress associated with housing insecurity, financial responsibilities, intimate partner violence, and racial discrimination. Stress may lead to poor health outcomes for mothers.
  - d. Provider shortages, including for prenatal care and high-risk maternity care, are common around the state, especially in rural communities. Access is further limited for low-income women.

### III. Prioritized Statements of Needs: Women/Maternal Domain

The needs statements, as well as their prioritized rank after the process was completed, are listed in the table below. A detailed description of the prioritization process may be found on pages 13-16 of the executive summary.

Rank	Need
1	High levels of maternal mortality
2	Lack of or inadequate access to comprehensive, family-centered, and culturally competent reproductive and well-woman health care and education, including for women with disabilities
3	Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, disability status, insurance status/type, primary language, sexual orientation, and weight
4	Lack of or inadequate access to supports for health and wellness including education, affordable and safe options for physical activity, and healthy foods
5	Inequitable access to health resources (including delivery hospitals) based on race/ethnicity, socioeconomic status, geographic location, and education
6 (tied)	Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)
6 (tied)	Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services
7	Lack of or inadequate comprehensive, affordable health and oral health insurance

**MSDH 2020 Title V Maternal and Child Health Services Block Grant  
Comprehensive Needs Assessment**  
*Domain Report: Perinatal/Infant*

**I. Setting a Baseline for Perinatal/Infant Health in Mississippi: A Summary of Federally Available Data**

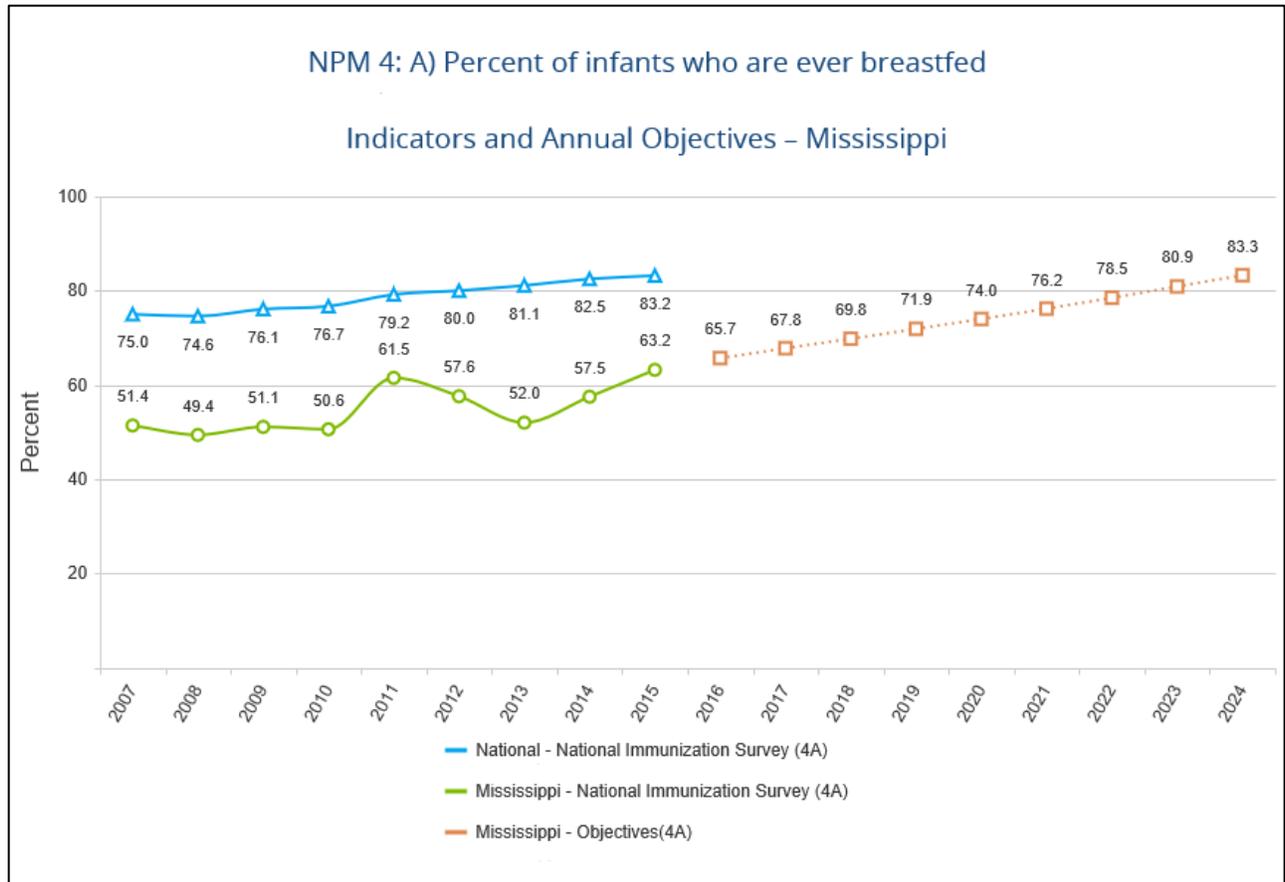
Each state is provided with a set of indicators that cover all Title V domains. These indicators are tied to the National Performance Measures and National Outcome Measures on which states have chosen to focus. The table below summarizes all of the indicators that are associated with perinatal/infant health for Mississippi.

Perinatal/Infant Health Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Risk-appropriate perinatal care – very low birth weight babies born in hospitals with a Level III+ NICU	81.7%	NA	Trending better
Breastfeeding – ever	63.2%	Worse	Trending better
Breastfeeding – exclusively through 6 months	13.0%	Worse	Trending better
Safe sleep – infant placed on back	56.9%	Worse	Trending slightly better
Neonatal abstinence syndrome (NAS)	3.0 per 1,000	Better	Trending worse
SUID mortality	152.9 per 100,000	Worse	Mixed
Infant mortality	8.7 per 1,000	Worse	Trending better
Preterm birth	13.6%	Worse	About the same
Low birth weight	11.6%	Worse	About the same
Early elective delivery	2.0%	Same	Trending better

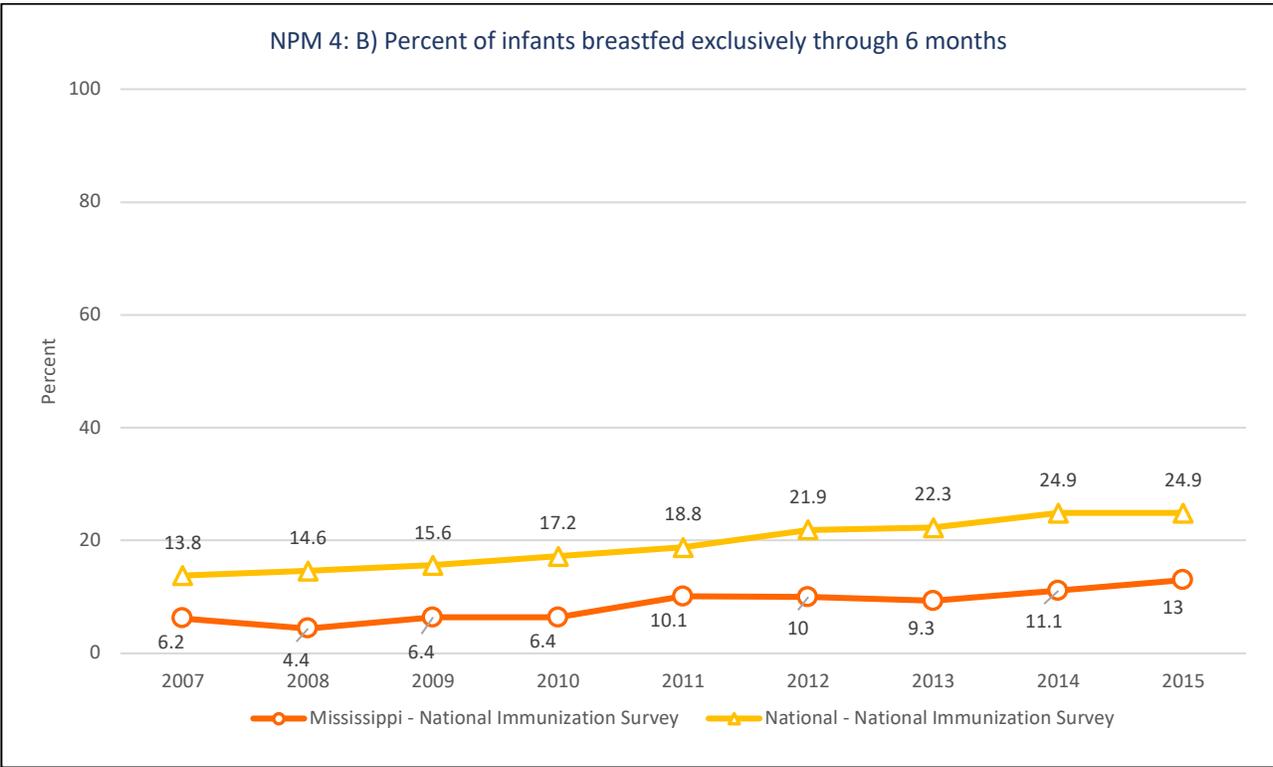
\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in arrears. See page 3 for information on FAD and to access current information.

Consistent with the guiding principle of promoting health equity and reducing disparities, several areas of disparity were noted across all domains in both the Federally Available Data (FAD) and qualitative findings. For this domain, indicator data show differences in outcomes based on race, ethnicity, socioeconomic status, and insurance status and type. Furthermore, these inequities are driven by many factors, including social determinants of health like education, poverty, structural racism, and housing safety and quality. Notable disparities in sentinel indicators are presented below.

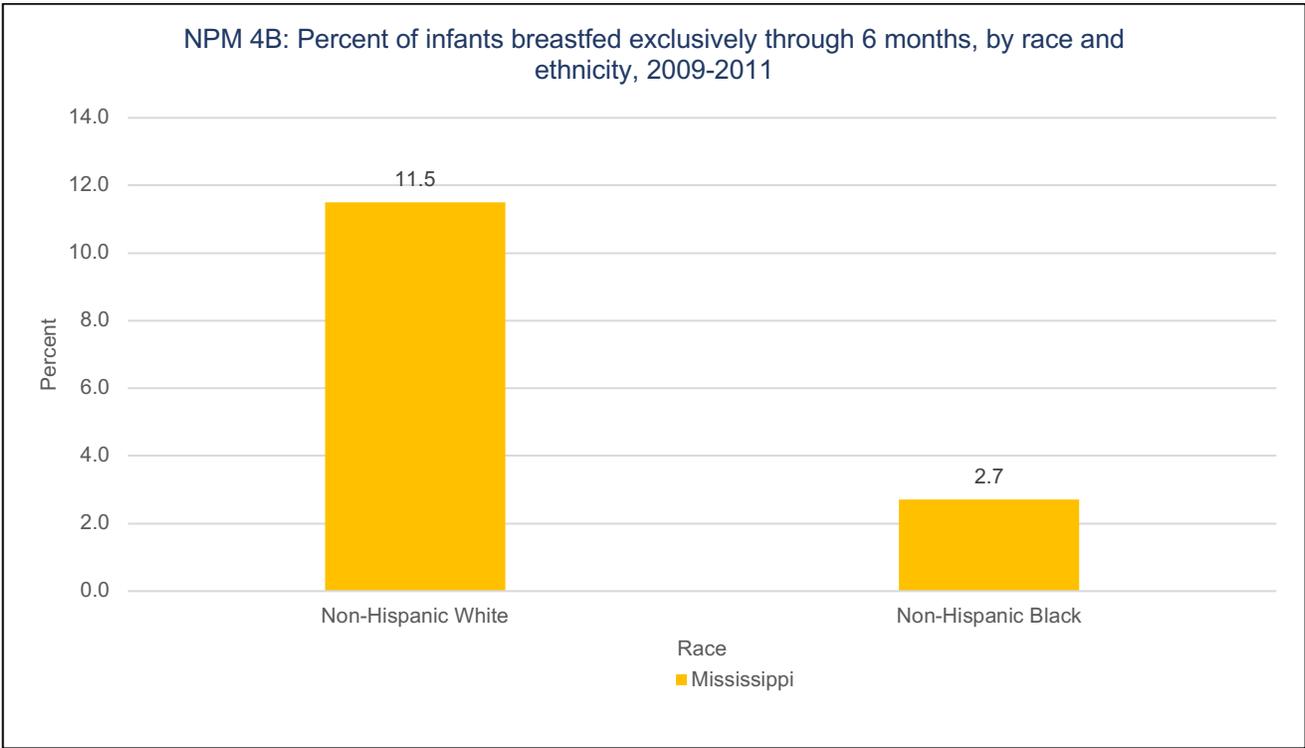
The following charts present the above data in a more detailed format and, where available, across time to show comparisons to national indicators and trends.



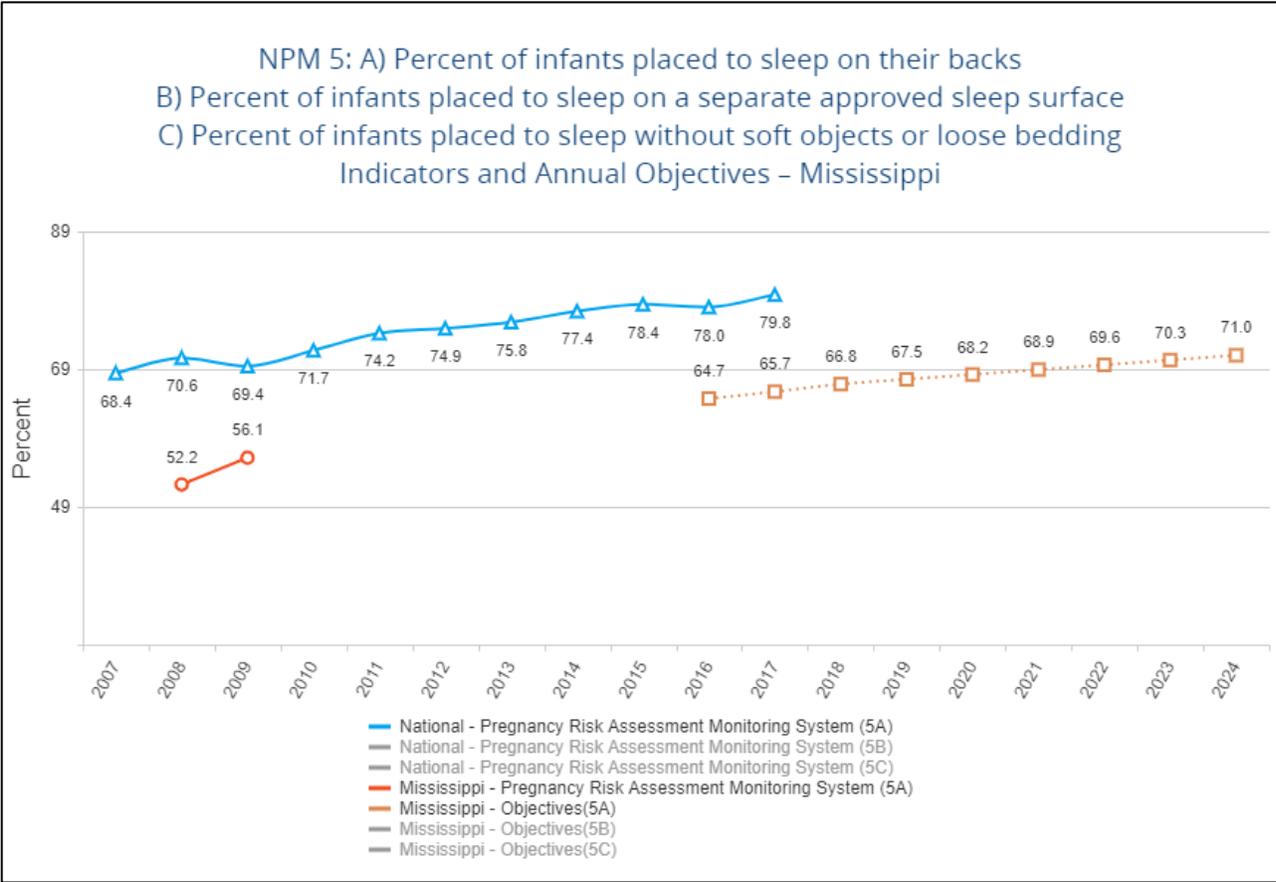
The above data, from the National Immunization Survey, compare Mississippi and the U.S. on NPM 4: A) (Percent of infants who are ever breastfed) between 2007 and 2015. Mississippi’s percentage is consistently lower than the national percentage. The national percentage has increased steadily over this period while the Mississippi percentage has fluctuated. The last three data points indicate an increasing trend in Mississippi.



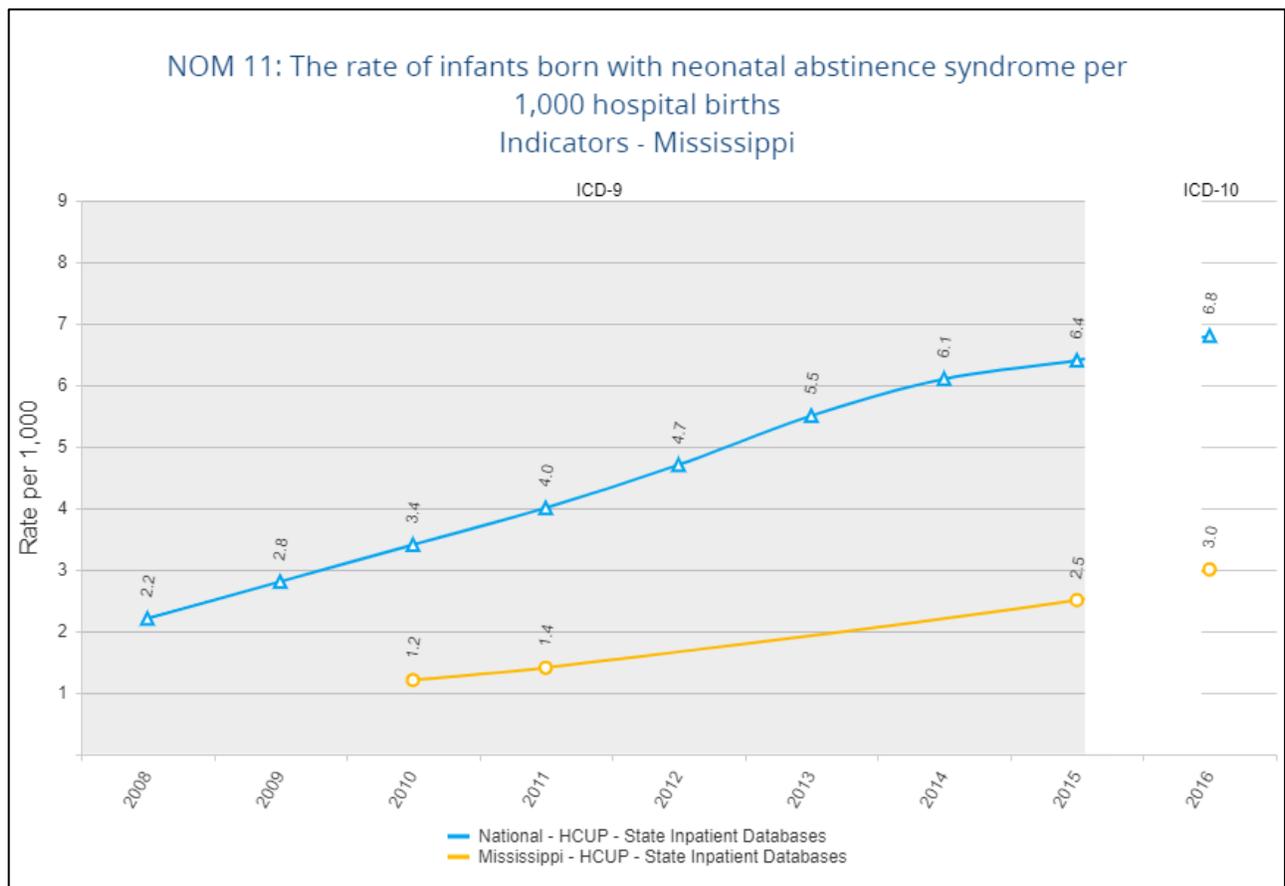
The above data, from the National Immunization Survey, compare Mississippi and the U.S. on NPM 4: B) (Percent of infants breastfed exclusively through 6 months) between 2007 and 2015. Mississippi’s percent is consistently lower than the national percent. Both the state and nation are trending better for this performance measure.



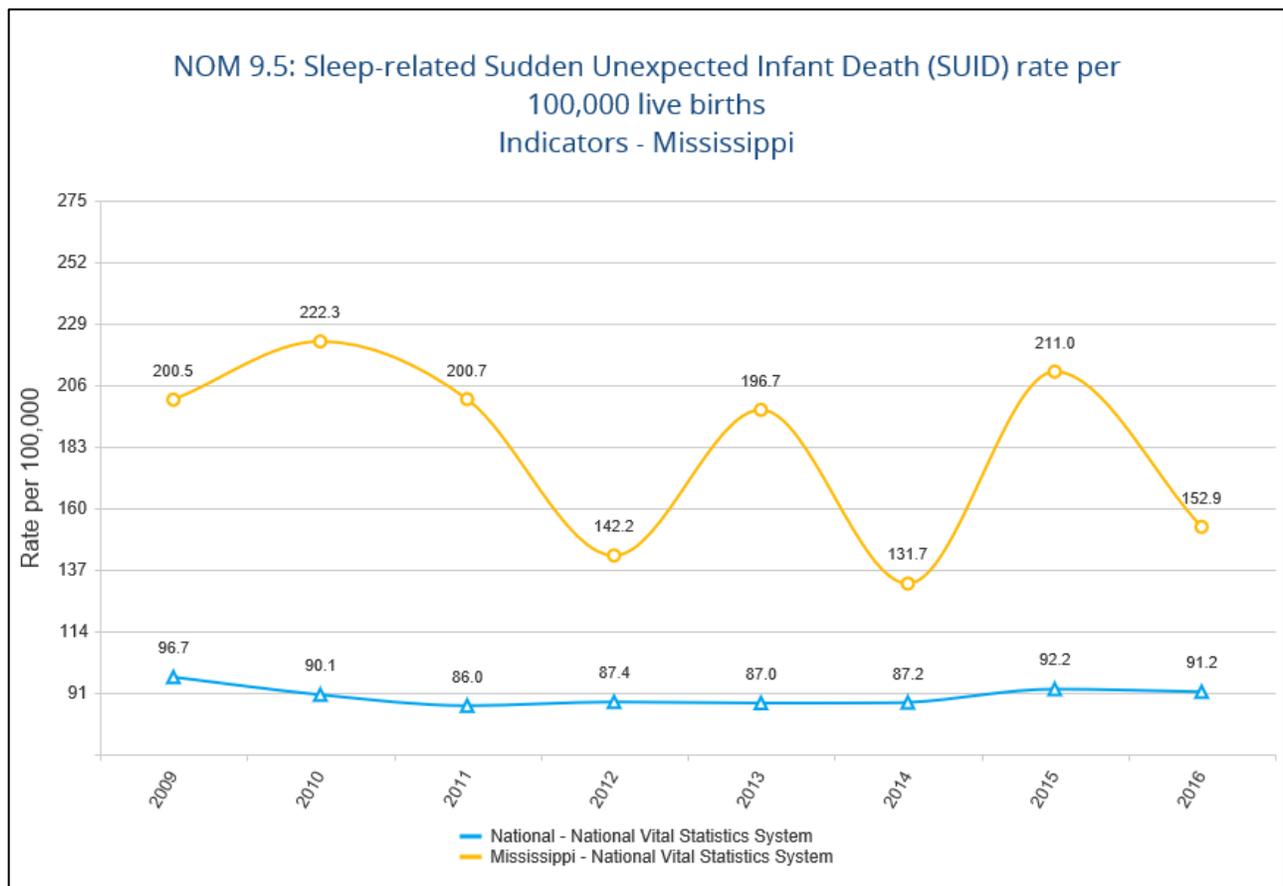
This chart presents the disparities in the percent of infants breastfed exclusively through 6 months by race and ethnicity. A significantly higher percentage of Non-Hispanic white infants are exclusively breastfed through 6 months compared to non-Hispanic black infants.



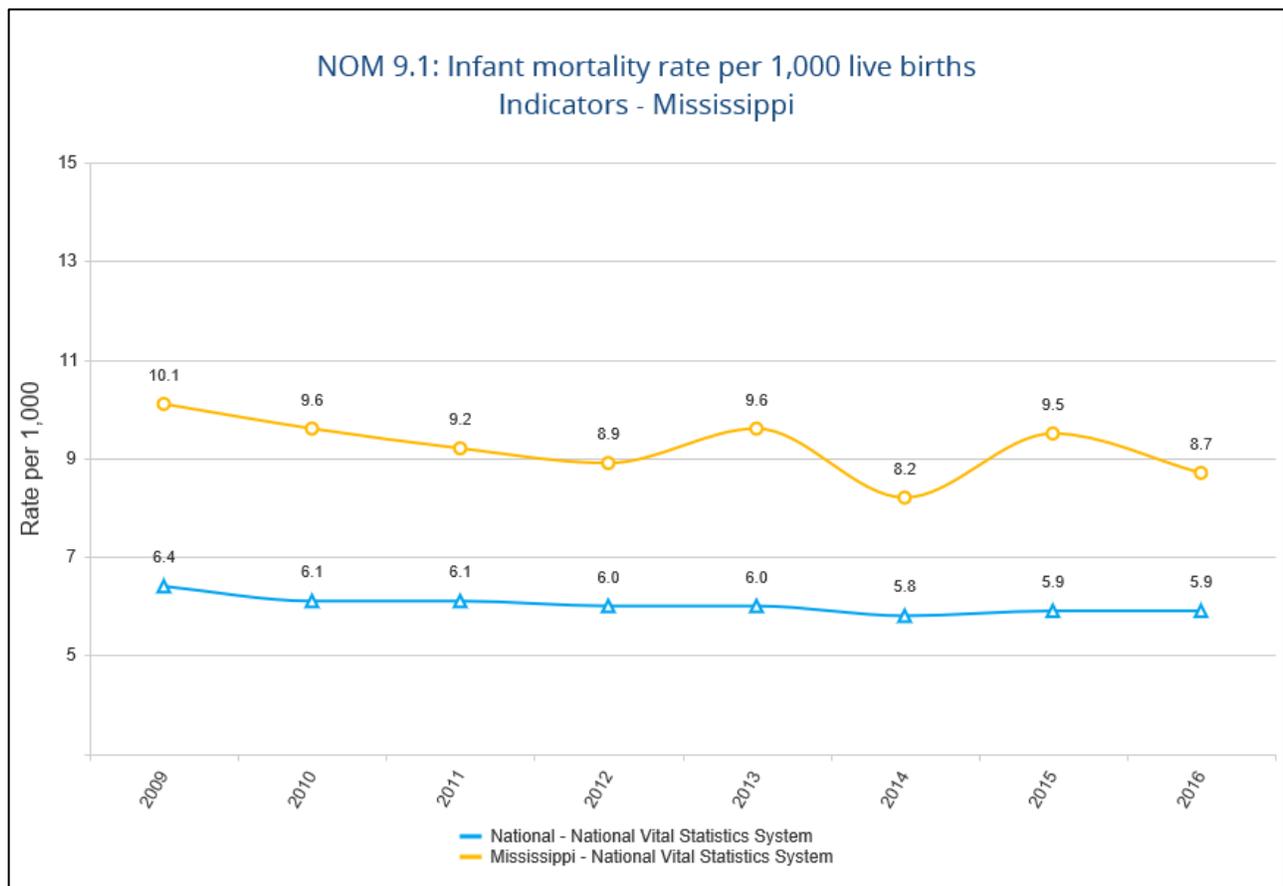
The above data, from the Pregnancy Risk Assessment Monitoring System, compare Mississippi and the U.S. on NOM 5: A) (Percent of infants placed to sleep on their backs), B) (Percent of infants placed to sleep on a separate approved sleep surface), and C) (Percent of infants placed to sleep without soft objects or loose bedding) between 2007 and 2017. Mississippi only reported data in 2008 and 2009 but, between those two years, the percentage increased. (PRAMS data is reported to the Centers for Disease Control and Prevention annually, but only appears in the national dataset if the preset Response Rate Threshold for the year was met by the state.) Nationally, the percentage increased steadily between 2007 and 2017 and was higher than Mississippi’s reported data in 2008 and 2009. The orange data points indicate Mississippi’s objectives for the coming years.



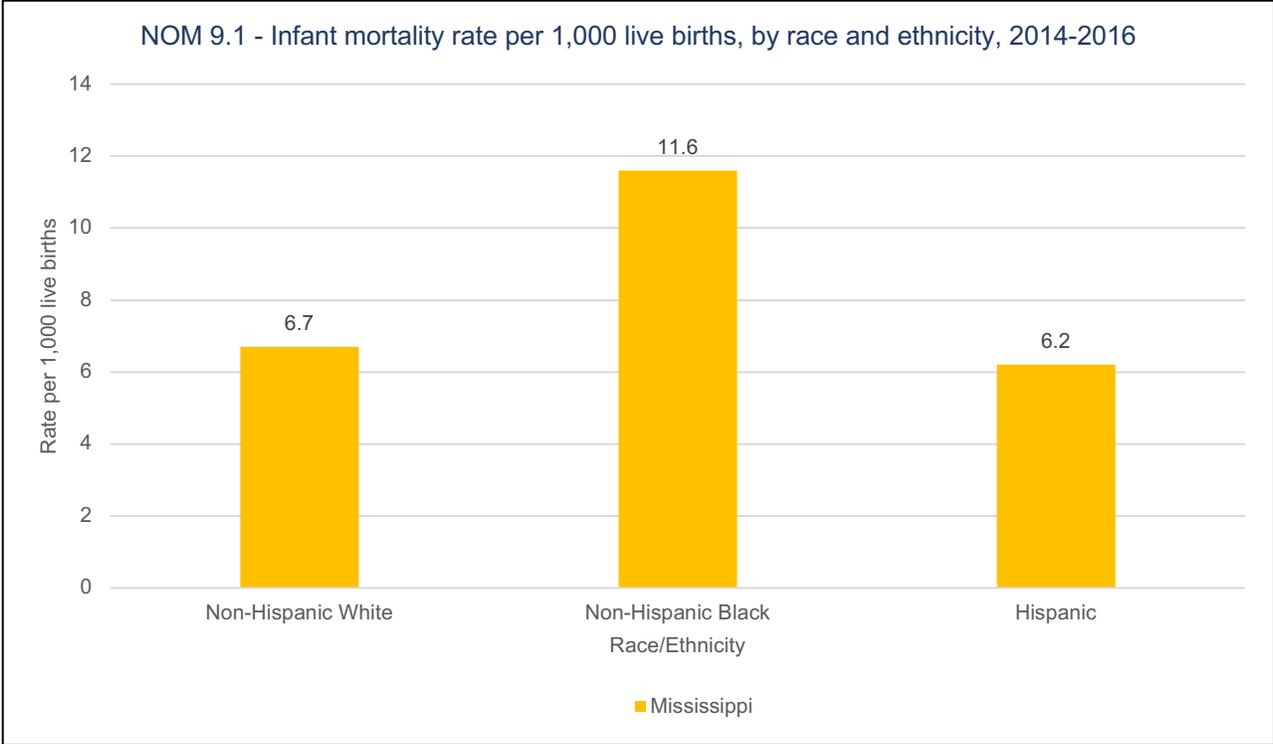
The above data, from the Healthcare Cost and Utilization Project – State Inpatient Databases, compare Mississippi and the U.S. on NOM 11 (The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births) between 2008 and 2016. Mississippi consistently reports rates lower than the national rate; however, both the state and national rates have steadily increased over time.



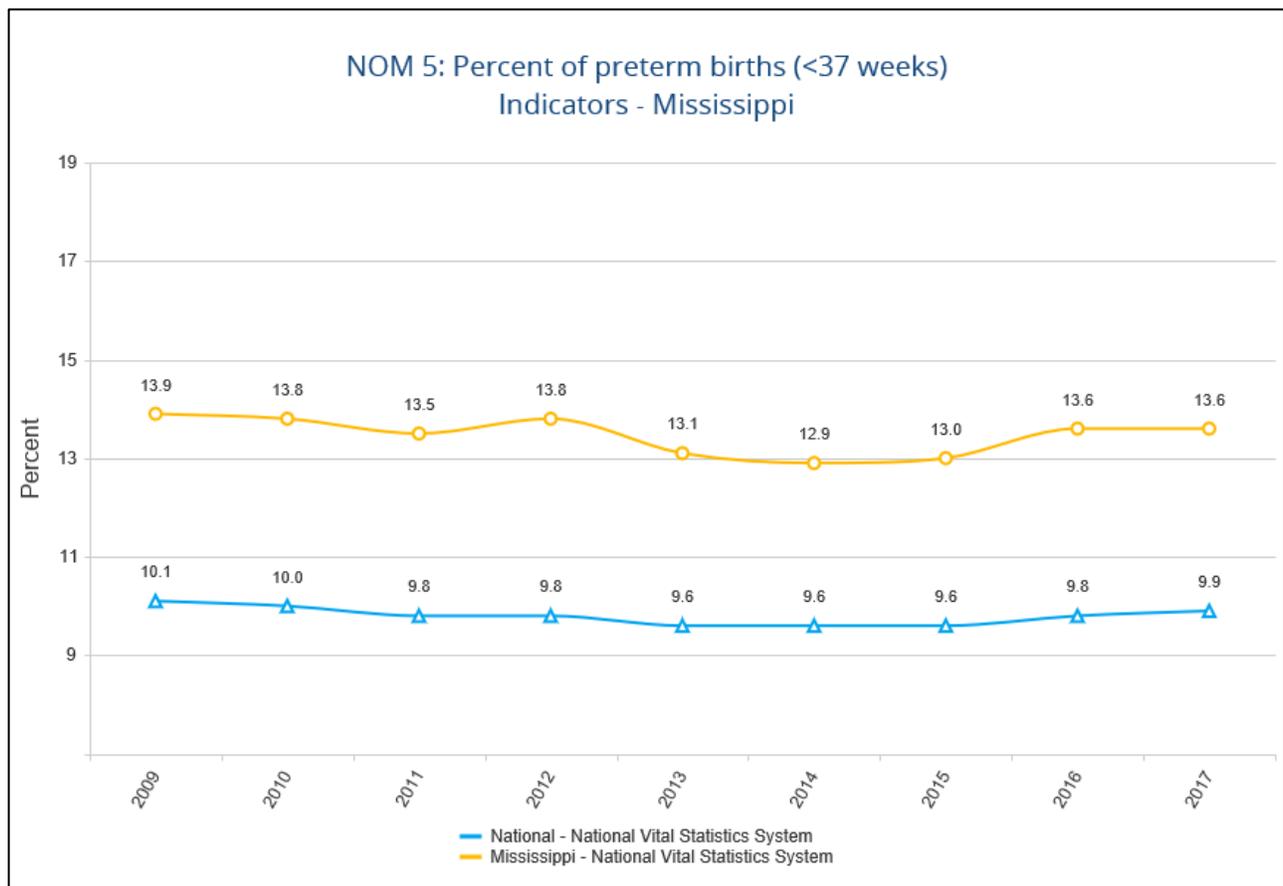
The above data, from the National Vital Statistics System, compare Mississippi and the U.S. on NOM 9.5 (Sleep-related Sudden Unexpected Infant Death [SUID] rate per 100,000 live births) between 2009 and 2016. Mississippi’s SUID rate is significantly higher than the national rate and has fluctuated greatly over time. The most recent two data points indicate a declining trend. The national rate steadily decreased between 2009 and 2014. In 2015, the national rate increased and subsequently decreased in 2016. In Mississippi, non-Hispanic black infants exhibit a higher SUID rate compared with non-Hispanic white infants.



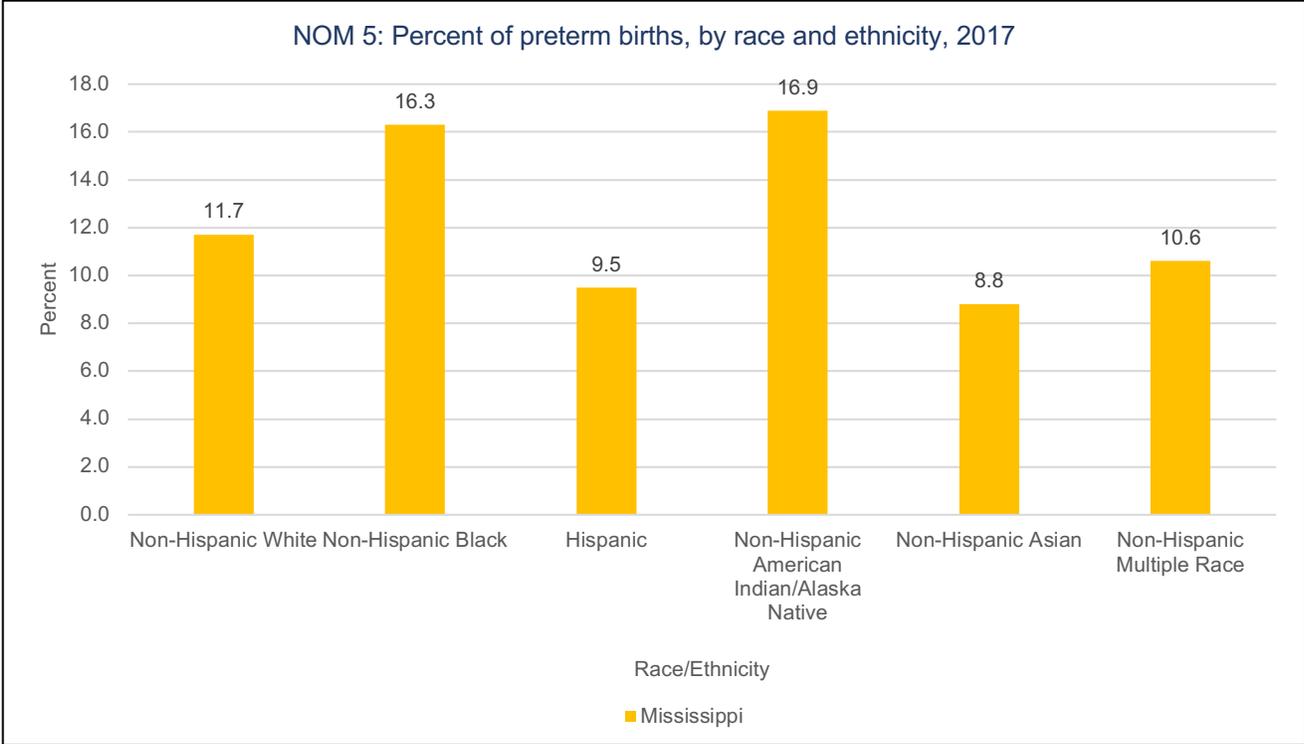
The above data, from the National Vital Statistics System, compare Mississippi and the U.S. on NOM 9.1 (Infant mortality rate per 1,000 live births) between 2009 and 2016. Mississippi's rate has declined over time, with some fluctuations. The state's rate is consistently higher than the national rate, which has remained relatively stable over time.



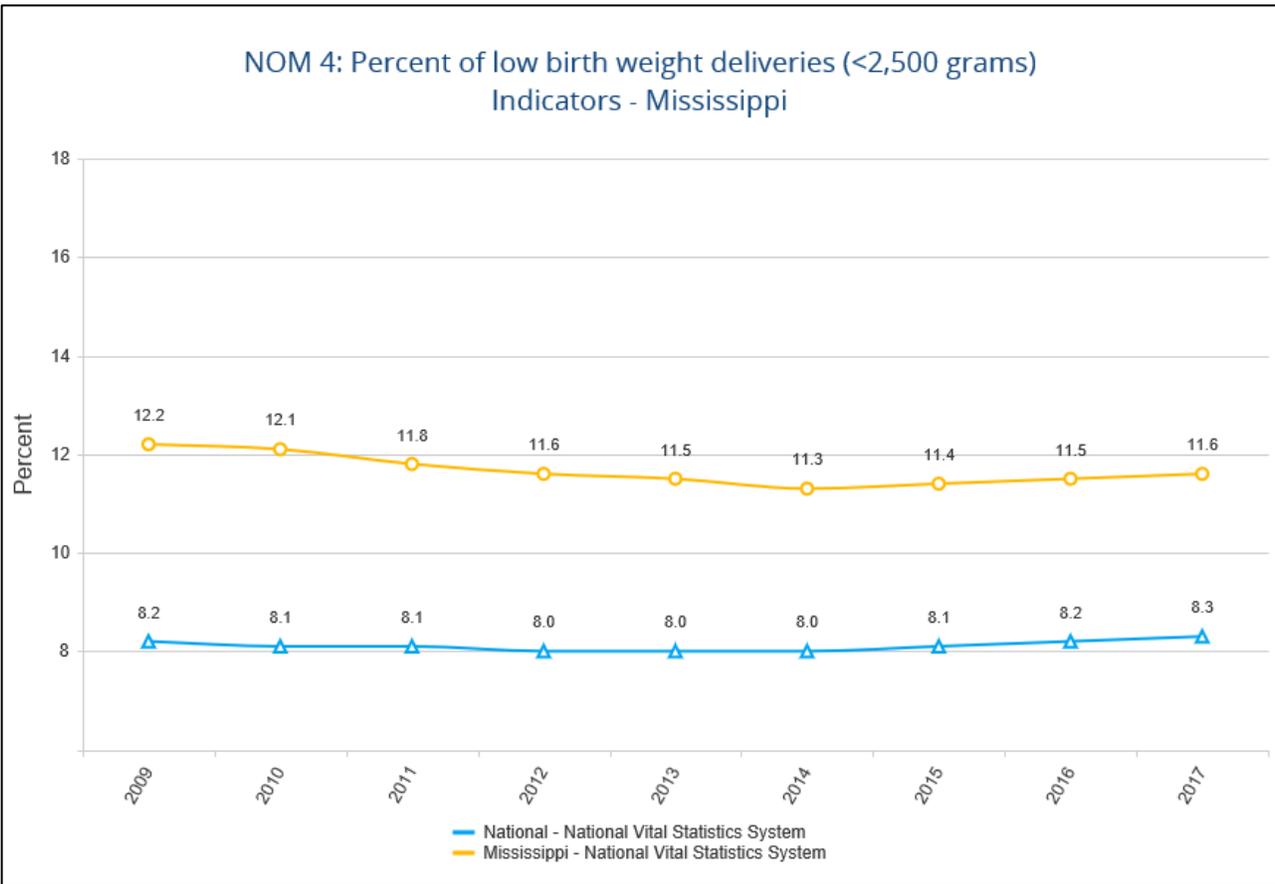
This chart presents disparities in the infant mortality rate per 1,000 live births by race and ethnicity according to the 2016 National Vital Statistics System data. Non-Hispanic black infants exhibited the highest infant mortality rate. The lowest infant mortality rate was among Hispanic infants.



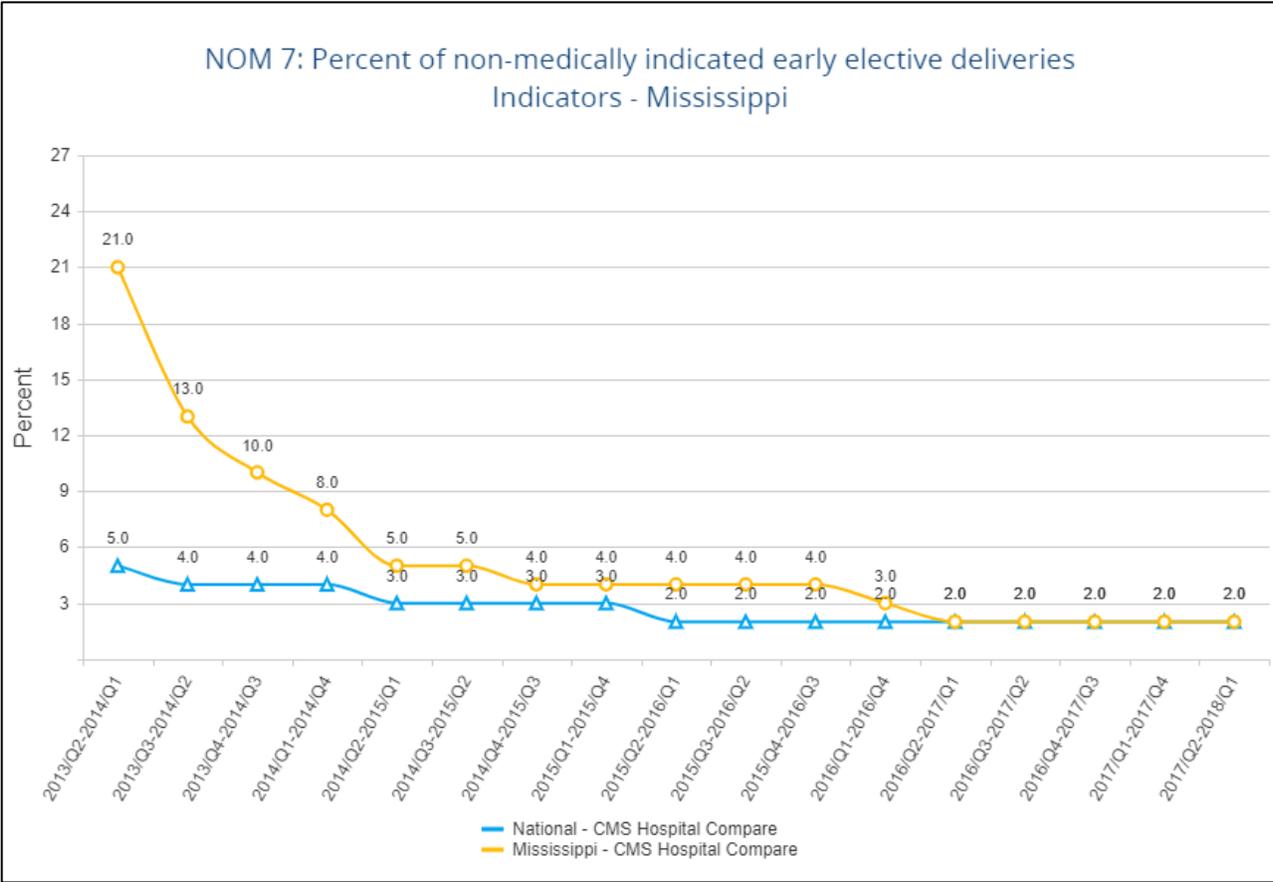
The above data, from the National Vital Statistics System, compare Mississippi and the U.S. on NOM 5 (Percent of preterm births [<37 weeks]) between 2009 and 2017. Mississippi’s percentage of preterm births is consistently higher than the nation’s percentage. Both the state and the U.S. reported slight increases in their percentages in 2016 and 2017, after several years of stability.



This chart presents disparities in the percent of preterm births by race and ethnicity according to National Vital Statistics System data. The highest percentage of preterm births was among non-Hispanic American Indian/Alaska Native infants. The lowest percentage was among non-Hispanic Asian infants.



The above data, from the National Vital Statistics System, compare Mississippi and the U.S. on NOM 4 (Percent of low birth weight deliveries [ $<2,500$  grams]) between 2009 and 2017. Mississippi consistently reports a higher percentage than the national percentage. The Mississippi percentage of low birth weight deliveries has steadily declined over time.



The above data, from CMS Hospital Compare, compare Mississippi and the U.S. on NOM 7 (Percent of non-medically indicated early elective deliveries) between 2013 (Q3) and 2018 (Q1). Since the spring of 2013, Mississippi's percentage has decreased significantly. From 2016 through the end of 2017, the Mississippi and U.S. percentages of non-medically indicated early elective deliveries remained steady at 2.0%.

**II. Statements of Needs: Perinatal/Infant Domain**

In an effort to gain more detailed information about community experiences, preferences, concerns, and perceptions, a series of focus groups, key informant interviews, and surveys were conducted in late 2019. Focus group transcripts, key informant interview notes, and survey responses were analyzed to identify common themes across data collection methods and broad stakeholder populations. A more detailed description of the data analysis may be found on pages 3-5 of the executive summary. These themes were then considered along with the FAD and other state quantitative data to guide the development of need statements.

Based on both quantitative and qualitative data, ten statements describing areas of need in the perinatal/infant domain were developed and presented to community stakeholders and agency leadership for discussion and prioritization. These are described below, along with the method that yielded the supporting evidence for each need. There is similarity for some needs across those identified in other domains.

**Legend for Data Collection Method and Abbreviation**

Data Collection Method	Abbreviation
Federally Available Data	F
Focus Groups	G
Key Informant Interviews	K
Surveys	S

1. **Inequitable access to health resources (including delivery hospitals) based on race/ethnicity, socioeconomic status, geographic location, and education (*identified in the following Data Collection Methods: G, K*)**
  - a. Barriers to health care and health maintenance include:
    - i. socioeconomic status
    - ii. education
    - iii. neighborhood crime and safety
    - iv. relationships
    - v. childcare
    - vi. policies and politics
    - vii. literacy
    - viii. equitable educational opportunities
  - b. Health care workforce shortages limit access to care within a reasonable distance, especially for specialty care.
  - c. Restrictions in scope of practice for advanced practice providers further limits access to care.
  - d. Lack of transportation, lack of awareness of available resources, and fragmented systems of care are barriers to accessing care.

- e. Quality of care may be poor, especially in rural areas. Provider education is needed on evidence-based care, cultural competence, and resources available in the community.
2. **Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, disability status, insurance status/type, primary language, sexual orientation, and weight (*identified in the following Data Collection Methods: G, K*)**
    - a. Individuals may receive poor quality care because of their socioeconomic and insurance statuses.
    - b. Health care providers do not listen to and include patients in decision-making. The health care system is not patient- or family-centered.
    - c. Spanish speaking/Latinx communities experience language-related barriers to care:
      - i. inaccurate translation of paperwork
      - ii. poor quality of interpretation
      - iii. The quality of care available for individuals, including children, who are undocumented was perceived to be poor.
  3. **Lack of or inadequate access to comprehensive reproductive health care (*identified in the following Data Collection Methods: G, K, S*)**
    - a. Stakeholders would like to have their reproductive choices respected by their providers.
    - b. They are not confident they receive accurate information from providers, especially regarding C-sections.
    - c. Stakeholders would like more reproductive health education, covering safe sex, healthy pregnancies, what to expect during labor and birth, and postpartum mental health.
    - d. Substance use during pregnancy, especially by teens, is concerning.
    - e. The high C-section rate may be due to provider preference and providers' aversion to risk. Providers may schedule repeat C-sections for subsequent births without assessing need.
    - f. There is a need to provide prenatal care for pregnant women who are immigrants.
  4. **Lack of supports for pregnant and parenting teens and young/new parents (*identified in the following Data Collection Methods: F, G, K, S*)**
    - a. Stakeholders perceive teen pregnancy as an increasing issue due to lack of education and parental involvement.
    - b. Young parents need classes and resources regarding infant and child care, including increased access to home visiting programs.
    - c. Immigrant communities may have a special need for infant safety education including breastfeeding, safe sleep, shaken baby syndrome, baby proofing the home, etc., bearing in mind people come from different cultures and may not have the same level of awareness.
  5. **High levels of infant mortality (and associated factors of preterm birth and low birth weight) (*identified in the following Data Collection Methods: F, G, K, S*)**
    - a. Infant care education from providers may be inconsistent and incomplete. Lack of infant care knowledge is perceived as the main cause of infant deaths.
    - b. Robust, hands-on parenting education and in-depth discussions with providers were recommended solutions.
    - c. Systemic racism and implicit bias impacts the care people of color receive and may contribute to the state's high infant mortality rate. Women of color, especially black

women, may not be taken seriously by providers when they believe they or their infant require care.

- d. Addressing inequitable access to care, especially due to race, is important to reduce the infant mortality rate.
- e. Poor quality pediatric care may contribute to infant deaths. Public insurance policies restricting covered care may result in children not receiving necessary care to avoid deaths.
- f. Late entry into prenatal care may contribute to infant mortality. The general population is unhealthy and there is a connection between maternal and infant health.
- g. Social determinants of health may be the predominant underlying cause of infant mortality. This includes:
  - i. housing insecurity
  - ii. low level of adult health literacy
  - iii. unemployment/underemployment
  - iv. poverty
  - v. food insecurity
- h. There is a need to change the culture regarding how people think about health so that preventive health behaviors, like safe sleep, breastfeeding, and healthy eating, are normalized. Key informants expressed a belief that there is a need for community education programs to address these topics.

**6. High levels and worsening trends of sleep-related/SUID deaths (*identified in the following Data Collection Methods: F, G, K, S*)**

- a. Some stakeholders are aware of safe sleep guidelines but have difficulty putting recommendations into practice.
- b. The education caregivers receive about safe sleep is limited to printed materials and short conversations with providers. Expectant parents would appreciate a “refresher”, even if they already have children.
- c. Top reasons families may have difficulty following safe sleep guidelines were:
  - 1. feel having baby in bed makes nighttime feedings easier
  - 2. other people in the family haven’t done all of these things
  - 3. prefer a “family bed” or to have baby sleep in the bed with family
- d. Providers need training and education so that families hear consistent messaging regarding safe sleep. Education should be extended to other caregivers, such as grandparents.

**7. Lack of or inadequate access to breastfeeding supports (*identified in the following Data Collection Methods: F, G, K, S*)**

- a. Providers encourage mothers to breastfeed. Mothers who chose not to breastfeed were frustrated that their providers did not respect their choice.
- b. Limited breastfeeding education and support services, including access to qualified lactation support professionals, are available. Businesses and workplaces may not support breastfeeding.
- c. Women who experience breastfeeding challenges may not be connected to resources beyond a limited amount of breastfeeding education immediately after birth.

- 8. Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum) (*identified in the following Data Collection Methods: G, K, S*)**
  - a. Mental health services are perceived as largely unavailable to those who are uninsured, underinsured, or covered by Medicaid.
  - b. Emergency psychiatric care may be available in some communities but non-urgent and preventive mental health services are not.
  - c. Many stakeholders described issues with postpartum depression and anxiety.
  - d. Stigma surrounding mental health and fear of having children taken by Mississippi Department of Child Protective Services may prevent individuals from seeking care when they need it.
  - e. Spanish speaking women may not have access to any mental health providers, especially in rural areas, due to the language barrier.
- 9. Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services (*identified in the following Data Collection Methods: G, S*)**
  - a. Individuals in need of treatment may feel hesitant to participate in residential rehabilitation because most facilities are not family-centered, forcing parents to leave their children.
  - b. More drug treatment programs are needed for pregnant women.
  - c. Forty-six percent (46%) of family survey respondents don't know or aren't sure of Mississippi's trends related to neonatal abstinence syndrome (NAS) while 45% reported an increasing trend.
- 10. Inadequate or lack of comprehensive, affordable health and oral health insurance (*identified in the following Data Collection Methods: G, K, S*)**
  - a. Lack of insurance was the main barrier to health care access. Acquiring insurance is confusing. Out-of-pocket expenses exceed what most families are able to pay.
  - b. Fourteen percent (14%) of survey respondents reported that they or someone in their house did not have health insurance; the most common reason stated for not having health insurance was that it is too expensive.
  - c. Extending Medicaid to one year postpartum would promote preconception care, prenatal care, and healthy pregnancies by improving continuity of care for women before and between pregnancies to manage chronic conditions and adopt healthy behaviors.

### III. Prioritized Statements of Needs: Perinatal/Infant Domain

The statements, as well as their prioritized rank after the process was completed, are listed in the table below. A detailed description of the prioritization process may be found on pages 13-16 of the executive summary.

Rank	Need
1	High levels of infant mortality (and associated factors of preterm birth and low birth weight)
2	High levels and worsening trends of sleep-related deaths/SUID
3	Lack of supports for pregnant and parenting teens and young/new parents
4 (tied)	Inequitable access to health resources (including delivery hospitals) based on race/ethnicity, socioeconomic status, geographic location, and education
4 (tied)	Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, insurance status/type, and primary language
4 (tied)	Inadequate or lack of comprehensive, affordable health and oral health insurance
5	Lack of or inadequate access to comprehensive reproductive health care
6 (tied)	Lack of or inadequate access to breastfeeding supports
6 (tied)	Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)
6 (tied)	Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services

**MSDH 2020 Title V Maternal and Child Health Services Block Grant  
Comprehensive Needs Assessment**  
*Domain Report: Child*

**I. Setting a Baseline for Child Health in Mississippi: A Summary of Federally Available Data**

Each state is provided with a set of indicators that cover all Title V domains. These indicators are tied to the National Performance Measures and National Outcome Measures on which states have chosen to focus. The table below summarizes all of the indicators that are associated with child health for Mississippi.

Child Health Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Developmental screening – child (9-35 months)	18.6%	Worse	Trending slightly better
Physical activity – child (6-11 years) (every day)**	35.5%	Better	Trending slightly better
Preventive dental visit – child (6-11 years)	86.1%	Worse	About the same
Household smoking – child (0-5 years)	20.3%	Worse	Trending better
Household smoking – child (6-11 years)	21.0%	Worse	Trending better
Child mortality	29.9 per 100,000	Worse	Trending better
Obesity (2-4 years)	14.5%	About the same	Trending slightly better
Child vaccination – child (19-35 months)	68.7%	About the same	Trending better
Hospitalization for non-fatal injury – child (0-9 years)	127.1 per 100,000	About the same	Trending better

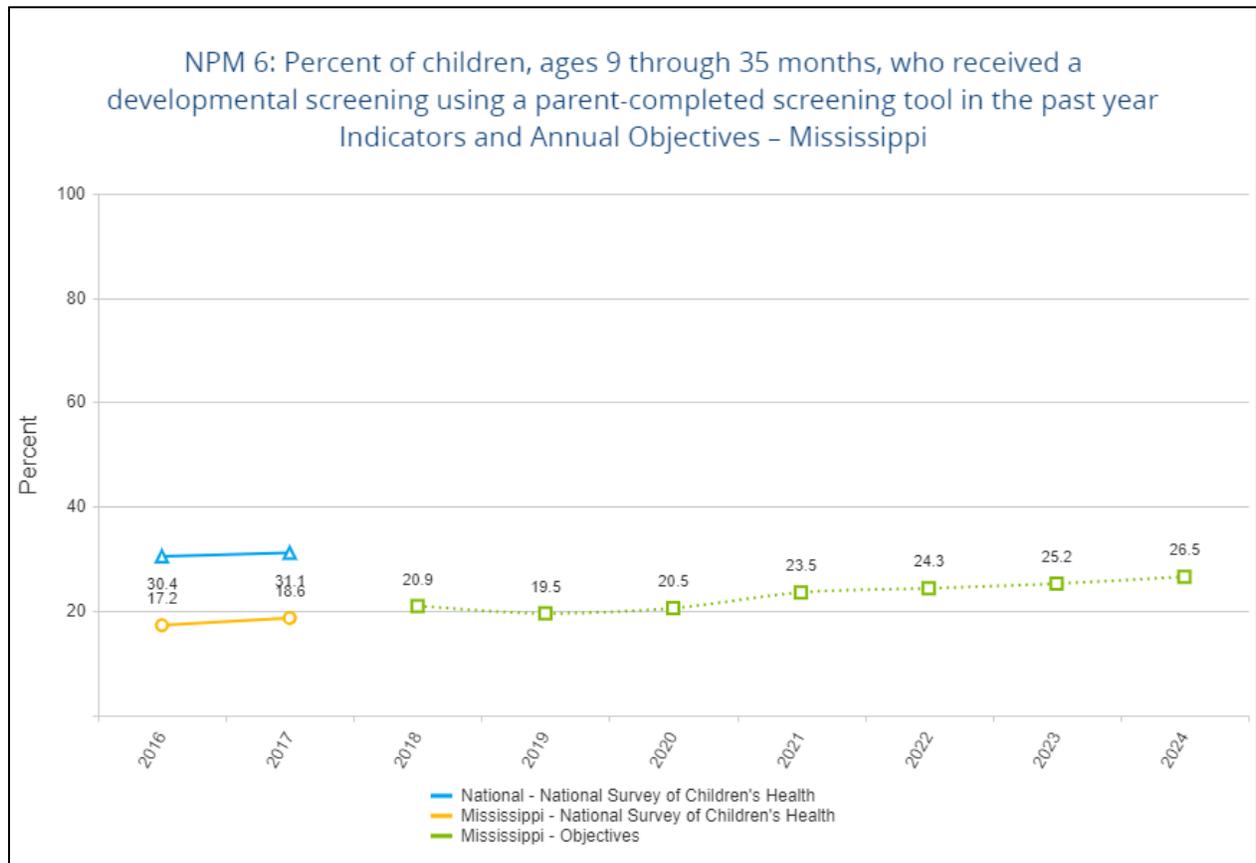
\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in arears. See page 3 for information on FAD and to access current information.

\*\*Data may be unreliable due to large confidence interval.

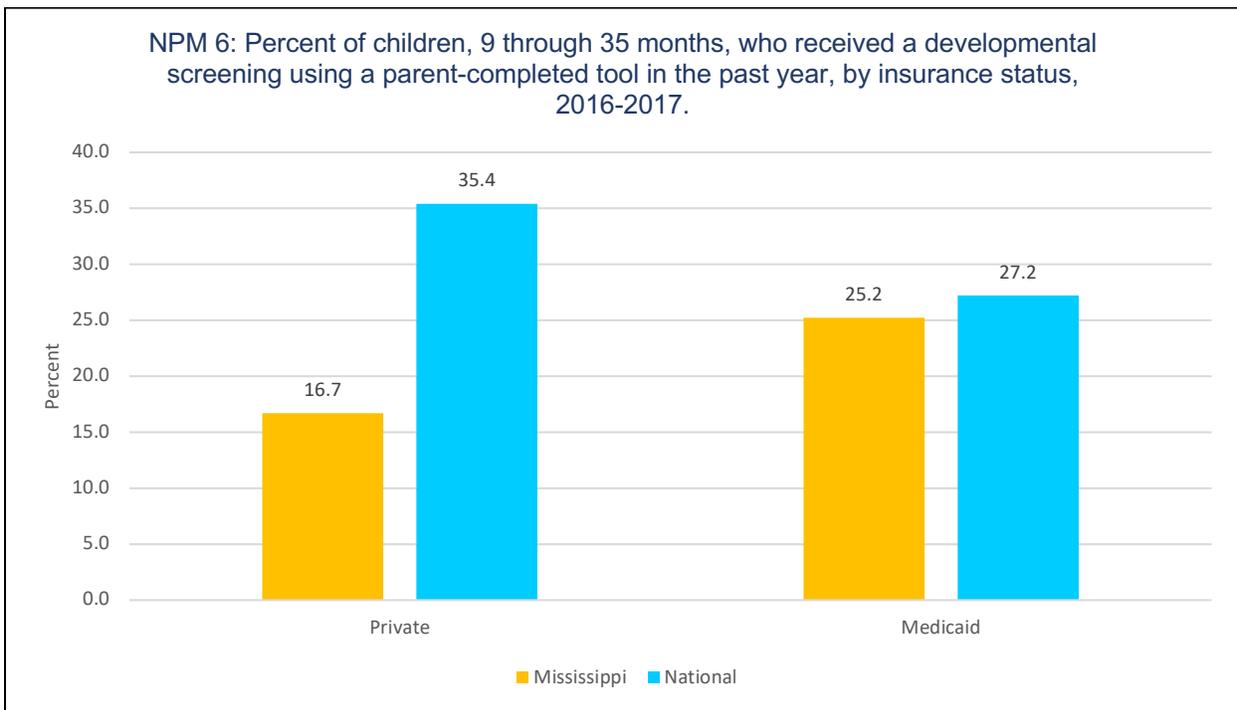
Consistent with the guiding principle of promoting health equity and reducing disparities, several areas of disparity were noted across all domains in both the Federally Available Data (FAD) and qualitative findings. For this domain, indicator data show differences in outcomes based on race, ethnicity, socioeconomic status, parental education, and insurance status and type. Furthermore, these

inequities are driven by many factors, including social determinants of health like education, poverty, structural racism, and housing safety and quality. Notable disparities in sentinel indicators are presented below.

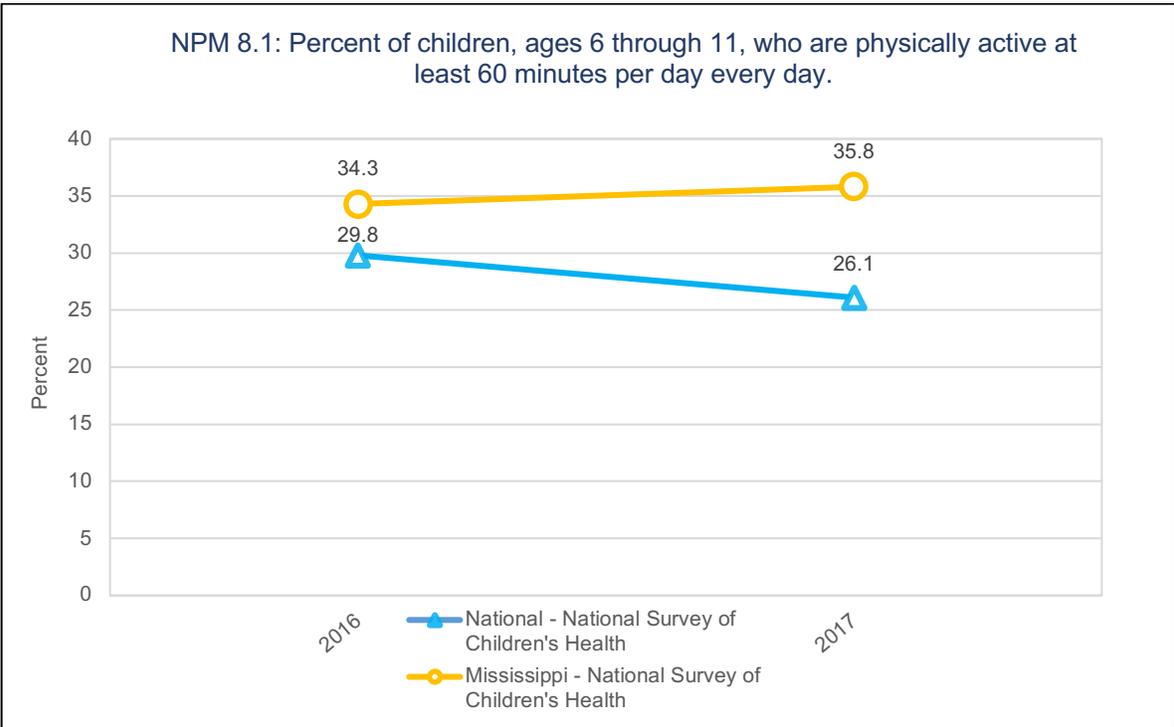
The following charts present the above data in a more detailed format and, where available, across time to show comparisons to national indicators and trends.



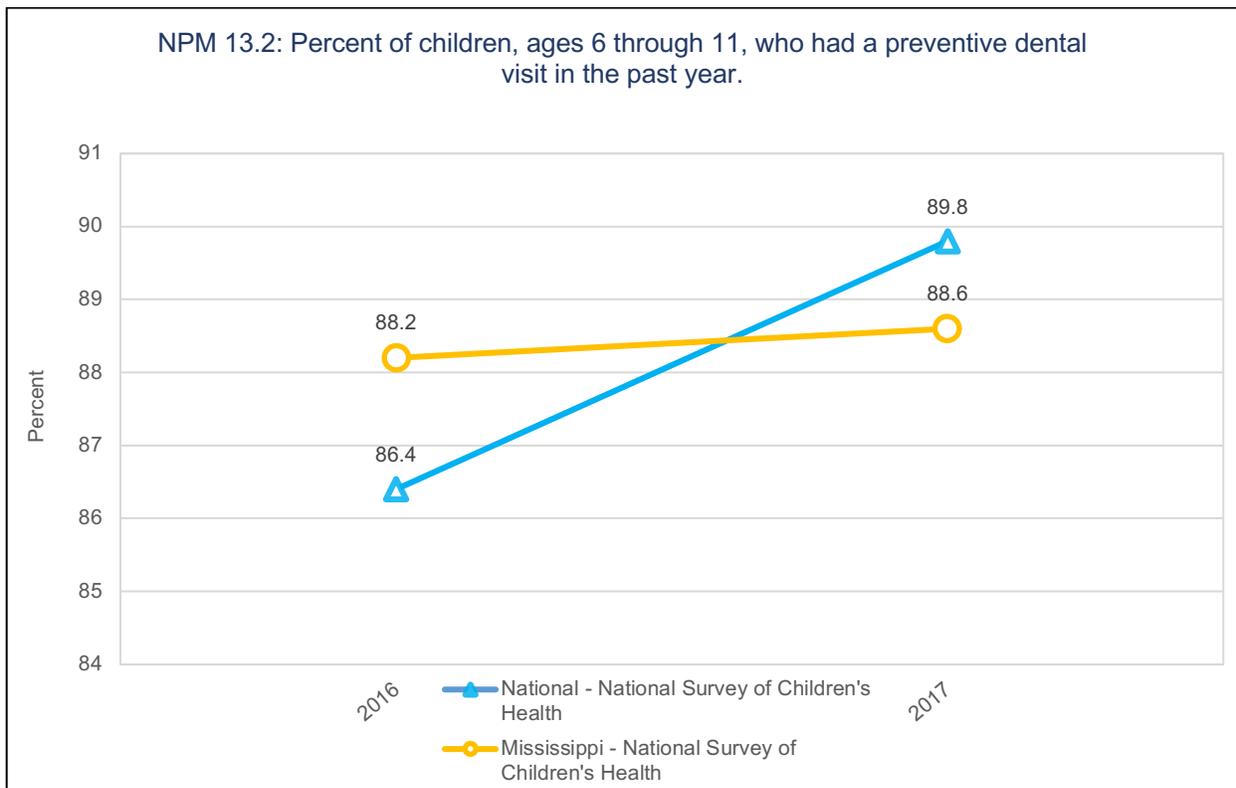
The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on NPM 6 (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year) between 2016 and 2017. For both years, Mississippi reported lower percentages than the national average; however, there was an increase from 2016 to 2017. The green line indicates Mississippi’s objectives for the coming years.



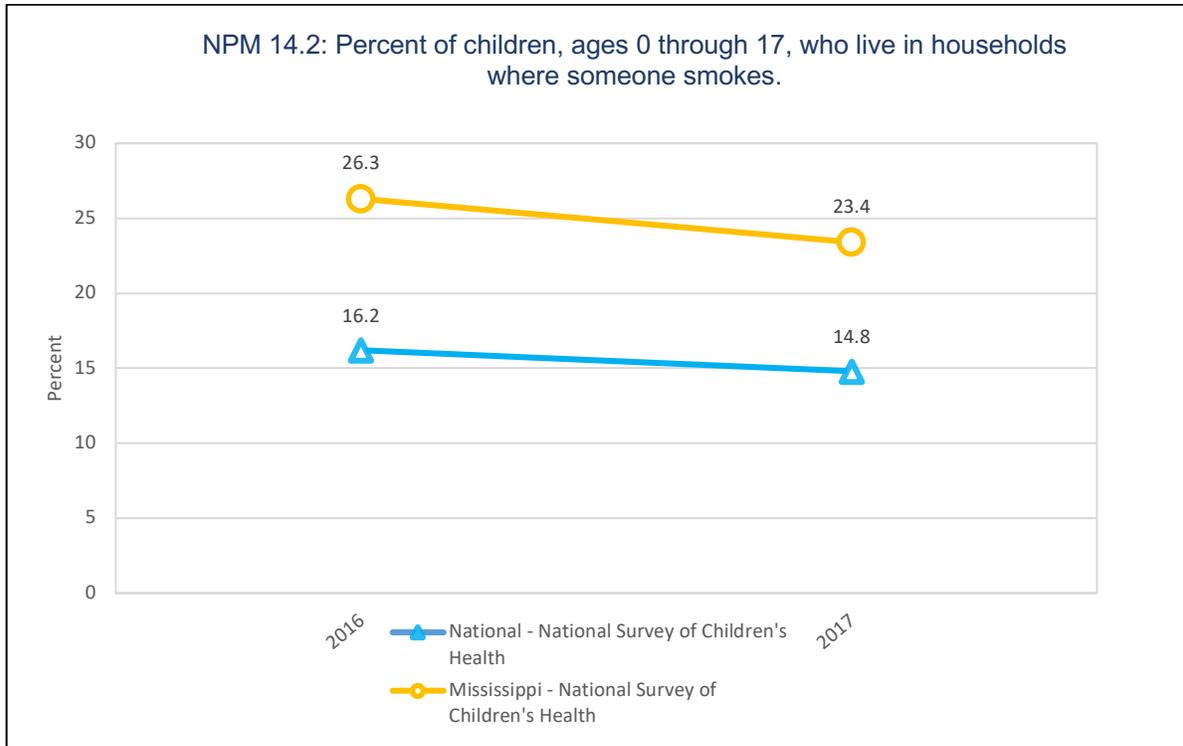
This chart presents the disparities in developmental screening by insurance type. Mississippi children with private insurance exhibited a lower percentage of receiving developmental screening compared to children with private insurance nationally. Mississippi children with private insurance also had a lower percentage of receiving a developmental screening compared to Mississippi children with Medicaid. This is in contrast to the national findings.



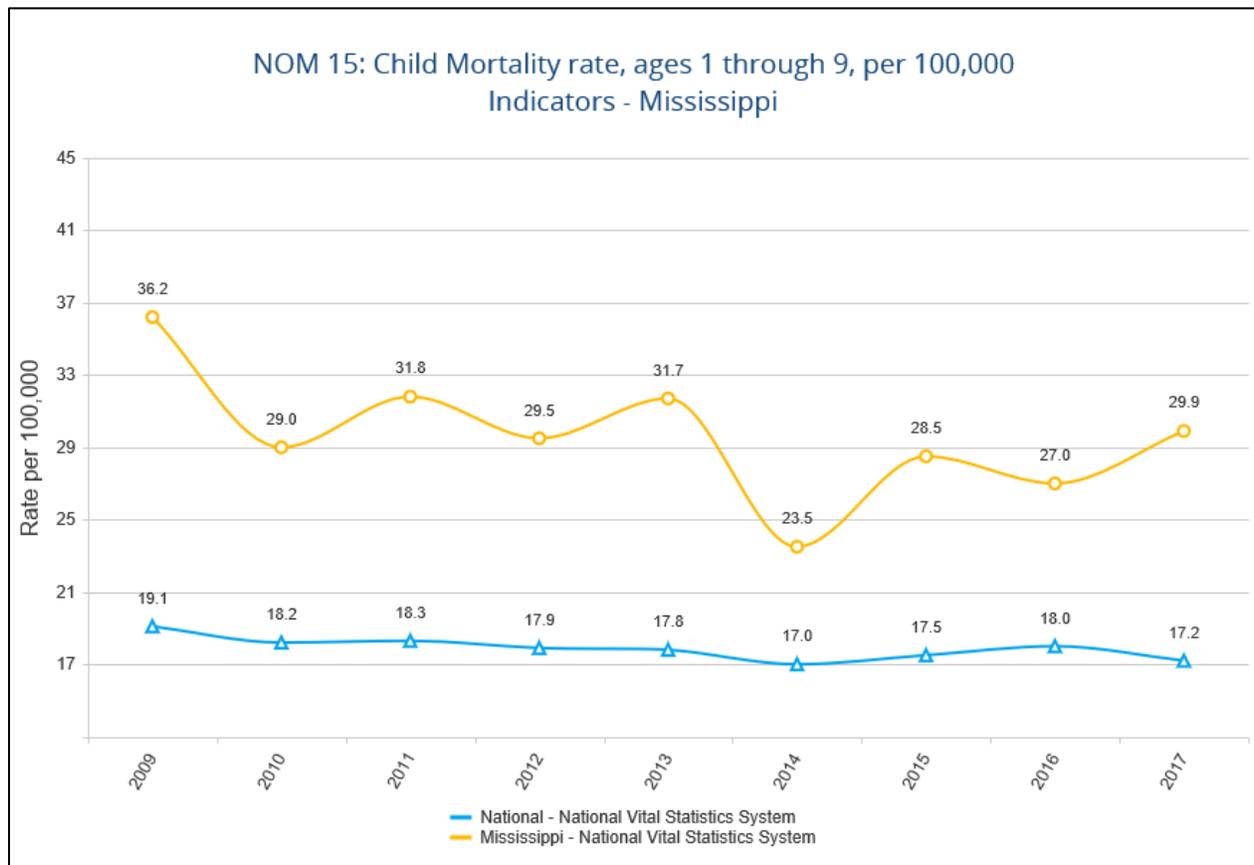
The above data, from the 2016 and 2017 National Surveys of Children’s Health, compare Mississippi and the U.S. on NPM 8.1 (Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day every day). For both years, Mississippi reported higher percentages of children meeting this performance measure compared to the national percentage. Mississippi’s percentage increased slightly between 2016 and 2017 while the national percentage decreased. (Note: Mississippi 2017 data for this measure should be interpreted with caution due to a large confidence interval surrounding the estimate.) Children who identify as non-Hispanic white or non-Hispanic black reported a higher percentage than children who identify as Hispanic.



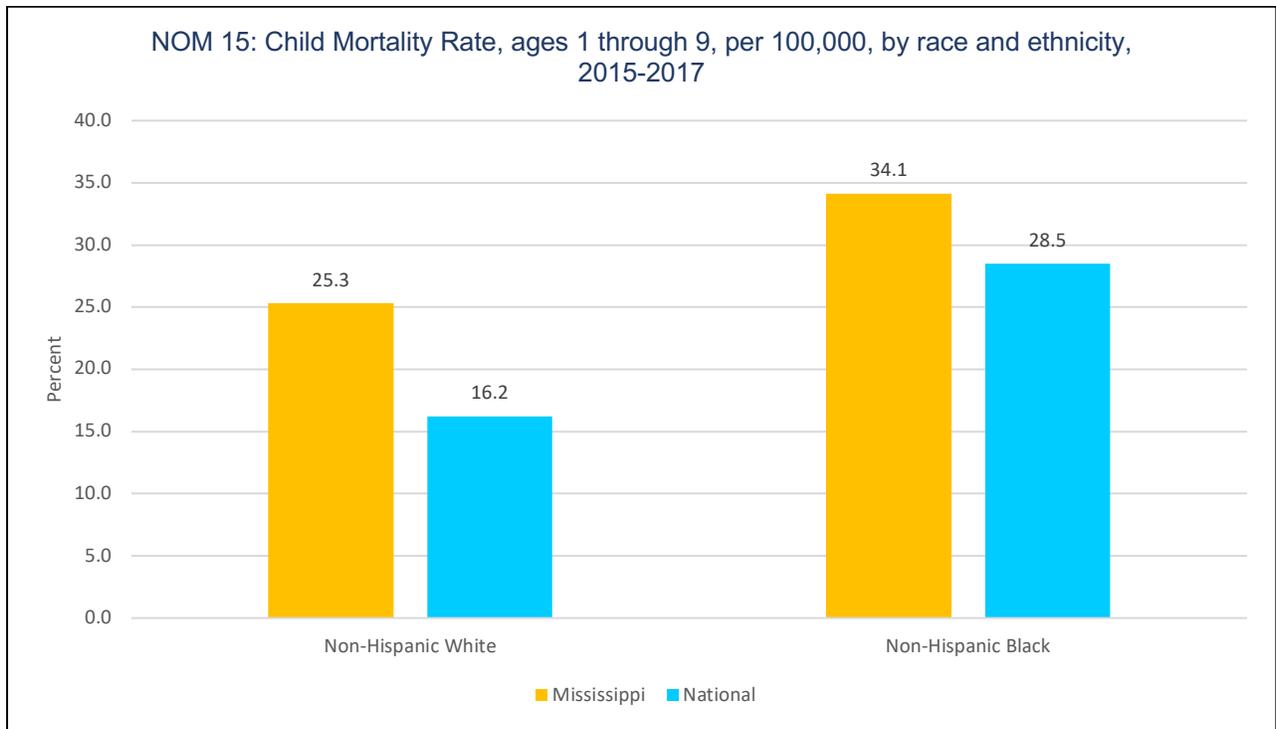
The above data, from the 2016 and 2017 National Surveys of Children’s Health, compare Mississippi and the U.S. on NPM 13.2 (Percent of children, ages 6 through 11, who had a preventive dental visit in the past year). Mississippi percentages were relatively the same between 2016 and 2017, while the national percentages increased. The Mississippi percentage was slightly higher than the national percentage in 2016, but was slightly lower than the national percentage in 2017. Mississippi children and adolescents (ages 1 through 17) who identify as non-Hispanic white exhibit a lower percentage of preventive dental visits compared with children and adolescents who identify as non-Hispanic black and Hispanic.



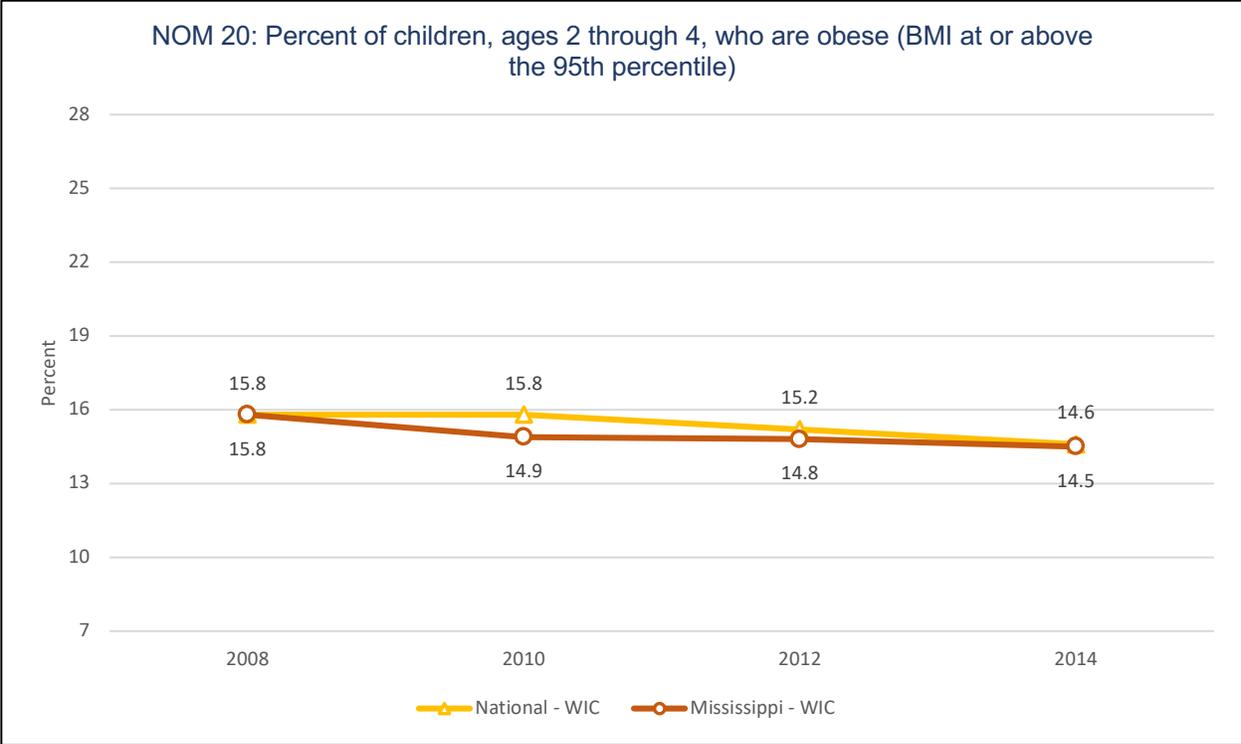
The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on NPM 14.2 (Percent of children, ages 0 through 17 who live in households where someone smokes). For both years, Mississippi reported percentages higher than the national percentage. Both Mississippi’s and the nation’s percentages decreased between 2016 and 2017.



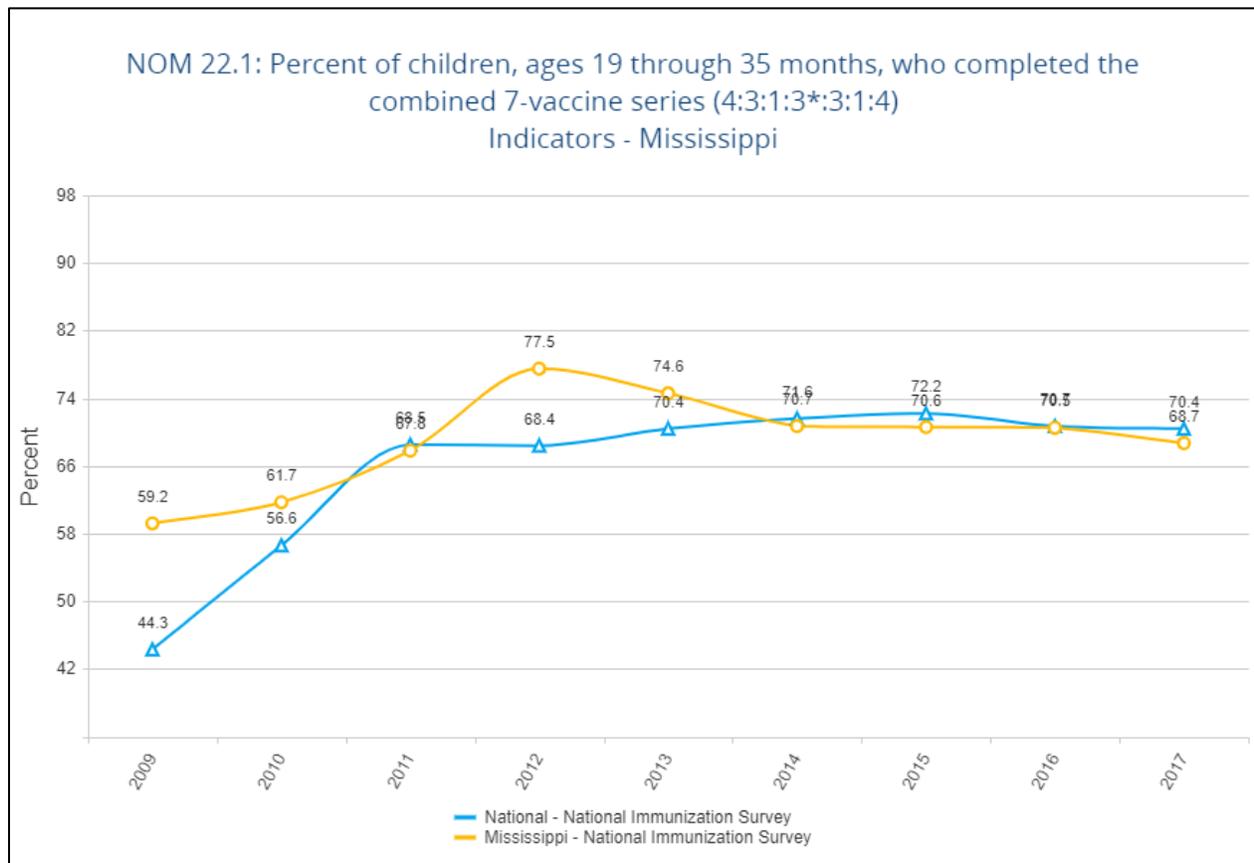
The above data, from the National Vital Statistics System, compare Mississippi and the U.S. on NOM 15 (Child Mortality rate, ages 1 through 9, per 100,000). Mississippi consistently reports significantly higher rates than the national rates. While the national rate has declined relatively steadily between 2009 and 2017, Mississippi's rate has fluctuated. The most recent data suggest an increase in the child mortality rate in Mississippi.



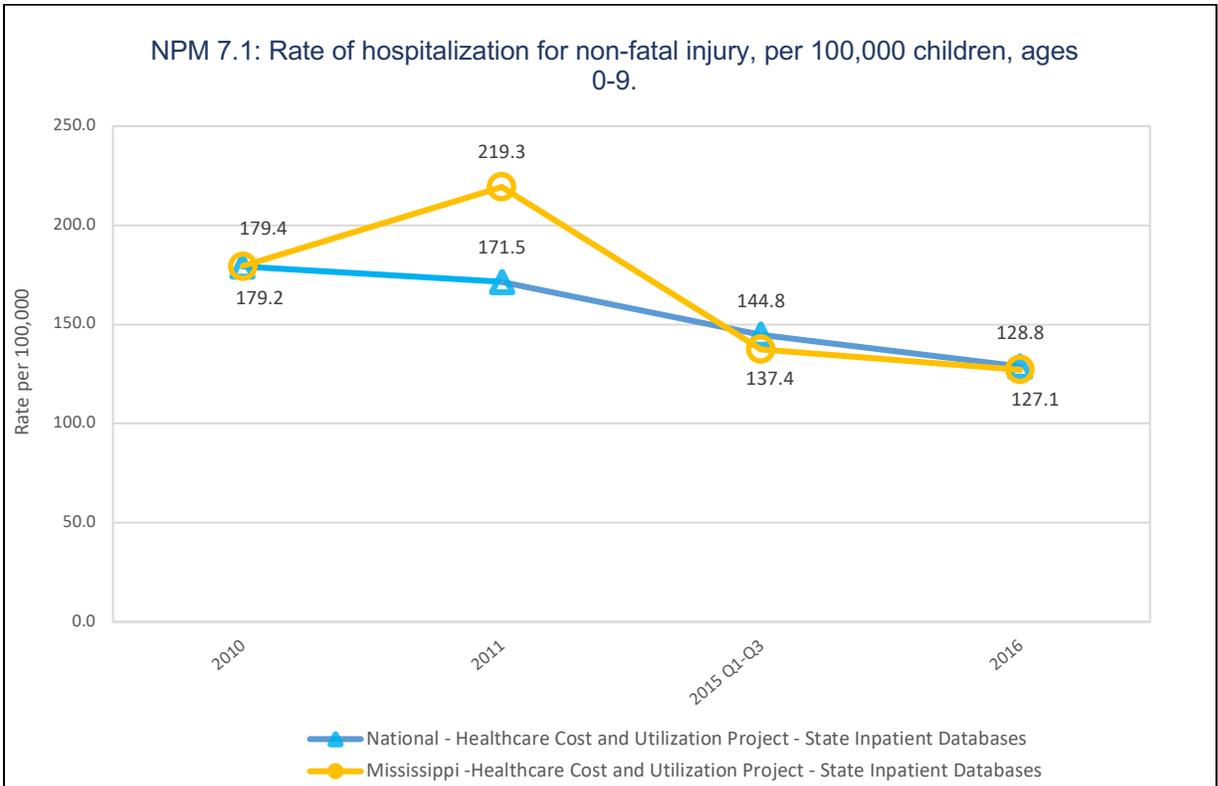
This chart presents the disparities in the child mortality rate by race and ethnicity according to the most recent National Vital Statistics System data (2015-2017). The mortality rate for children who identify as non-Hispanic black is significantly higher than the rate for children who identify as non-Hispanic white.



The above data, from the Women, Infant, and Children's (WIC) program, compare Mississippi and the U.S. on NOM 20 (Percent of children, ages 2 through 4, who are obese [BMI at or above the 95<sup>th</sup> percentile]) between 2008 and 2014. During this six-year period, both Mississippi and the nation demonstrated slow declines in the percentage of children, ages 2 through 4, who were obese. Mississippi's percentage dropped slightly below the national percentage from 2010 – 2014.



The above data, from the National Immunization Survey, compare Mississippi and the U.S. on NOM 22.1 (Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3\*:3:1:4)). Both the U.S. and Mississippi have reported increased percentages since 2009; however, Mississippi experienced a peak in 2012, followed by a steady decline. Mississippi maintained a percentage higher than the nation from 2009 – 2010 and 2012 – 2013. Children with Medicaid demonstrated a lower percentage of having completed the combined 7-vaccine series when compared to children with private health insurance.



The above data, from the Healthcare Cost and Utilization Project – State Inpatient Databases, compare Mississippi and the U.S. on NPM 7.1 (Rate of hospitalization for non-fatal injury per 100,000 children, ages 0-9). The Mississippi rate peaked in 2011 before falling below the national rate in 2015 and 2016. Children who identify as non-Hispanic white demonstrated a higher rate of hospitalization for non-fatal injury compared to children who identify as non-Hispanic black or Hispanic. Children in metro areas demonstrated a higher rate than non-metro areas.

## II. Statements of Needs: Child Domain

In an effort to gain more detailed information about community experiences, preferences, concerns, and perceptions, a series of focus groups, key informant interviews, and surveys were conducted in late 2019. Focus group transcripts, key informant interview notes, and survey responses were analyzed to identify common themes across data collection methods and broad stakeholder populations. A more detailed description of the data analysis may be found on pages 3-5 of the executive summary. These themes were then considered along with the FAD and other state quantitative data to guide the development of need statements.

Based on both quantitative and qualitative data, eight statements describing areas of need in the child domain were developed and presented to community stakeholders and agency leadership for discussion and prioritization. These are described below, along with the method that yielded the supporting evidence for each need. There is similarity for some needs across those identified in other domains.

### Legend for Data Collection Method and Abbreviation

Data Collection Method	Abbreviation
Federally Available Data	F
Focus Groups	G
Key Informant Interviews	K
Surveys	S

- 1. Lack of awareness of healthy nutrition guidelines and portion sizes (*identified in the following Data Collection Methods: G, K, S*)**
  - a. The nutritional quality of school lunches has improved but students show preference for less healthy options.
  - b. Healthy, affordable food options may be difficult for families to access. Fast food options are inexpensive and convenient.
  - c. Fifty percent (50%) of survey respondents reported their children consume two or fewer servings of fruits and vegetables each day.
  - d. Caregivers need education on healthy eating, appropriate levels of physical activity, and chronic disease prevention.
- 2. Lack of or inadequate access to mental health services that are comprehensive and age-appropriate (*identified in the following Data Collection Methods: F, G, K, S*)**
  - a. Communities lack mental and behavioral health services for children and adolescents.
  - b. Unmonitored access to social media, video games, and the internet may contribute to child mental and behavioral health challenges.
  - c. Bullying in schools is a significant concern. Children may develop unhealthy coping strategies, such as physical violence.

- d. Increasing access to school-based mental health services may address child mental health needs.
  - e. Early identification of mental health is important so proper interventions can be employed.
  - f. Caregivers need resources and education on child mental health to support early identification of needs.
- 3. Lack of or inadequate access to affordable and safe options for physical activity (*identified in the following Data Collection Methods: F, G, K, S*)**
- a. Physical activity is limited among young children. Overuse of technology prevents physical activity in children.
  - b. Almost 60% of survey respondents reported their children exercise for at least 60 minutes/day fewer than 5 days each week.
  - c. Safe and affordable recreational options are limited for some families. Gyms, parks, community centers, etc. are uncommon or too expensive. Some spaces are not safe due to lack of maintenance and high crime rates in some communities.
- 4. Lack of timely, appropriate, and consistent health and developmental screenings (*identified in the following Data Collection Methods: F, S*)**
- a. Developmental screening levels were low overall. The following differences in health and developmental screenings based on the age of the child were described:
    - i. Younger children were more likely to have had developmental and hearing screenings
    - ii. Older children were more likely to have had vision, blood pressure, and blood sugar/diabetes screenings.
- 5. Limited access to affordable oral health care and insurance (*identified in the following Data Collection Methods: F, G, K, S*)**
- a. There is a shortage of oral health providers for children, especially in rural areas.
  - b. Public dental insurance covers annual dental visits but no services beyond that. It is difficult to find providers who will accept this coverage.
  - c. Untreated lip and tongue ties were concerning for caregivers of infants. Difficulty breastfeeding, failure to thrive, and speech impediments were some of the challenges associated with untreated lip and tongue ties.
  - d. Out-of-pocket costs for oral health services are prohibitive for many families. Providers often require multiple visits to address an oral health need.
- 6. Lack of comprehensive, family-centered, and culturally-competent health care (*identified in the following Data Collection Methods: F, G, K, S*)**
- a. Barriers to accessing care include:
    - i. long wait lists for appointments and/or limited office hours
    - ii. distance between providers (desire for a one-stop shop)
    - iii. lack of “sick” and “well” waiting rooms at pediatric practices
    - iv. referral processes that are difficult to navigate
  - b. Navigating the health care system is frustrating. There is little collaboration and communication between providers. Communication with physician offices is poor.
  - c. Barriers specific to the Spanish speaking/Latinx communities include:
    - i. inaccurate translation of paperwork
    - ii. poor quality of interpretation
    - iii. low quality care available for children who are undocumented

- 7. Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education (*identified in the following Data Collection Methods: G, K, S*)**
  - a. Pediatric specialty health and oral health providers are scarce, especially in rural areas. It is difficult to access primary care for their children due to scheduling and wait lists.
  - b. Access to services may be restricted by travel time, appointment schedules, and distance to providers. Access is especially difficult for working families with inflexible schedules and limited transportation options.
  - c. Barriers to health care and health maintenance include:
    - i. socioeconomic status
    - ii. education
    - iii. neighborhood crime and safety
    - iv. relationships
    - v. childcare
    - vi. policies and politics
    - vii. literacy
    - viii. equitable educational opportunities
- 8. Lack of or inadequate smoking, alcohol, and substance use prevention education (*identified in the following Data Collection Methods: G, K, S*)**
  - a. Children may begin smoking and using substances at young ages.
  - b. Drugs and alcohol are widely available in many communities, including to school age children.
  - c. School-based prevention education should be effective and begin at a young age.
  - d. Children may smoke and use substances with their parents.

### III. Prioritized Statements of Needs: Child Domain

The statements, as well as their prioritized rank after the process was completed, are listed in the table below. A detailed description of the prioritization process may be found on pages 13-16 of the executive summary.

Rank	Need
1 (tied)	Lack of comprehensive, family-centered, and culturally-competent health care
1 (tied)	Lack of timely, appropriate, and consistent health and developmental screenings
2	Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education
3 (tied)	Lack of or inadequate access to affordable and safe options for physical activity
3 (tied)	Lack of or inadequate access to mental health services that are comprehensive and age-appropriate
4	Lack of awareness of healthy nutrition guidelines and portion sizes
5 (tied)	Lack of or inadequate smoking, alcohol, and substance use prevention education
5 (tied)	Limited access to affordable oral health care and insurance

**MSDH 2020 Title V Maternal and Child Health Services Block Grant  
Comprehensive Needs Assessment**  
*Domain Report: Adolescent*

**I. Setting a Baseline for Adolescent Health in Mississippi: A Summary of Federally Available Data**

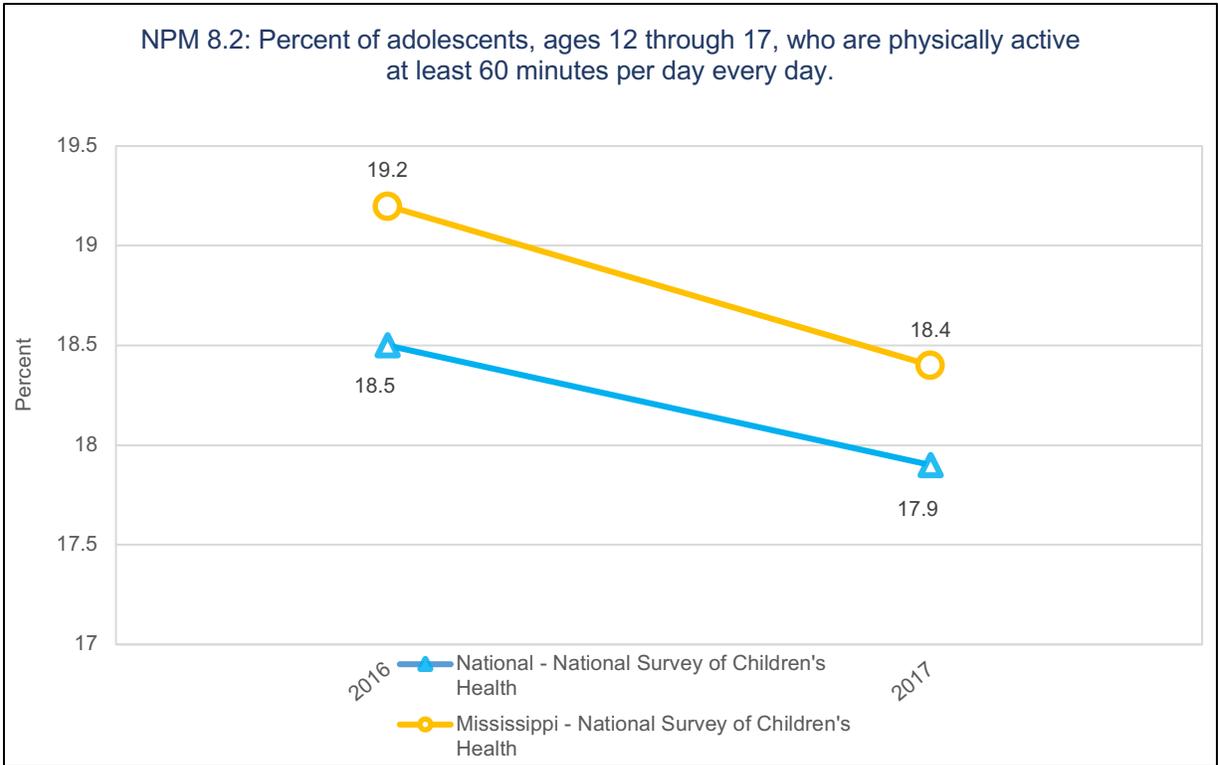
Each state is provided with a set of indicators that cover all Title V domains. These indicators are tied to the National Performance Measures and National Outcome Measures on which states have chosen to focus. The table below summarizes all of the indicators that are associated with adolescent health for Mississippi.

Adolescent Health Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Physical activity (every day)	18.4%	Better	Trending slightly worse
Bullying (victimization)	24.3%	Worse	Trending worse
Adolescent well-visit	77.0%	Slightly worse	Trending better
Preventive dental visit – adolescent	88.9%	Better	About the same
Adolescent mortality	48.4 per 100,000	Worse	Trending better
Adolescent motor vehicle death	28.0 per 100,000	Worse	Trending better
Adolescent suicide	9.6 per 100,000	Slightly better	Mixed
HPV vaccination	49.6%	Worse	Trending better
Obesity (10-17 years)	19.2%	Worse	Trending worse
Household smoking - child (12-17 years)	21.2%	Worse	Trending slightly worse
Hospitalization for non-fatal injury (10-19 years)	204.4 per 100,000	Better	Trending better
Teen births	31.0 per 1,000	Worse	Trending better

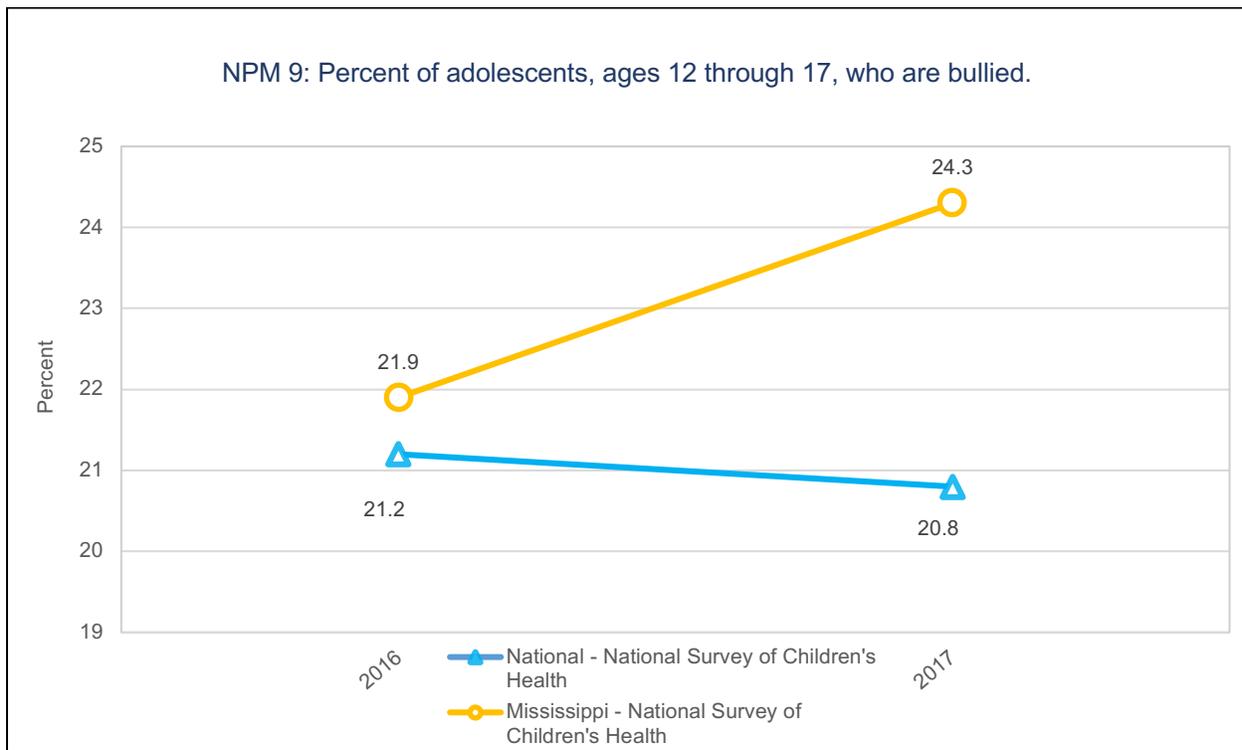
\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in arrears. See page 3 for information on FAD and to access current information.

Consistent with the guiding principle of promoting health equity and reducing disparities, several areas of disparity were noted across all domains in both the Federally Available Data (FAD) and the qualitative findings. For this domain, indicator data show differences in outcomes based on race, ethnicity, and socioeconomic status. Furthermore, these inequities are driven by many factors,

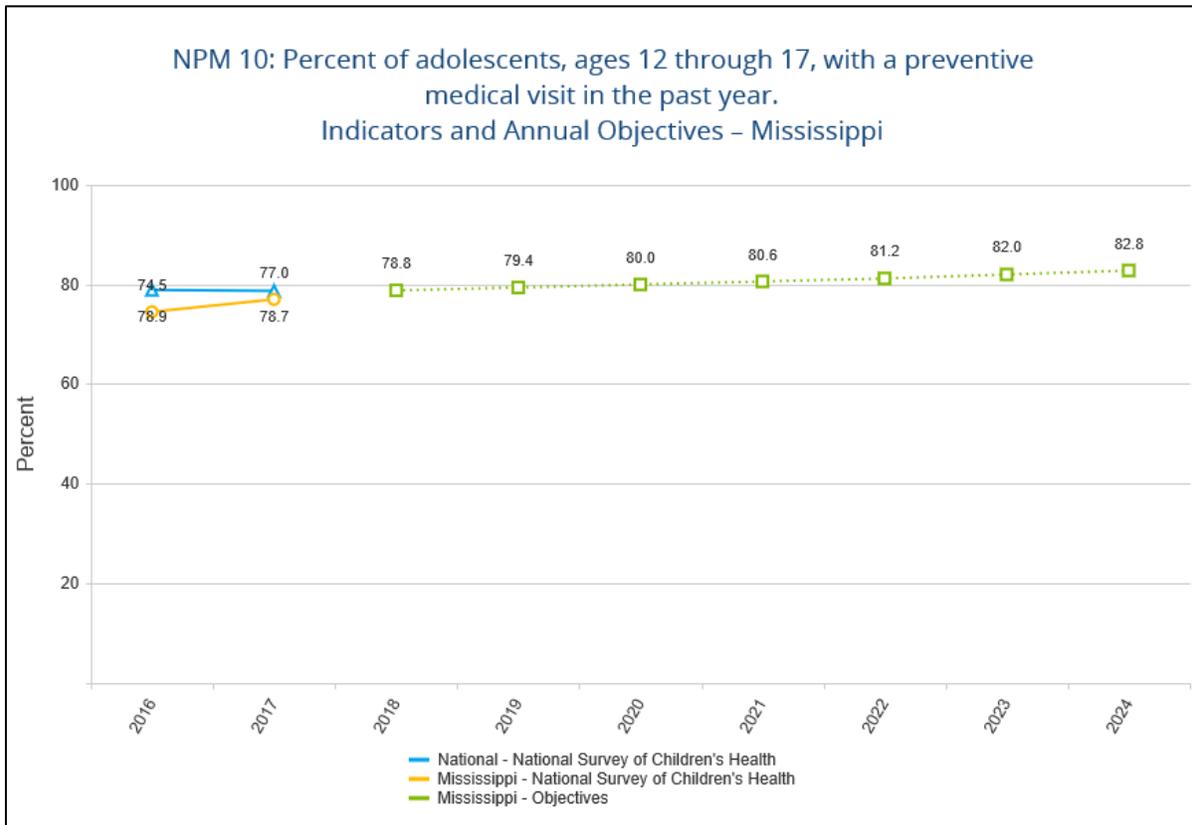
including social determinants of health like education, poverty, structural racism, and housing safety and quality. Notable disparities in sentinel indicators are presented below. The following charts present the above data in a more detailed format and, where available, across time to show comparisons to national indicators and trends.



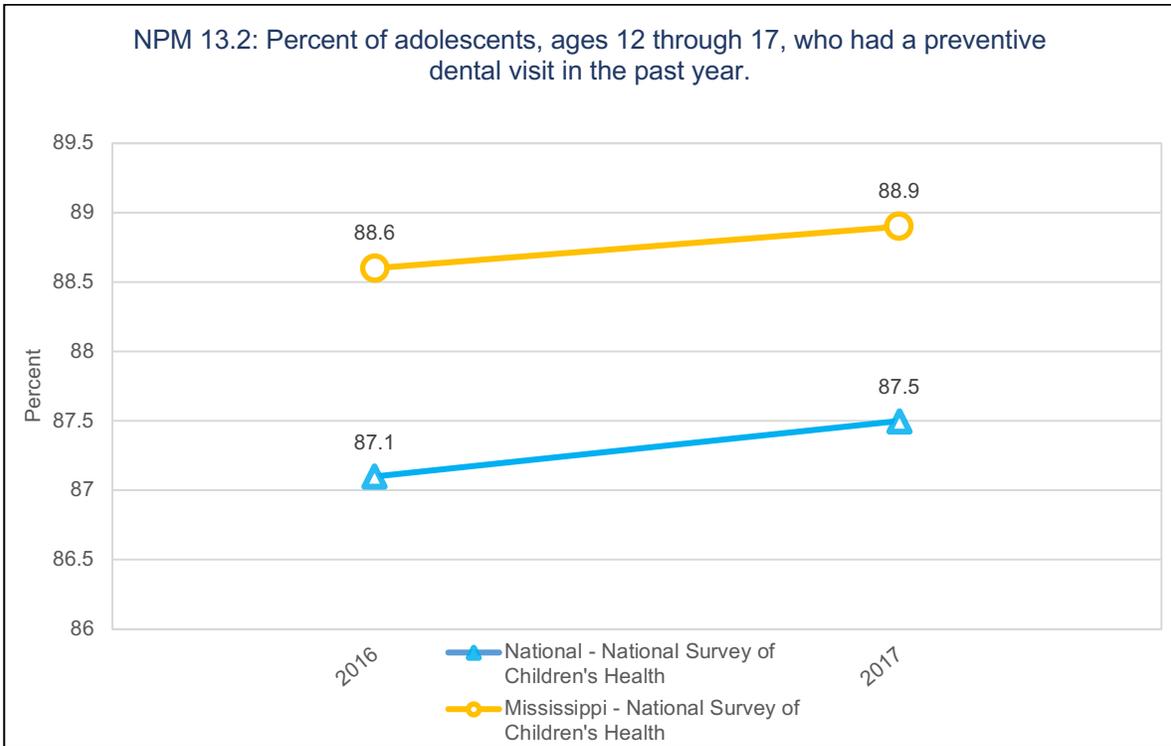
The above data, from the 2016 and 2017 National Survey of Children’s Health, compare Mississippi and the U.S. on NPM 8.2 (Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day everyday). For both years, Mississippi adolescents had higher percentages compared to adolescents nationally. However, percentages have decreased slightly across the two years for both Mississippi and the nation. Fewer than one in five adolescents report being physically active for at least 60 minutes per day every day of the week.



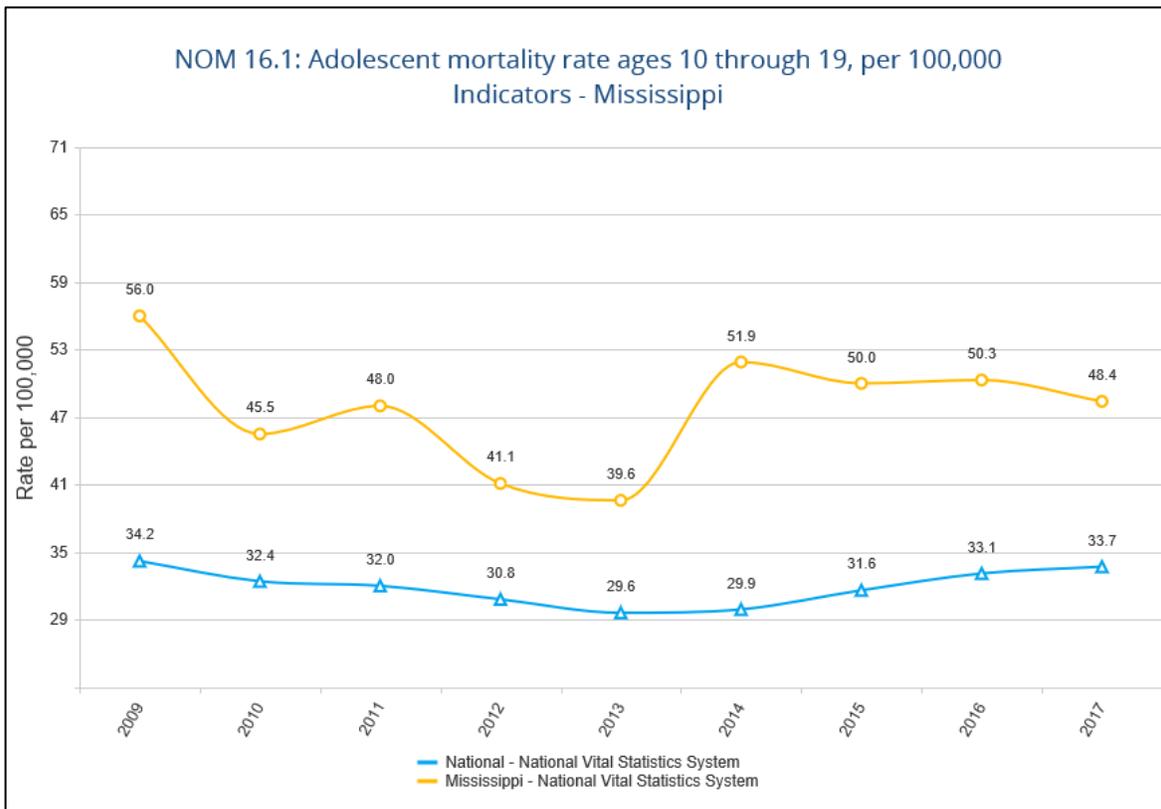
The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on NPM 9 (Percent of adolescents, ages 12 through 17, who are bullied). Approximately one in four adolescents in Mississippi report being bullied. The state’s percentage increased from 2016 to 2017 while the national percentage decreased slightly over the same period of time.



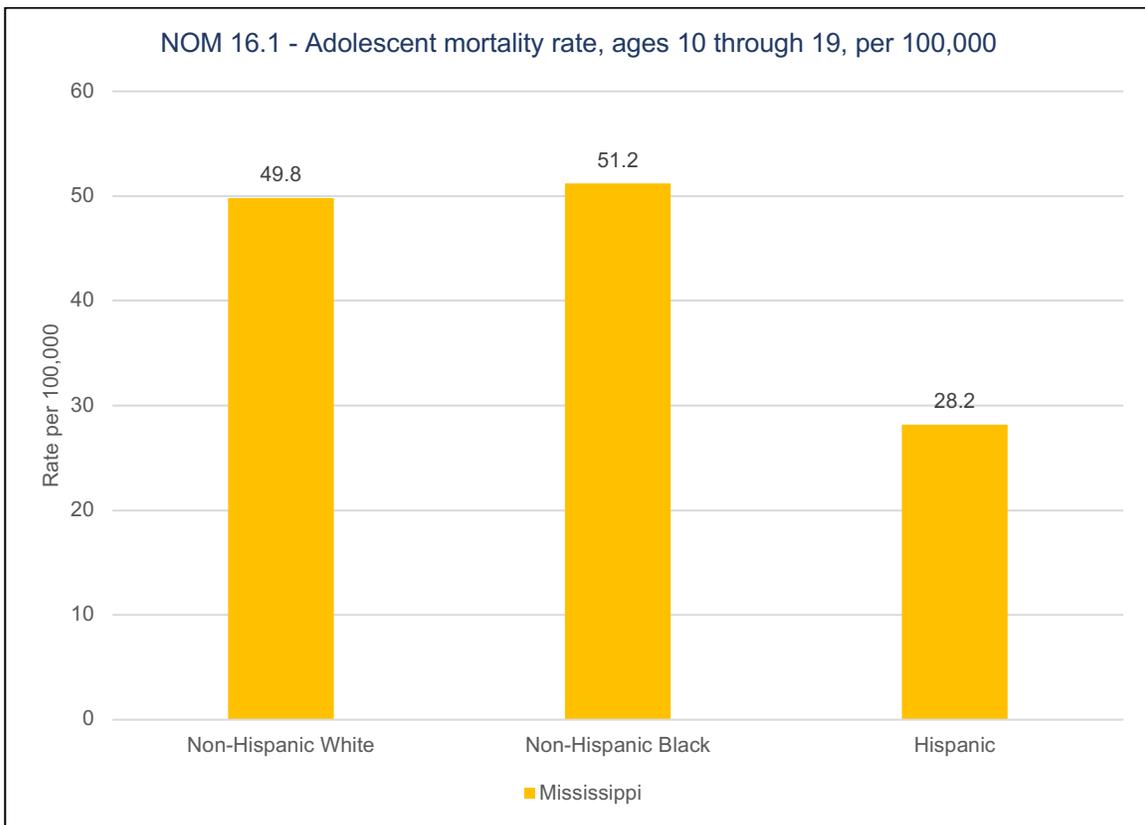
The above data, from the 2016 and 2017 National Surveys of Children’s Health, compare Mississippi and the U.S. on NPM 10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year). The green points indicate Mississippi’s annual objectives for this performance measure. Mississippi’s percentage increased between 2016 and 2017, at which point it was similar to the national percentage. Adolescents who identify as non-Hispanic white exhibit a lower percentage of preventive medical visits compared with adolescents who identify as non-Hispanic black.



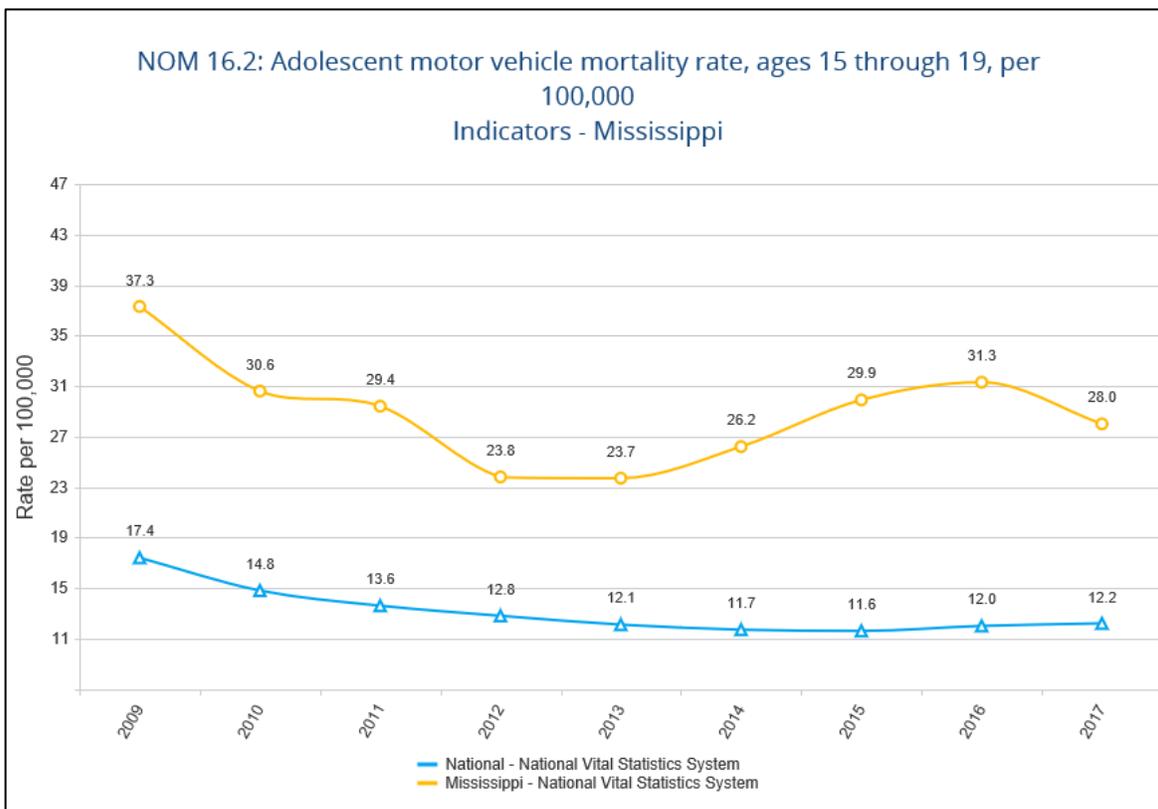
The above data, from the 2016 and 2017 National Surveys of Children’s Health, compare Mississippi and the U.S. on NPM 13.2 (Percent of adolescents, ages 12 through 17, who had a preventive dental visit in the past year). The national and Mississippi trends both increased slightly between 2016 and 2017. Mississippi’s percentage was slightly higher than the national percentage for both years. Mississippi children and adolescents (ages 1 through 17) who identify as non-Hispanic white exhibit a lower percentage of preventive dental visits compared with children and adolescents who identify as non-Hispanic black and Hispanic.



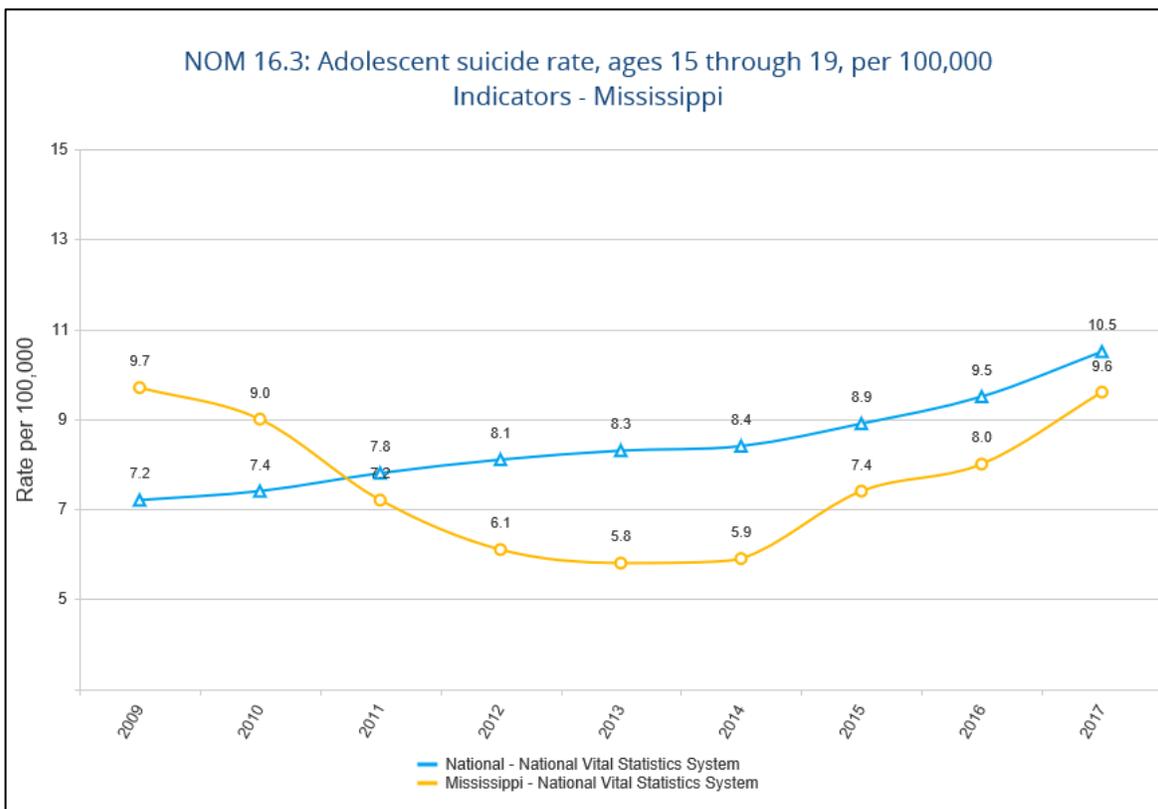
The above data, from the National Vital Statistics System from years 2009 to 2017, compare Mississippi and the U.S. on NOM 16.1 (Adolescent mortality rate ages 10 through 19, per 100,000). Mississippi's rate fluctuated between 2009 and 2014 before declining between 2014 and 2017. Mississippi's rate remained well above the national rate for adolescent mortality despite relative improvements from 2012-2013.



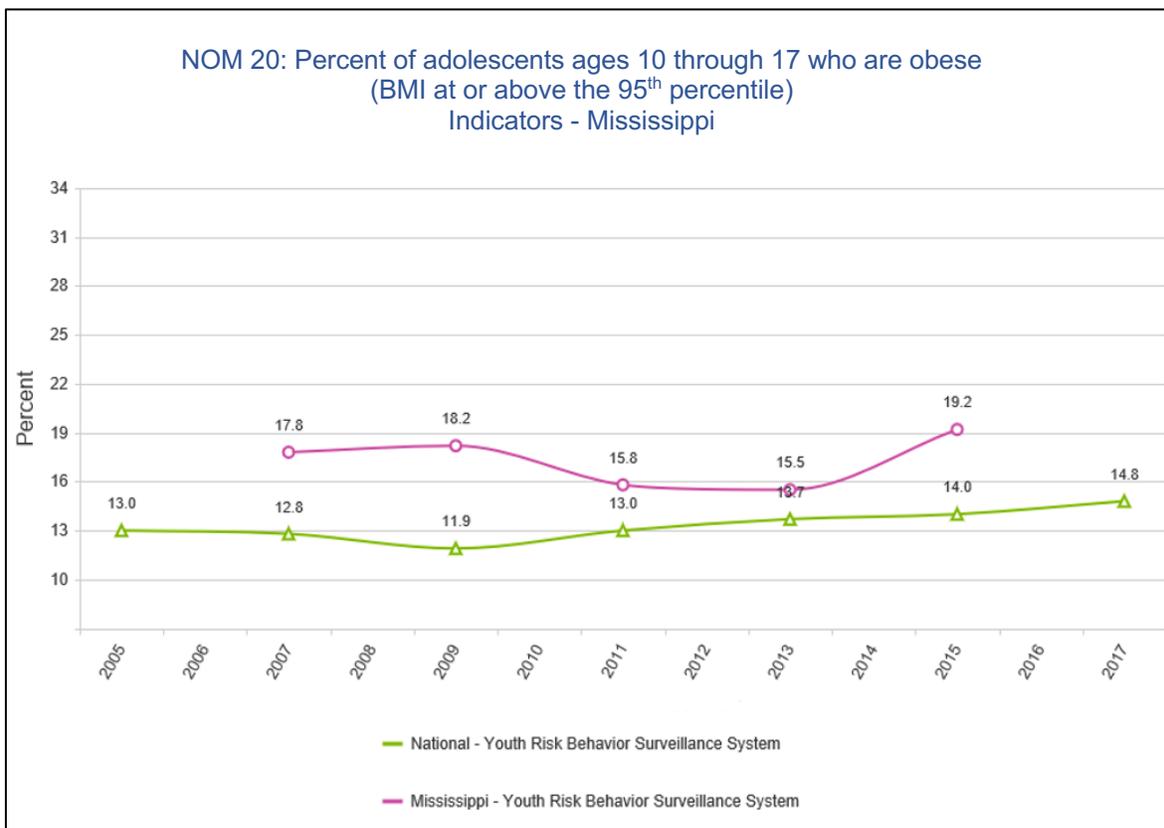
This chart presents disparities in the adolescent mortality by race and ethnicity according to the most recent National Vital Statistics System data (2017). The highest adolescent mortality rate was among non-Hispanic black adolescents (51.2 per 100,000). The lowest mortality rate was among Hispanic adolescents (28.2 per 100,000). The largest difference between Mississippi and national adolescent mortality rates was among adolescents who identify as non-Hispanic white.



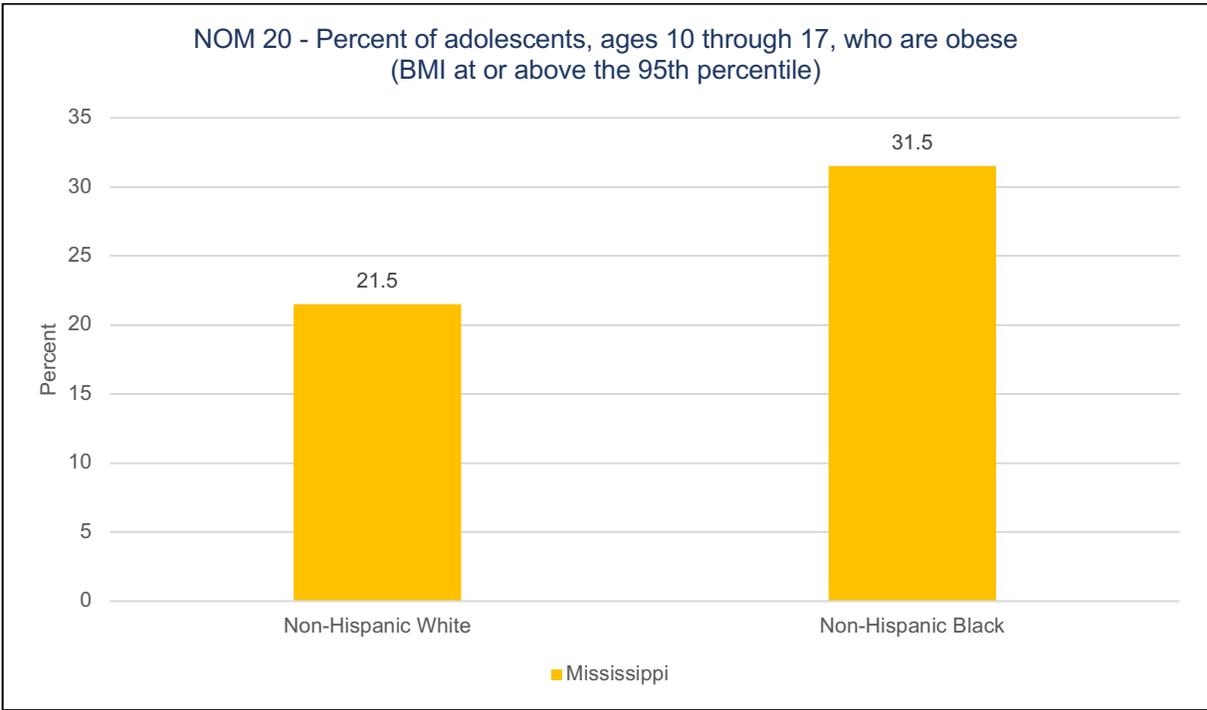
The above data, from the National Vital Statistics System from years 2009 to 2017, compare Mississippi and the U.S. on NOM 16.2 (Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000). Mississippi's rate was consistently at least twice that of the national average. While the U.S. rate has slowly declined since 2009, Mississippi followed the same trajectory until 2013. There was an increase in the rate between 2014 and 2016 before declining again in 2017.



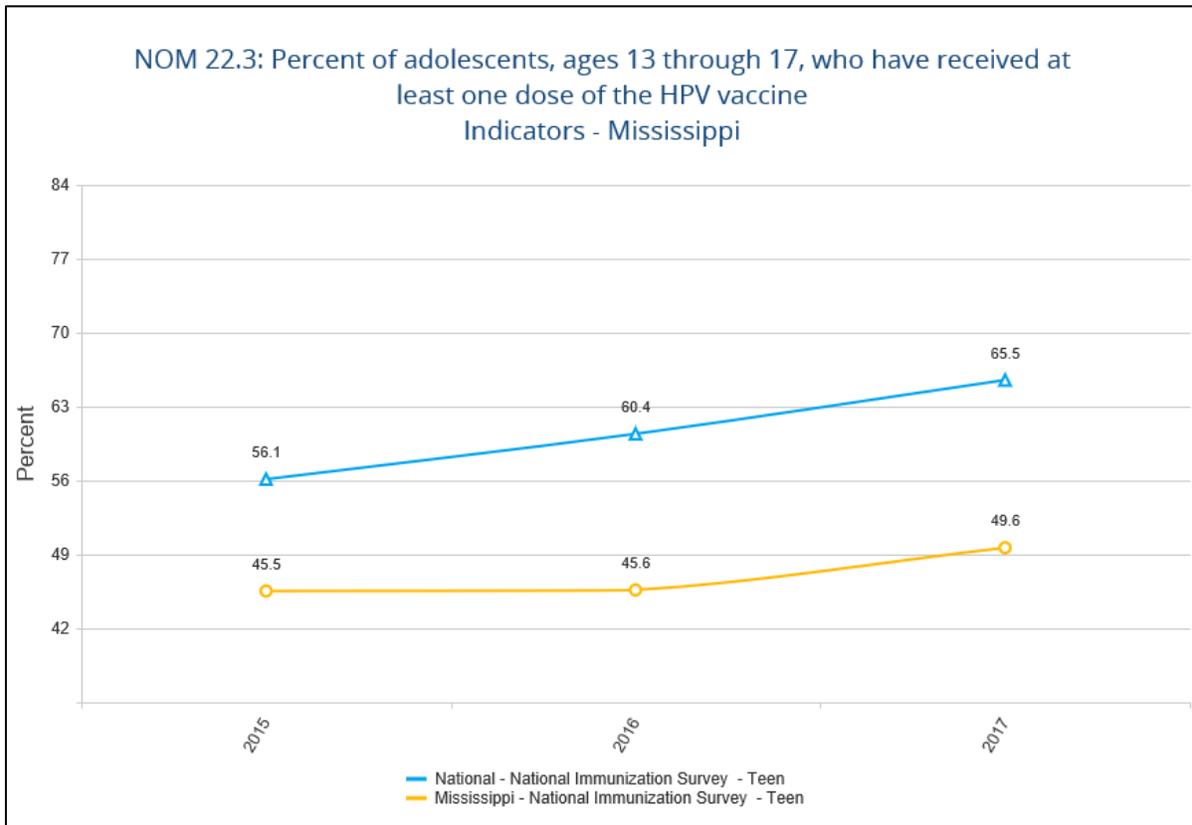
The above data from the National Vital Statistics System from 2009 to 2017 compare Mississippi and the U.S. on NOM 16.3 (Adolescent suicide rate, ages 15 through 19, per 100,000). Mississippi's rate has fluctuated relative to the consistent increase in the national data; however, since 2011, Mississippi's rates have been lower than the national average. The data reveal an overall worsening trend. The adolescent suicide rate was higher for adolescents who identify as non-Hispanic white compared with non-Hispanic black and also among small/medium metro areas compared with non-metro areas.



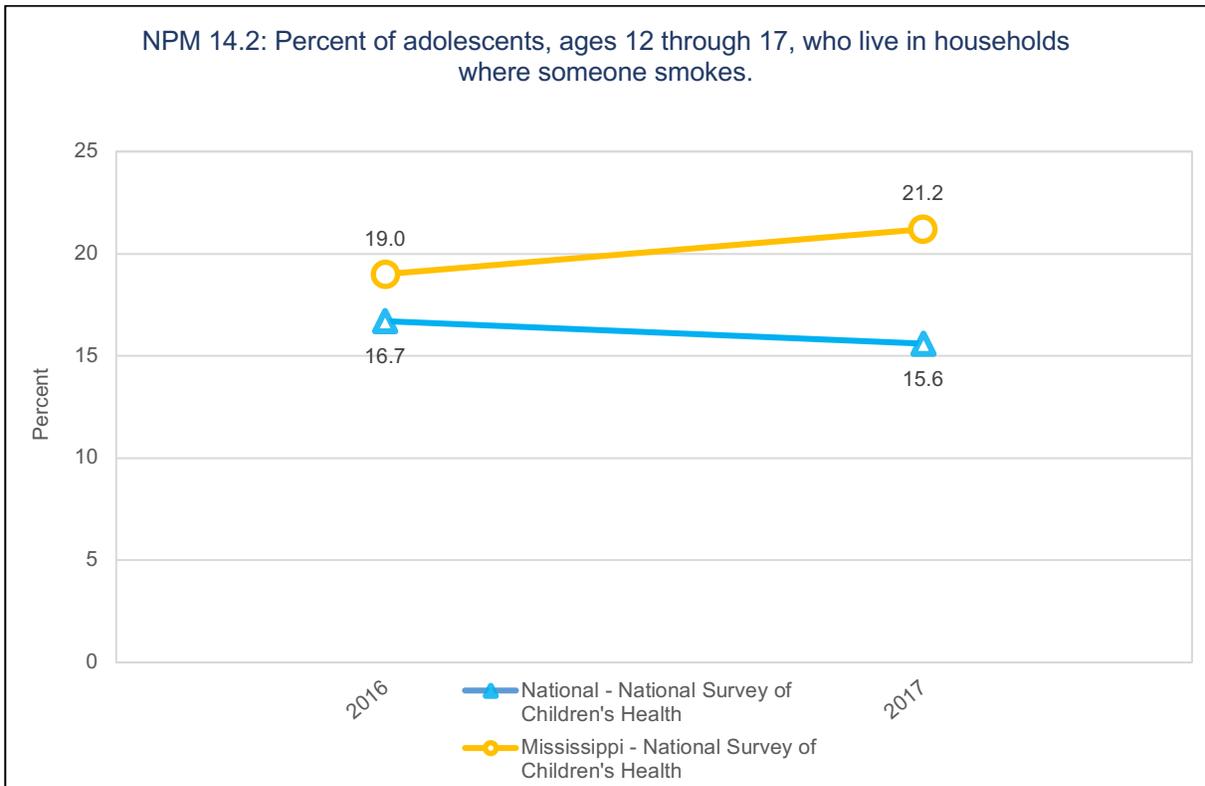
The above data, from the Youth Risk Behavior Surveillance System from the years 2005 to 2017 (National) and 2007 to 2015 (Mississippi), compare Mississippi and the U.S. on NOM 20 (Percent of adolescents, ages 10 through 17, who are obese [BMI at or above the 95<sup>th</sup> percentile]). Mississippi's percentage was consistently higher than national data. The data indicate worsening trends for both the state and the nation.



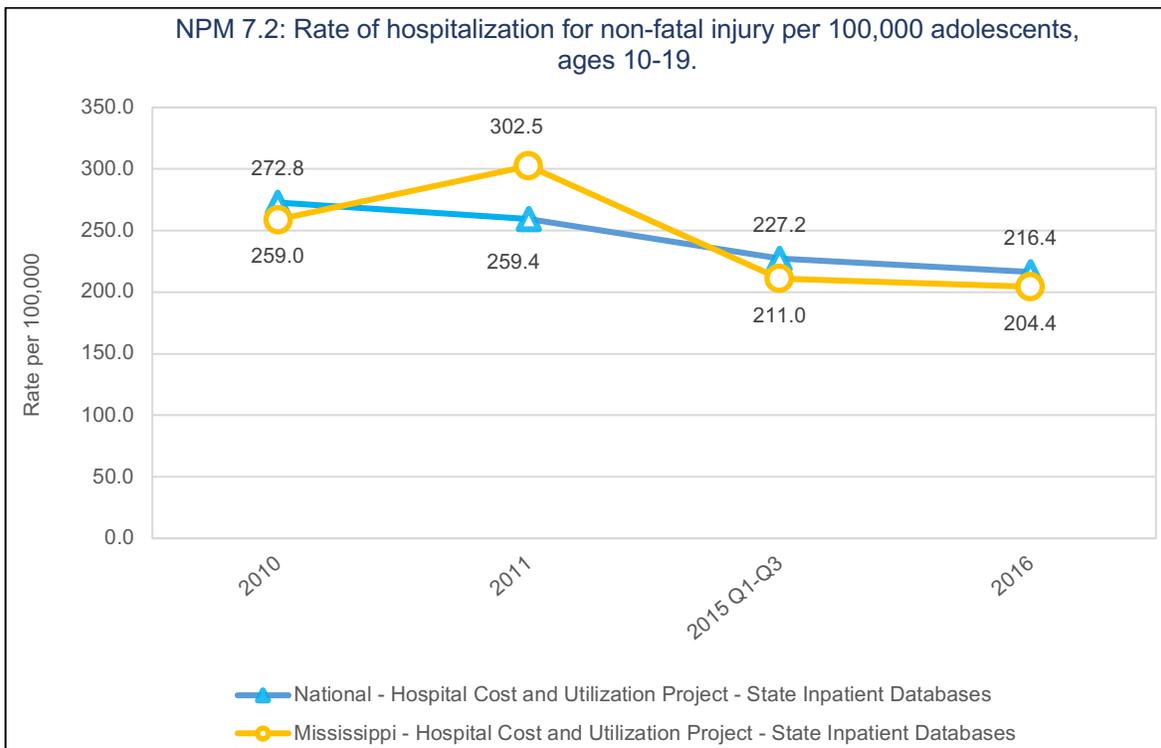
The above data, from the 2016-2017 National Survey of Children’s Health, presents disparities in the percent of adolescents, ages 10 through 17, who are obese (BMI at or above the 95% percentile) by race and ethnicity. Children who identify as non-Hispanic black had a higher percent of obesity compared to children who identify as non-Hispanic white.



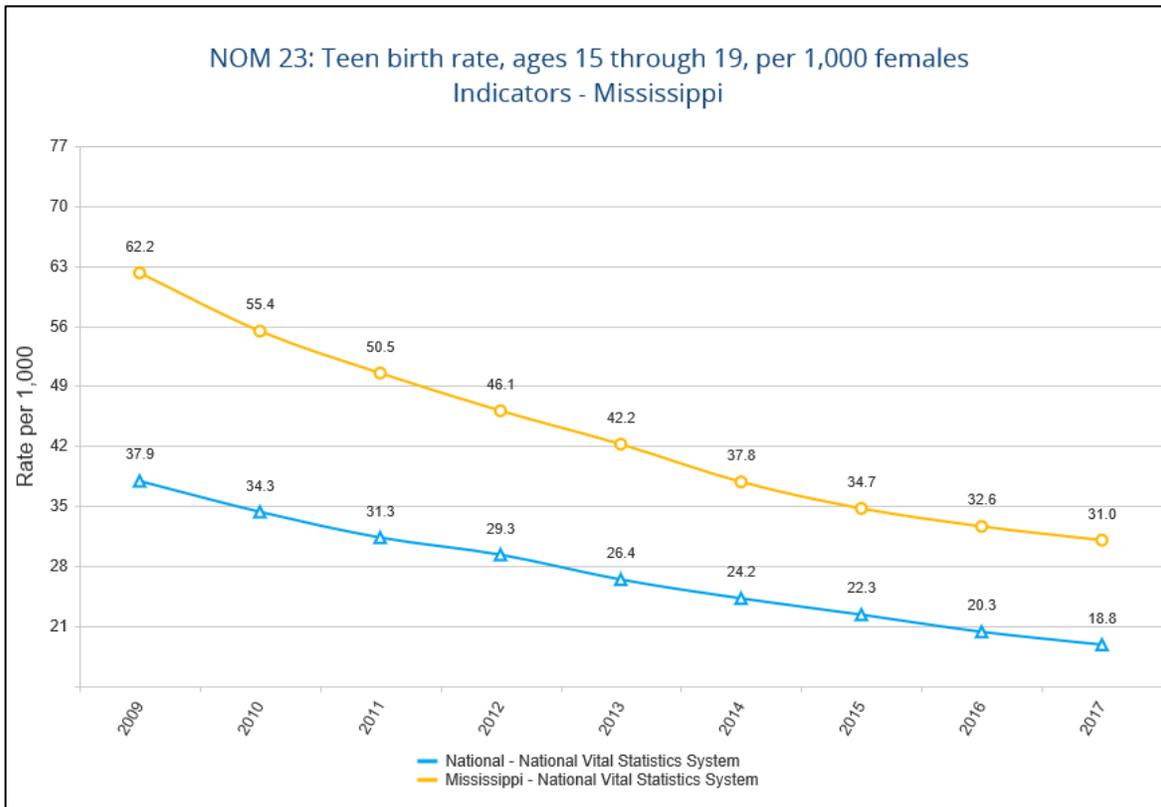
The above data, from the National Immunization Survey (Teen) for 2015 through 2017, compare Mississippi and the U.S. on NOM 22.3 (Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine). While Mississippi’s percentage has remained lower than the national average in all available years, there is an overall trend towards improvement. A lower percentage of adolescents who identify as non-Hispanic white and Hispanic received a least one dose of the HPV vaccine compared to adolescents who identify as non-Hispanic black and multiple race.



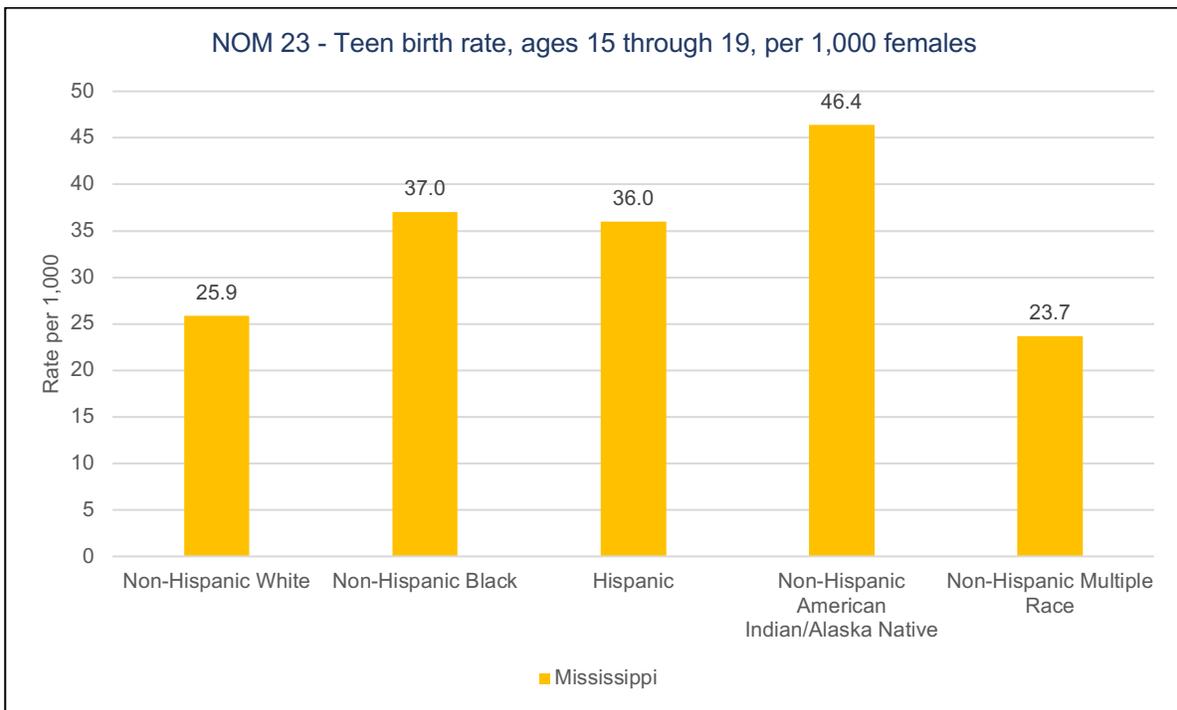
The above data, from the 2016 and 2017 National Surveys of Children’s Health, compare Mississippi and the U.S. on NPM 14.2 (Percent of adolescents, ages 12 through 17, who live in households where someone smokes). Mississippi’s percentage remained higher than the national percentage over the two-year period and increased while the national percent decreased slightly.



The above data, from the 2010 – 2016 Hospital Cost and Utilization Project – State Inpatient Databases, compare Mississippi and the U.S. on NPM 7.2 (Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 – 19). Mississippi’s rate fluctuated across this reporting period. The most recent data indicate a decreasing trend that has fallen below the national rate. The national rate steadily declined from 2010 to 2016. Adolescents who identify as non-Hispanic white exhibited a higher rate of hospitalization compared with adolescents who identify as non-Hispanic black and Hispanic. Non-metro areas exhibited higher rates of hospitalization compared with small and large metro areas.



The above data, from the National Vital Statistics System from years 2009 to 2017, compare Mississippi and the U.S. on NOM 23 [Teen birth rate, ages 15 through 19, per 1,000 females) between the years of 2009 and 2017. Mississippi’s rates have been consistently higher than the national average; however, both Mississippi and the U.S. have seen large decreases in rates since 2009.



This chart presents the disparities in the teen birth rate, ages 15 through 19, per 1,000 females by race and ethnicity according to the most recent National Vital Statistics System data (2017). Adolescents who identify as American Indian/Alaska Native exhibited the highest teen birth rate in the state (46.4 per 1,000). Adolescents who identify as Non-Hispanic multiple race reported the lowest birth rate (23.7 per 1,000).

## II. Statements of Needs: Adolescent Domain

In an effort to gain more detailed information about community experiences, preferences, concerns, and perceptions, a series of focus groups, key informant interviews, and surveys were conducted in late 2019. Focus group transcripts, key informant interview notes, and survey responses were analyzed to identify common themes across data collection methods and broad stakeholder populations. A more detailed description of the data analysis may be found on pages 3-5 of the executive summary. These themes were then considered along with the FAD and other state quantitative data to guide the development of need statements.

Based on both quantitative and qualitative data, 11 statements describing areas of need in the child domain were developed and presented to community stakeholders and agency leadership for discussion and prioritization. These are described below, along with the method that yielded the supporting evidence for each need. There is similarity for some needs across those identified in other domains.

### Legend for Data Collection Method and Abbreviation

Data Collection Method	Abbreviation
Federally Available Data	F
Focus Groups	G
Key Informant Interviews	K
Surveys	S

- 1. Lack of or inadequate access to affordable and safe options for physical activity, exercise, and recreation (*identified in the following Data Collection Methods: F, G, K, S*)**
  - Physical activity is limited among adolescents.
  - Many communities do not have safe, affordable spaces for physical activity.
  - Almost 55% of adolescent survey respondents reported exercising for at least 30 minutes for fewer than 5 days a week.
- 2. Inadequate and insufficient health and sexual health education (*identified in the following Data Collection Methods: F, G, K,*)**
  - Desire for school-based programs to be more comprehensive
    - Including discussion of pregnancy, sexually transmitted infections (STIs), safe sex, sexual abuse, and healthy relationships.
  - Education should begin at younger ages.
  - Key informants report quality of sex education is highly variable from school to school.
    - Some instructors have little training on evidence-based curricula.
  - Parents want resources to discuss effectively sexual health with their children.
  - Adolescents need respectful, culturally competent, medically accurate information regarding their sexual health.
  - Health education, including sexual education, should be tailored for adolescents with disabilities.

- g. In the absence of education, adolescents with disabilities, like all adolescents, may turn to peers or the internet for information.
3. **Lack of or inadequate access to comprehensive reproductive health care, including for adolescents with disabilities (*identified in the following Data Collection Methods: G, K, S*)**
    - a. Adolescents may feel embarrassed about discussing sexual and reproductive health, which is a barrier to accessing health care and health information.
  4. **Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education (*identified in the following Data Collection Methods: F, G, K, S*)**
    - a. Vaping, synthetic marijuana, marijuana, and alcohol consumption are the substances described as commonly used by adolescents.
      - i. Over 65% of adolescent survey respondents classified vaping, smoking, and smokeless tobacco as moderate or big problems.
      - ii. Over 55% of adolescent survey respondents classified alcohol use and abuse as a moderate or big problem.
      - iii. Forty-eight percent (48%) of adolescent survey respondents classified drug use and abuse as a moderate or big problem.
    - b. Unmet mental health needs, including depression and anxiety, may lead to substance abuse.
    - c. There is a need for more comprehensive and effective school-based prevention education.
    - d. Family and peers play an important role as adolescents often choose to engage in substance use if they see it in their homes and communities.
  5. **Lack of or inadequate access to mental health services that are comprehensive and age-appropriate (*identified in the following Data Collection Methods: F, G, K, S*)**
    - a. Adolescents face a number of mental health crises that include bullying, interpersonal violence, and suicide.
      - i. Over 65% of adolescent survey respondents reported depression and anxiety as moderate or big problems.
      - ii. Over 57% of adolescent survey respondents reported bullying as a moderate or big problem.
    - b. Unmonitored access to social media, video games, and the internet was perceived to contribute to adolescent mental and behavioral health challenges.
    - c. Adolescents shared that it would be helpful to:
      - i. learn healthy coping strategies
      - ii. have access to therapy
      - iii. have a relationship with a trusted adult to turn to for non-judgmental support
    - d. Adolescents are embarrassed to seek mental health support.
    - e. Increasing access to school-based mental health services may address adolescent mental health needs.
  6. **Lack of supports for pregnant and parenting teens (*identified in the following Data Collection Methods: F, G, K, S*)**
    - a. Teen pregnancy is perceived as an increasingly important issue due to lack of education and parental involvement.
    - b. Pregnant teens may smoke and drink while pregnant, which may negatively affect infant health.
    - c. There may be a connection between teen pregnancy and infant mortality.

- d. Adolescents may want to be pregnant because of lack of opportunities
    - i. Adolescents have “nothing to do” and see parenthood as a rite of passage.
  - e. For sex education to be effective and impactful, topics beyond STDs and contraceptives should be discussed, encompassing teens’ long-term goals for their lives
    - i. Pregnancy prevention should be tied to those goals.
- 7. Inadequate or insufficient preparation, information, and resources to support transition to adulthood (life skills, job preparedness) (identified in the following Data Collection Methods: G, K, S)**
- a. Adolescents want better preparation, information, and resources to support them to handle adult life (job training programs and life skills courses).
- 8. Limited access to adult role models and mentors (identified in the following Data Collection Methods: S)**
- a. Adolescents need trusted adult role models and mentors.
  - b. Some adolescents perceived they did not have these.
- 9. Inadequate or lack of comprehensive, affordable health and oral health care and insurance (identified in the following Data Collection Methods: F, G, S)**
- a. Adolescents who age out of Medicaid and cannot afford coverage or out-of-pocket costs have to go without oral health care.
  - b. Orthodontics are not covered by public dental insurance.
  - c. Over 24% of adolescent survey respondents did not attend a preventive dental visit in the past year.
  - d. Older adolescents (early 20s) noted that they and many people in their communities earn too much money from their jobs to qualify for Medicaid but not enough money to afford insurance or the out-of-pocket costs of care.
- 10. Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education (identified in the following Data Collection Methods: G, K, S)**
- a. Barriers to adolescents accessing health care include losing coverage once they become adults and Medicaid expires, as well as, a lack of resources and education to transition from pediatric to adult care
  - b. Barriers to health care and health maintenance include:
    - i. socioeconomic status
    - ii. education
    - iii. neighborhood crime and safety
    - iv. relationships
    - v. childcare
    - vi. policies and politics
    - vii. literacy
    - viii. equitable educational opportunities
- 11. Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, insurance status/type, sexual orientation, and gender identity (identified in the following Data Collection Methods: G, K, S)**
- a. Individuals may receive poor-quality care because of their socioeconomic status and insurance status.
  - b. Adolescents are in need of quality, respectful, confidential, teen-friendly health care, including care related to physical, mental, and sexual health.

- c. Barriers specific to Spanish speaking/Latinx communities include:
  - i. inaccurate translation of paperwork
  - ii. poor quality of interpretation
  - iii. low-quality care available for children who are undocumented

### III. Prioritized Statements of Needs: Adolescent Domain

The statements, as well as their prioritized rank after the process was completed, are listed in the table below. A detailed description of the prioritization process may be found on pages 13-16 of the executive summary.

Rank	Need
1	Inadequate or insufficient preparation, information, and resources to support transition to adulthood (life skills, job preparedness)
2	Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education
3	Lack of or inadequate access to comprehensive reproductive health care, including for adolescents with disabilities
4	Limited access to adult role models and mentors
5 (tied)	Inadequate and insufficient health and sexual health education
5 (tied)	Lack of or inadequate access to mental health services that are comprehensive and age-appropriate
6	Lack of or inadequate substance abuse treatment (smoking, alcohol, drugs) and prevention education
7 (tied)	Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, insurance status/type, sexual orientation, and gender identity
7 (tied)	Lack of or inadequate access to affordable and safe options for physical activity, exercise, and recreation
8 (tied)	Lack of supports for pregnant and parenting teens
8 (tied)	Inadequate or lack of comprehensive, affordable health and oral health care and insurance

**MSDH 2020 Title V Maternal and Child Health Services Block Grant  
Comprehensive Needs Assessment**  
*Domain Report: Children and Youth with Special Health Care Needs (CYSHCN)*

**I. Setting a Baseline for CYSHCN in Mississippi: A Summary of Federally Available Data**

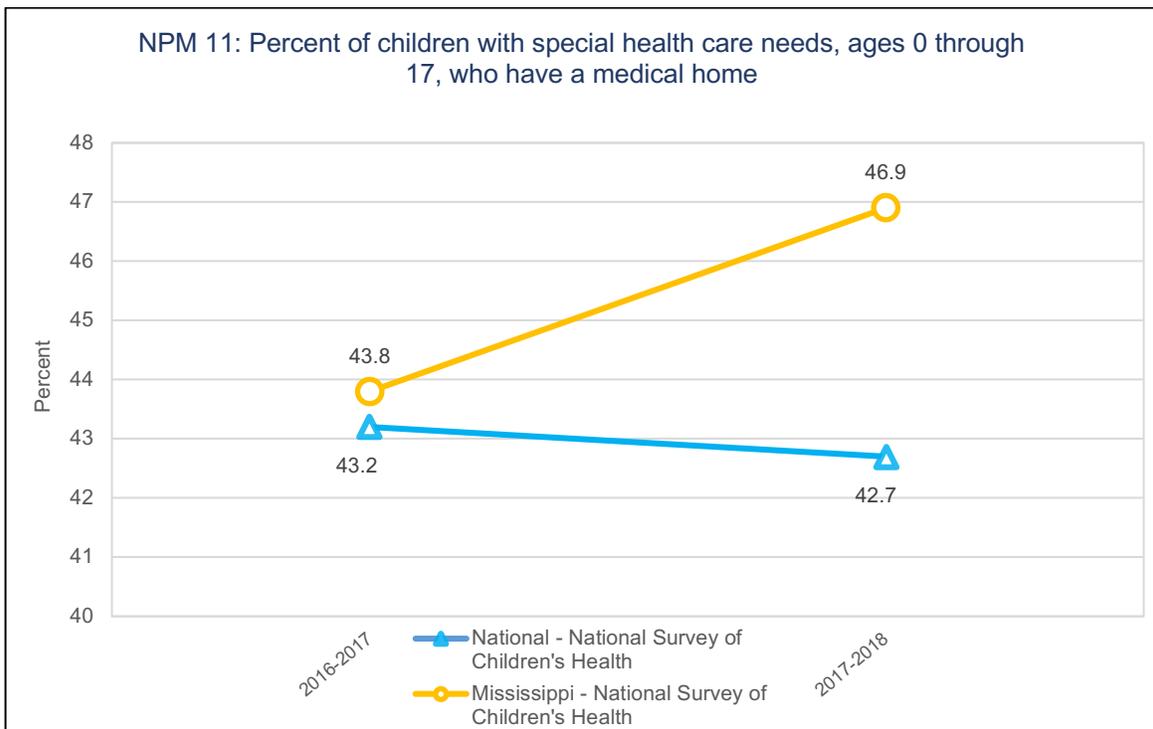
Each state is provided with a set of indicators that cover all Title V domains. These indicators are tied to the National Performance Measures and National Outcome Measures on which states have chosen to focus. The table below summarizes all of the indicators that are associated with CYSHCN for Mississippi. Note: Examination of trends across time are somewhat limited due to changes in data collection strategies at the federal level and availability of only two data points.

CYSHCN Indicators	Most Recently Available Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Medical home	46.9%	Better	Trending better
Transition**	22.3%	Slightly better	Trending slightly worse
Adequate insurance	68.1%	Better	Trending slightly better
CSHCN systems of care (received all components of a well-functioning system: family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition)	15.6%	About the same	No change
Mental health treatment	Data not available specifically for CYSHCN at state level		
Forgone health care			
Child vaccination			
Flu vaccination			
HPV vaccination			

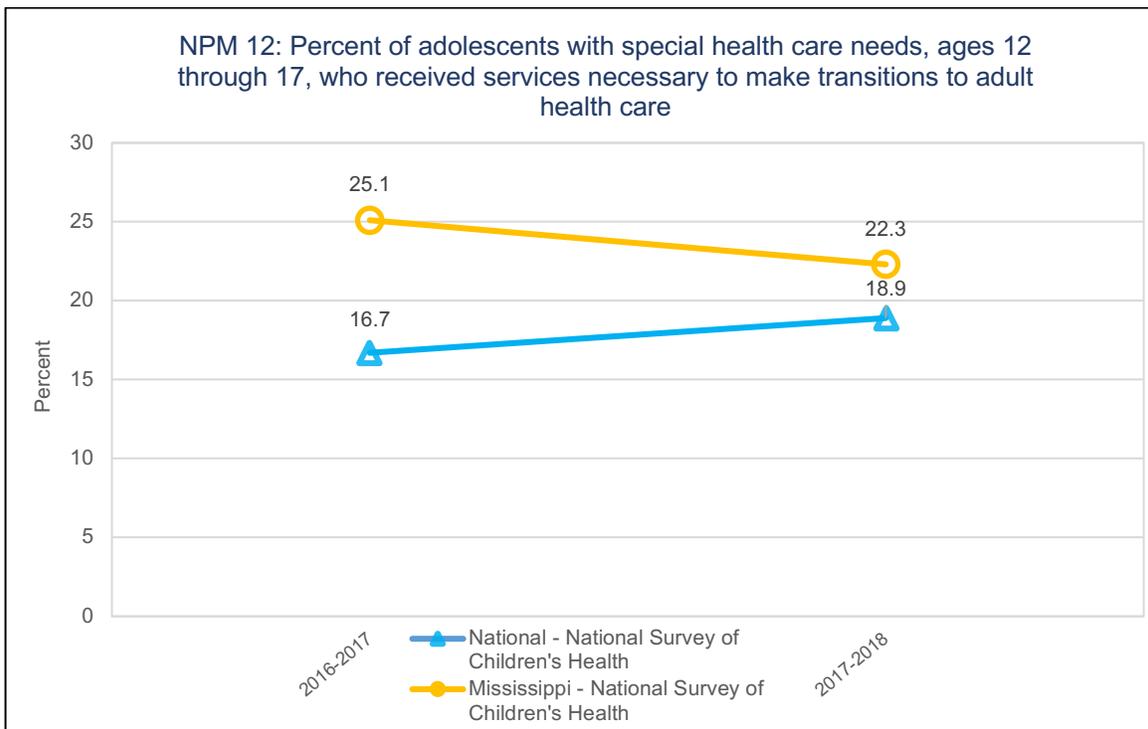
\*Most recently available value as of March 2020. Actual dates may vary as data are often reported in arears. See page 3 for information on FAD and to access current information.

\*\*Data may be unreliable due to small sample.

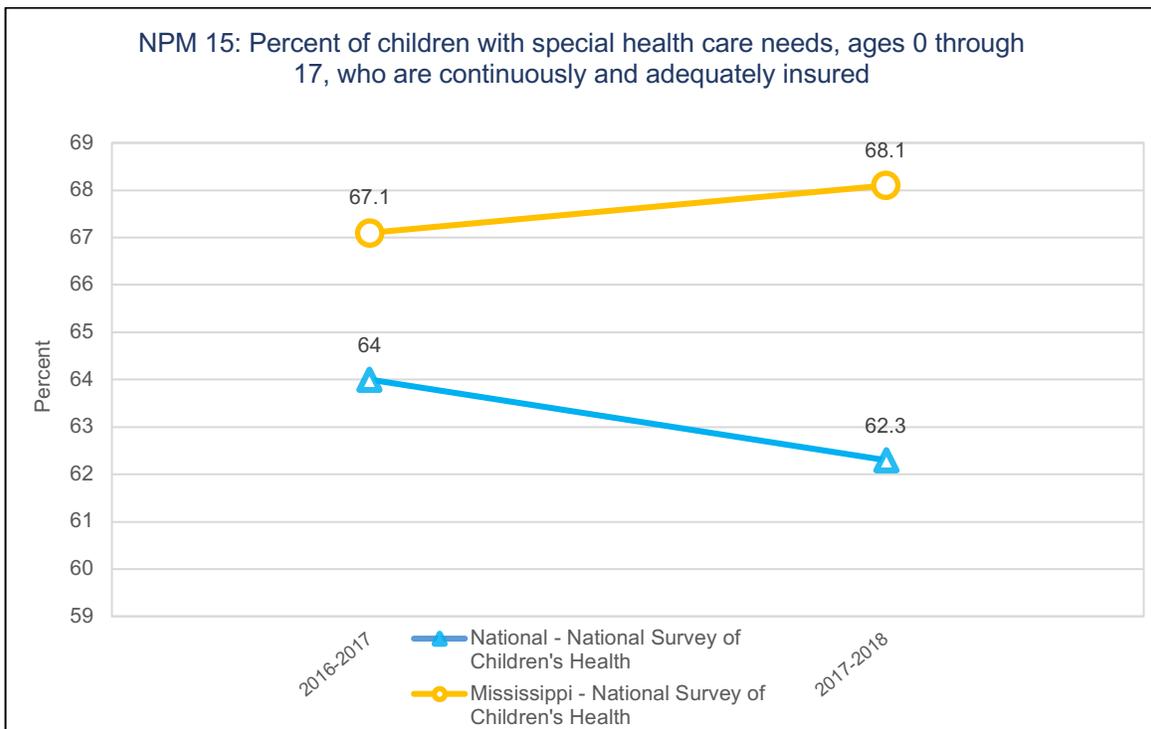
The following charts present the above data in a more detailed format and, where available, across time to show comparisons to national indicators and trends. Small sample sizes preclude stratifying state CYSHCN data to identify disparities in outcomes based on sociodemographic factors.



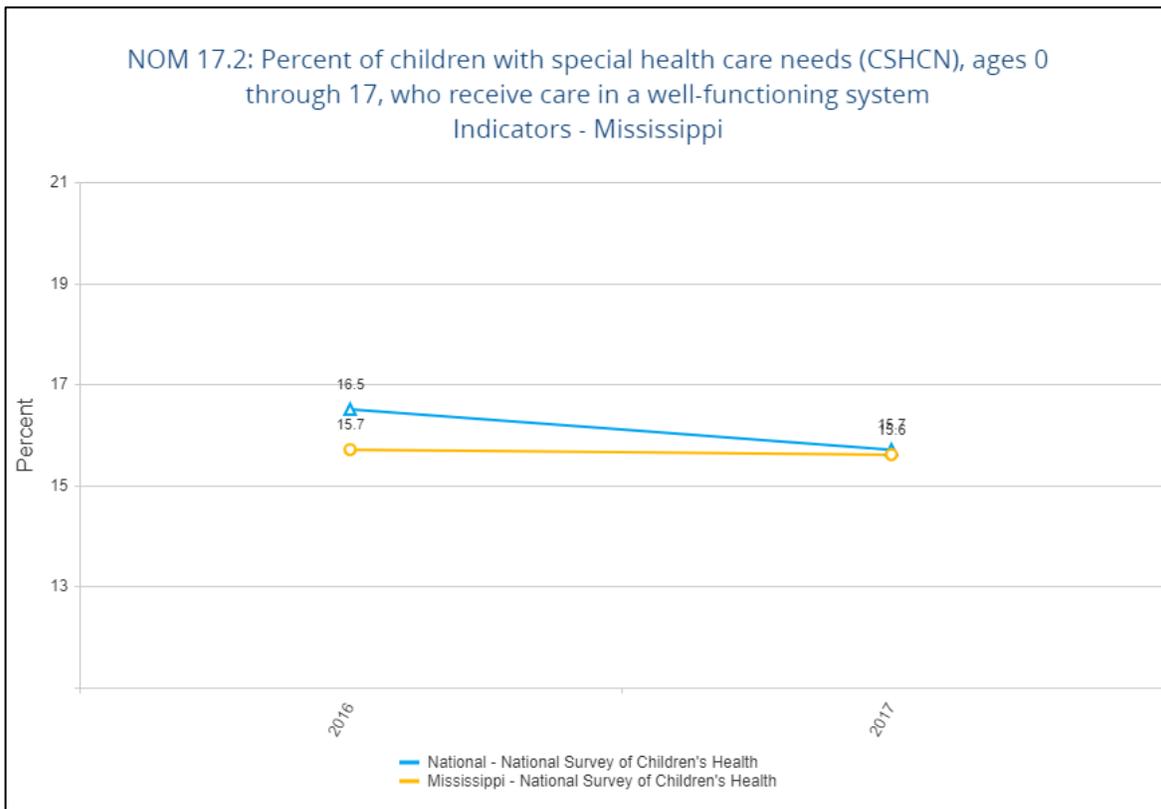
The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on NPM 11 (Percent of children with special health care needs, ages 0 through 17, who have medical home) between 2016 and 2018. For the two reporting periods included above, Mississippi reported higher percentages of CYSHCN who had a medical home compared to the national data. Mississippi data are trending better while national data are trending worse.



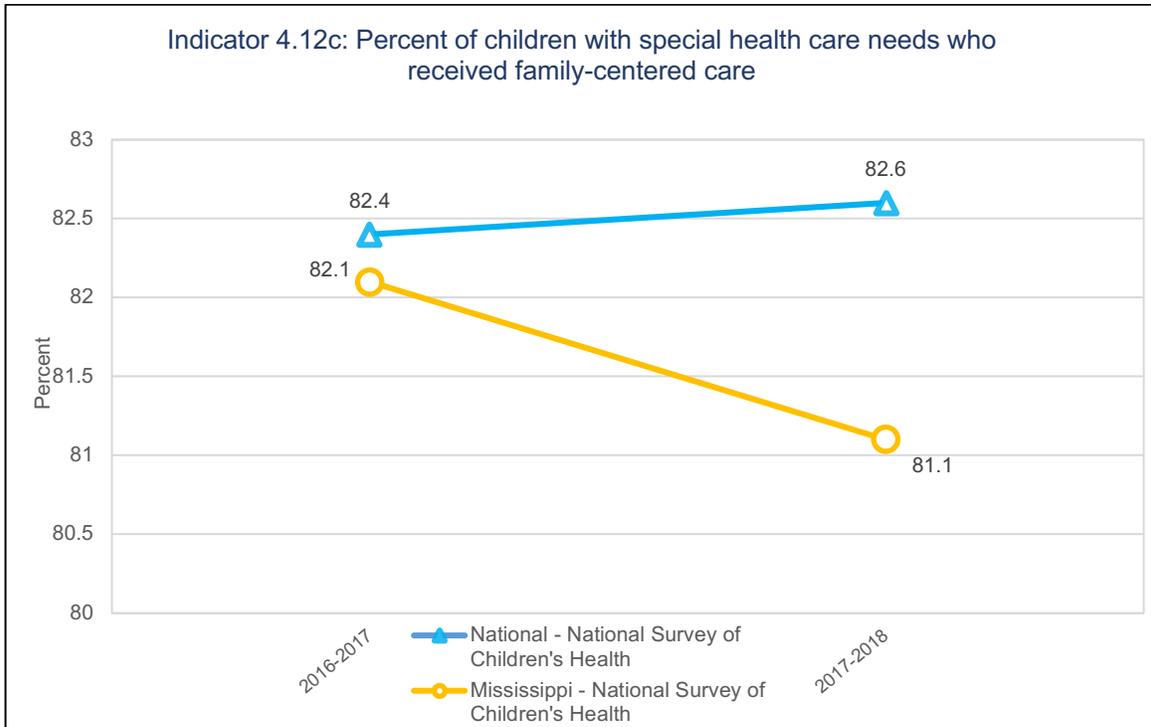
The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on NPM 12 (Percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care) between 2016 and 2018. For the two reporting periods included above, Mississippi reported higher percentages of CYSHCN who received services necessary to make transitions to adult health care compared to the national data. Mississippi is trending slightly worse for this measure while the nation is trending slightly better.



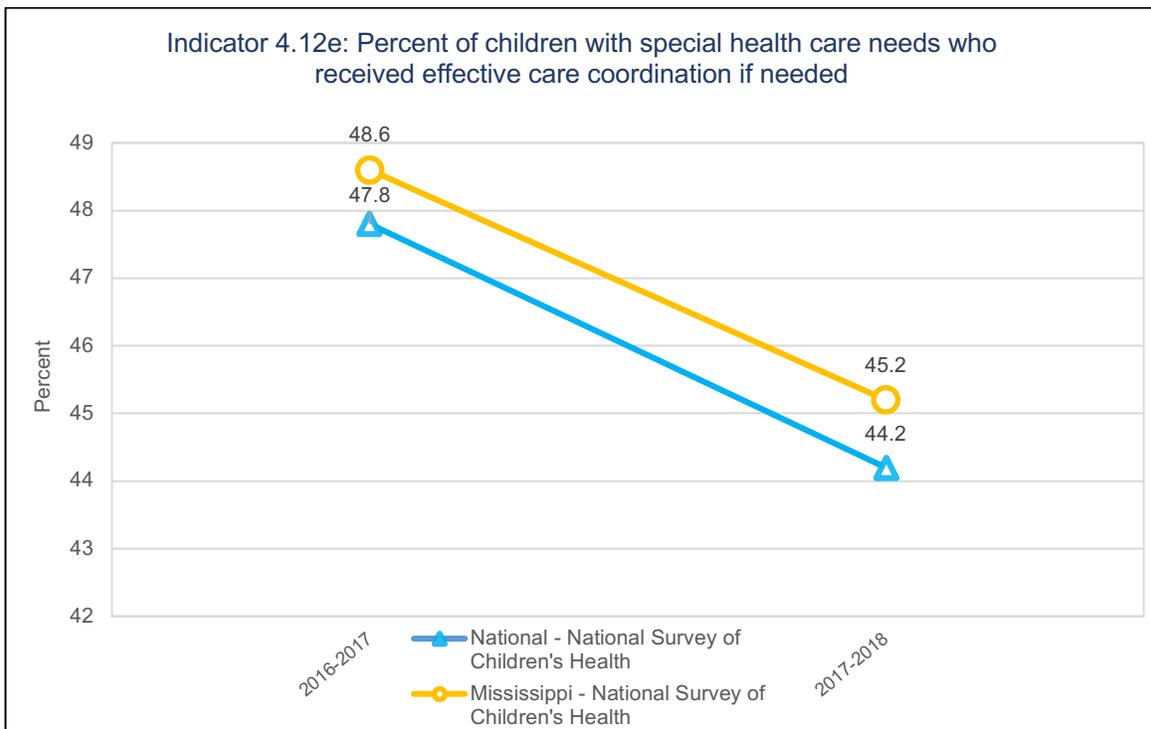
The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on NPM 15 (Percent of children with special health care needs, ages 0 through 17, who are continuously and adequately insured) between 2016 and 2018. For the two reporting periods included above, Mississippi reported percentages higher than the national percentages. Mississippi is trending slightly better over the two reporting periods while the nation is trending worse.



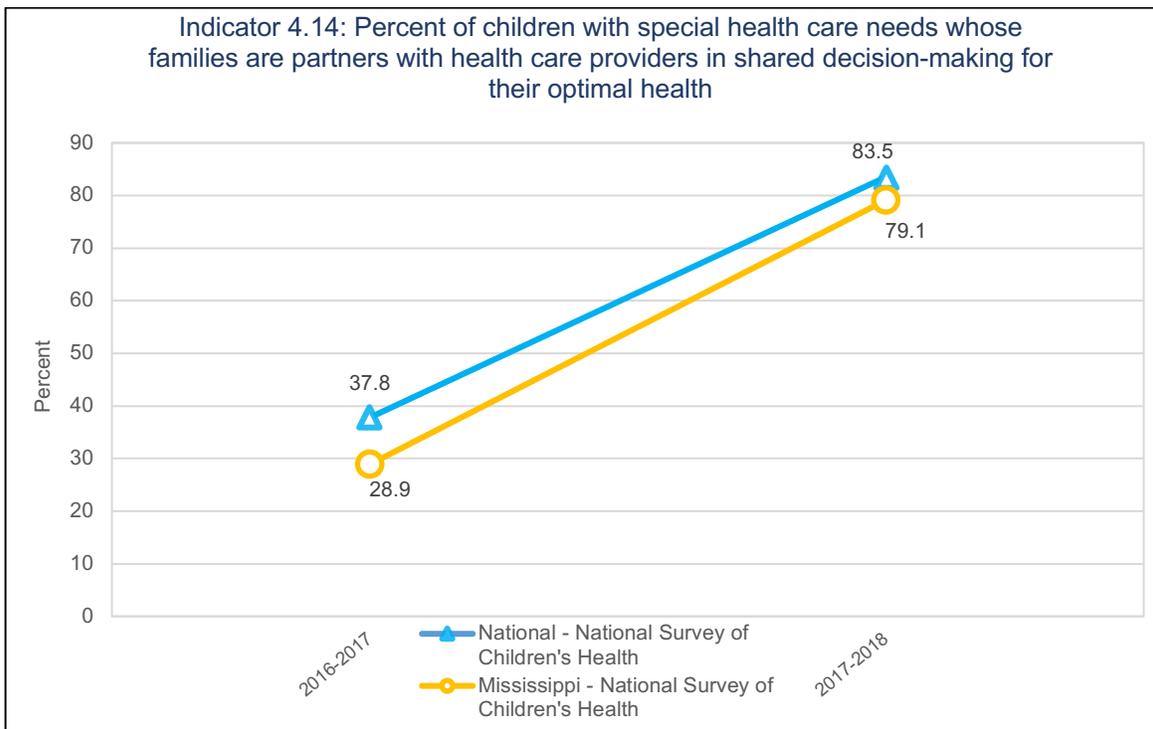
The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on NPM 17.2 (Percent of children with special health care needs, ages 0 through 17, who receive care in a well-functioning system) between 2016 and 2017. Mississippi reported percentages lower than the national percentages for both reporting periods. Mississippi’s percentage has remained stable while the national percentage has decreased slightly.



The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on indicator 4.12c (Percent of children with special health care needs who received family-centered care) between 2016 and 2018. For the two reporting periods included above, Mississippi reported percentages lower than the national percentages. Though national percentages have remained relatively stable over the two years, Mississippi is trending slightly worse.



The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on indicator 4.12e (Percent of children with special health care needs who received effective care coordination if needed) between 2016 and 2018. Mississippi reported percentages higher than the national percentages. Both Mississippi and the nation reported a similar decrease in the percentage of CYSHCN who received effective care coordination if needed.



The above data, from the National Survey of Children’s Health, compare Mississippi and the U.S. on indicator 4.14 (Percent of children with special health care needs whose families are partners with health care providers in shared decision-making for their optimal health) between 2016 and 2018. Mississippi reported percentages lower than the national percentages. Both Mississippi and the nation are trending better over the two reporting periods, with the percentages increasing significantly for both.

## II. Statements of Needs: CYSHCN Domain

In an effort to gain more detailed information about community experiences, preferences, concerns, and perceptions, a series of focus groups, key informant interviews, and surveys were conducted in late 2019. Focus group transcripts, key informant interview notes, and survey responses were analyzed to identify common themes across data collection methods and broad stakeholder populations. A more detailed description of the data analysis may be found on pages 3-5 of the executive summary. These themes were then considered along with the FAD and other state quantitative data to guide the development of need statements.

Based on both quantitative and qualitative data, 12 statements describing areas of need in the child domain were developed and presented to community stakeholders and agency leadership for discussion and prioritization. These are described below, along with the method that yielded the supporting evidence for each need. There is similarity for some needs across those identified in other domains.

### Legend for Data Collection Method and Abbreviation

Data Collection Method	Abbreviation
Federally Available Data	F
Focus Groups	G
Key Informant Interviews	K
Surveys	S

1. **Lack of or inadequate supports for transition to all aspects of adulthood (*identified in the following Data Collection Methods: F, G, K, S*)**
  - a. After age 19, coverage and benefits are lost or limited for many YSHCN.
  - b. Adult services are limited or non-existent after YSHCN are no longer served in a pediatric or school-based setting.
  - c. It is difficult to access disability insurance for supplemental income.
  - d. There is a lack of conversation and guidance around transition planning.
  - e. The approach to transitioning to adult-based care is often not holistic and focuses on one aspect of transition to adulthood.
  - f. Education, resources, and programs are needed to help YSHCN successfully transition to adulthood.
  - g. YSHCN may have limited to no conversations with their health care provider regarding access to adult based health care and limited encouragement from their provider to take responsibility for their health-related needs (i.e., taking medication, understanding their health condition).
  - h. YSHCN report limited engagement with their provider at health-related appointments, but noted feeling involved and included in health care decisions.
  - i. YSCHN desire to finish high school/obtain their GED, have and maintain health insurance, and engage in social relationships.

2. **Lack of or inadequate access to coordinated, comprehensive care (*identified in the following Data Collection Methods: F, G, K, S*)**
  - a. Services across all sectors are fragmented, and caregivers are responsible for communication between their child's providers.
  - b. CYSHCN do not have access to a Shared Plan of Care to aid in communication across systems.
  - c. Care coordination is needed throughout the lifespan, including the health care and education systems, to support caregivers and provide resources. Communication among primary care, specialty providers and the school system is necessary.
  - d. Providers expressed frustration with the lack of/inadequate follow-up care provided to CYSHCN and their families.
3. **Inadequate insurance, including cost and benefit coverage issues (*identified in the following Data Collection Methods: F, G, K, S*)**
  - a. Some services are difficult to access. Services most commonly reported as unable to get or dissatisfied with were:
    - i. mental and behavioral health
    - ii. oral health
    - iii. occupational therapy
    - iv. speech therapy
  - b. Most commonly reported reasons for difficulty accessing service providers were:
    - i. services were not covered by insurance
    - ii. services were too expensive
    - iii. waiting list for services too long
    - iv. did not know where to go/who to see
    - v. providers knowledgeable about CYSHCN and specific diagnoses were unavailable
  - c. Some equipment is difficult to access. The most commonly reported reason for difficulty accessing this equipment was that it is not covered by insurance.
  - d. Equipment most commonly reported as unable to get or were dissatisfied with was:
    - i. eyeglasses/contacts
    - ii. hearing aids
    - iii. specialty and mobility equipment
  - e. It is difficult to access disability insurance for supplemental income.
  - f. YSHCN desire to have and maintain health insurance coverage.
4. **Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain (*identified in the following Data Collection Methods: F, G, K, S*)**
  - a. The concentration of specialty services and programs is in urban areas. There is limited availability of providers in rural areas. Travel time, appointment availability, and caretakers' work schedules further limit access to providers.
  - b. Lack of transportation is a barrier to accessing health care, especially in rural areas.
  - c. Receiving a diagnosis for a child and accessing appropriate services is difficult for caregivers due to the length of process and complexity.

5. **Lack of or inadequate support for family/caregiver wellbeing (*identified in the following Data Collection Methods: F, G, S*)**
  - a. Families experience high rates of caregiver stress related to the time, energy, and financial costs of coordinating and advocating for their child around health care, education, and other day-to-day considerations.
  - b. Caregivers identified a need for high quality and affordable parent support from the community. Knowledge of available services and the ability to access more support services should be expanded.
  - c. Having a CYSHCN affects family dynamics and relationships within families for siblings and spouses.
  - d. Extended family members provide significant support, including respite care, to CYSHCN and their families.
6. **Inadequate support for caregivers navigating the system of care (*identified in the following Data Collection Methods: G, S*)**
  - a. It is difficult for caregivers to navigate across systems that provide services to their CYSHCN. Delayed diagnoses and intervention because of communication barriers across systems is frustrating.
  - b. Barriers included:
    - i. general confusion about the system
    - ii. bureaucracy
    - iii. lack of care coordination and support available for families of CYSHCN.
  - c. Immigrant communities may not have knowledge of available resources and have an even greater need for help navigating the health care system.
7. **Lack of or inadequate access to CYSHCN-specific health education (*identified in the following Data Collection Methods: G, K, S*)**
  - a. The following topics are of interest to caregivers of CYSHCN:
    - i. information about their child's diagnosis
    - ii. career/employment opportunities
    - iii. developing an emergency preparedness plan
    - iv. healthy behaviors
    - v. recreational activities
    - vi. finding an adult health care provider
  - b. General health education should be tailored to meet the needs of CYSHCN and their caregivers.
  - c. Latinx/Immigrant communities may have limited awareness of and additional needs for education around disabilities, including developmental delays, and the importance of early intervention.
8. **Insufficient special education services (*identified in the following Data Collection Methods: G, S*)**
  - a. Caregivers noted a lack of access to special education services due to limited knowledge of where to go and who to see to access those services.
  - b. Special education services and integration of their children into school-based settings are unsatisfactory due to limited resources for special education services.
  - c. Teachers and administrators may have limited knowledge of specific special health care needs and diagnoses.

9. **Youth with SHCN are not meeting guidelines for physical activity and nutrition (*identified in the following Data Collection Methods: S*)**
  - a. Youth with SHCN reported very limited regular physical activity.
  - b. They also reported primarily sedentary activities, including:
    - i. watching television
    - ii. listening to music
    - iii. spending time on their computer, tablet, or smartphone
10. **Lack of provider workforce that is knowledgeable about CYSHCN, especially in rural areas and for adult services (*identified in the following Data Collection Methods: G, K, S*)**
  - a. Across the state, few providers are knowledgeable about treating CYSHCN.
  - b. Providers and services for CYSHCN are perceived as lower quality in rural areas.
  - c. Caregivers want their children to receive high quality services and supports, but coverage limitations and high out-of-pocket costs often make it difficult or impossible.
  - d. Many providers do not accept Medicaid.
11. **Lack of or inadequate accessibility and accommodation supports, including physical environment, interpreter services, and materials (*identified in the following Data Collection Methods: G, K, S*)**
  - a. Caregivers expressed a lack of inclusion with typically developing peers and desired for their CYSHCN to be a thriving member of the community.
  - b. There are limited recreational and extracurricular activities available for CYSHCN.
  - c. Barriers to these activities include:
    - i. limited knowledge of available community programs
    - ii. high cost of programs and services
    - iii. limited knowledge of community program providers for CYSHCN
  - d. Community accommodations for CYSHCN with physical disabilities are limited, including a lack of adequate equipment at clinics for people with disabilities.
  - e. Interpretation and translation services are limited when taking their child to health care appointments.
12. **Lack of or inadequate access to timely assessments and appropriate referral (*identified in the following Data Collection Methods: G, K, S*)**
  - a. There is a lack of early identification of developmental delays, due in part to limited provider and parent education and awareness of the importance of early identification.
  - b. Availability of and access to screening and treatment centers is limited. There is a backlog of screenings and long wait lists at screening centers.
  - c. Caregivers encounter the following barriers to receiving assessments and referrals:
    - i. insurance does not cover service or provider
    - ii. out-of-pocket cost is too high
    - iii. long wait list
    - iv. providers are unwilling to screen

### III. Prioritized Statements of Needs: CYSHCN Domain

The statements, as well as their prioritized rank after the process was completed, are listed in the table below. A detailed description of the prioritization process may be found on pages 13-16 of the executive summary.

Rank	Need
1	Lack of or inadequate access to coordinated, comprehensive care
2	Lack of or inadequate supports for transition to all aspects of adulthood
3 (tied)	Inadequate support for caregivers navigating the system of care
3 (tied)	Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain
3 (tied)	Lack of provider workforce that is knowledgeable about CYSHCN, especially in rural areas and for adult services
4	Lack of or inadequate access to timely assessments and appropriate referral
5 (tied)	Lack of or inadequate support for family/caregiver wellbeing
5 (tied)	Inadequate insurance, including cost and benefit coverage issues
6 (tied)	Insufficient special education services
6 (tied)	Lack of or inadequate access to CYSHCN-specific health education
7 (tied)	Lack of or inadequate accessibility and accommodation supports, including physical environment, interpreter services, and materials
7 (tied)	Youth with SHCN are not meeting guidelines for physical activity and nutrition

## Appendix. Socio-Demographics of Focus Group Participants and Family and Adolescent Survey Respondents: Women/Maternal, Perinatal/Infant, Child, and Adolescent Domains

### Demographics of Focus Group Participants: Women/Maternal, Perinatal/Infant, Child, and Adolescent Domains

Characteristic	Number	Percent
<b>Gender</b>		
Female	44	73%
Male	16	27%
Other	0	0%
<b>Race</b>		
Black or African American	31	52%
White	21	35%
Other*/Two or more races	8	13%
<b>Ethnicity</b>		
Not-Hispanic or Latino	52	88%
Hispanic or Latino	7	12%
<b>Marital Status</b>		
Single/Never Married	37	62%
Married	11	18%
Separated/Divorced/Widowed	12	20%
<b>Highest Level of Education Completed</b>		
Less than high school	7	12%
High school/GED	25	44%
Some college	16	28%
2-year college degree	5	9%
4-year college degree	3	5%
Graduate/Professional degree	1	2%
<b>Total Household Income</b>		
Less than \$10,000	28	53%
\$10,000 to \$19,999	5	9%
\$20,000 to \$29,999	5	9%
\$30,000 to \$39,999	11	21%
\$40,000 to \$49,999	2	4%
\$50,000 or more	1	2%
<b>Disability Status</b>		
Does Not have a Disability	46	79%
Has a Disability	9	16%
Prefer Not to Answer	3	5%
<b>Children in the Household</b>		
Yes	40	70%
No	17	30%

\*Other includes American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Asian

### Demographics of Focus Group Participants: CYSHCN Domain

Characteristic	Number	Percent
<b>Participant</b>		
Mother	12	63%
Father	1	5%
Grandparent	0	0%
Other	6	32%
<b>Race/Ethnicity</b>		
Black or African American	8	53%
White	7	47%
Hispanic or Latino	0	0%
<b>Highest Level of Education Completed</b>		
Less than high school	3	20%
High school/GED	3	20%
Some college	2	13%
Vocational Training /Trade School/2-year college degree	1	7%
4-year college degree or higher	6	40%
<b>Total Household Income</b>		
Less than \$30,000	6	43%
\$30,000 to \$39,999	1	7%
\$40,000 to \$49,999	1	7%
\$50,000 to \$59,999	1	7%
\$60,000 to \$69,999	1	7%
\$70,000 or more	4	29%

**Demographics of Family Survey Respondents: Women/Maternal, Perinatal/Infant, Child, and Adolescent Domains**

Characteristic	Number	Percent
<b>Gender</b>		
Female	408	91%
Male	28	6%
Other/Prefer Not to Answer	11	2%
<b>Race</b>		
Black or African American	181	41%
White	244	56%
Other*/Two or more races	14	3%
<b>Ethnicity</b>		
Not Hispanic or Latino	413	95%
Hispanic or Latino	23	5%
<b>Marital Status</b>		
Single/Never Married	110	25%
Married	241	55%
Separated/Divorced/Widowed	87	20%
<b>Household Health Insurance Status</b>		
All individuals have insurance	487	86%
One or more individuals uninsured	80	14%
<b>Highest Level of Education Completed</b>		
Less than high school	1	0%
High school/GED	33	7%
Some college	71	16%
2-year college degree	87	20%
4-year college degree	112	25%
Graduate/Professional degree	139	32%
<b>Total Household Income</b>		
Less than \$10,000	12	3%
\$10,000 to \$19,999	21	5%
\$20,000 to \$29,999	39	9%
\$30,000 to \$39,999	44	10%
\$40,000 to \$49,999	42	10%
\$50,000 to \$59,999	31	7%
\$60,000 to 69,999	28	6%
\$70,000 or more	215	50%
<b>Age</b>		
21 years and younger	5	1%
22 to 30 years	43	11%
31 to 40 years	100	24%
41 to 50 years	97	24%
51 years and older	164	40%
<i>Mean = 46    Range = 19 - 90</i>		

\*Other includes American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Asian

### Demographics of Adolescent Survey Respondents: Adolescent Domain

Characteristic	Number	Percent
<b>Gender</b>		
Female	41	71%
Male	17	29%
<b>Race/Ethnicity</b>		
Black or African American	10	78%
White	45	17%
Other*/Two or more races	3	5%
<b>Ethnicity</b>		
Not Hispanic or Latino	56	97%
Hispanic or Latino	2	3%
<b>Type of Health Insurance</b>		
No Insurance	5	8%
CHIP	4	7%
Private Insurance	34	57%
Medicaid or Medicare	5	8%
TRICARE	3	5%
Other/I don't know	9	15%
<b>Age</b>		
Younger adolescent: 12 to 17 years	24	41%
Older adolescent: 18 to 24 years	34	59%

\*Other includes American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Asian

*Note: There were 176 individual who responded to this survey but were older than 24 years old. Their responses were not included in this analysis.*

## Demographics of Family Survey Respondents: CYSHCN Domain

Characteristic	Number	Percent
<b>Relationship to CYSHCN</b>		
Mother	126	77%
Father	5	3%
Grandparent	14	9%
Other	19	12%
<b>Race/Ethnicity</b>		
Black or African American	89	54%
White	67	41%
Other*	1	4%
<b>Ethnicity</b>		
Not Hispanic or Latino	140	90%
Hispanic or Latino	16	10%
<b>Survey Language</b>		
English	113	100%
Spanish	0	0%
<b>Highest Level of Education Completed</b>		
Less than high school	7	4%
High school/GED	31	20%
Some college	28	18%
Vocational Training /Trade School/2-year college degree	27	17%
4-year college degree or higher	65	41%
<b>Ages of CYSHCN</b>		
Birth to 3 years	33	16%
4 to 9 years	41	20%
10 to 13 years	48	23%
14 to 17 years	45	21%
18 to 20 years	19	9%
21 to 26 years	24	11%
<b>Type of Survey Taken</b>		
Paper	113	52%
Online	103	48%

\*Other includes American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Asian

## Demographics of Youth Survey Respondents: CYSHCN Domain

Characteristic	Number	Percent
<b>Gender</b>		
Female	32	52%
Male	30	48%
Prefer to self-describe	0	0%
<b>Race/Ethnicity</b>		
Black or African American	26	43%
White	33	54%
Other*/Two or more races	2	3%
<b>Ethnicity</b>		
Not Hispanic or Latino	57	95%
Hispanic or Latino	3	5%
<b>Type of Health Insurance</b>		
No Insurance	3	5%
CHIP	1	2%
Private Insurance	18	28%
Medicaid	35	54%
Medicare	5	8%
TRICARE	0	0%
Other/I don't know	3	5%
<b>Age</b>		
12 years old or younger	0	0%
13 to 17 years	34	55%
18 to 21 years	11	18%
22-26 years	13	21%
Older than 26 years	4	6%
<b>Highest Level of School Completed</b>		
Still in middle school	9	16%
Still in high school	22	39%
Left high school without a diploma	4	7%
Received a high school diploma/GED	9	16%
Some college, but left and did not graduate	1	2%
Still in college	5	9%
Vocational Training /Trade School/2-year college degree	1	2%
4-year college degree or higher	5	9%
<b>Type of Survey Taken</b>		
Paper	54	87%
Online	8	13%

\*Other includes American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Asian

*Mississippi's Title V Maternal and Child Health (MCH) Needs Assessment was led by staff from the Office of Health Services at the Mississippi State Department of Health (MSDH).*

**State Health Officer**

**Thomas Dobbs, MD, MPH**

**Director of Health Services**

**Beryl Polk, PhD, RD, LD**

**Title V MCH Director**

**Marilyn Johnson, MBA**

[marilyn.johnson@msdh.ms.gov](mailto:marilyn.johnson@msdh.ms.gov)

**Title V Children with Special Health Care Needs Director**

**Augusta Bilbro**

[augusta.bilbro@msdh.ms.gov](mailto:augusta.bilbro@msdh.ms.gov)

**Epidemiologist Consultant**

**Charity M. Willis, MPH**

[charity.moody@msdh.ms.gov](mailto:charity.moody@msdh.ms.gov)

*For any additional questions about the Mississippi Needs Assessment, please contact Charity Willis.*

MSDH would like to thank Title V program staff members, local partners, and all the service providers, adolescents, and families who contributed to this needs assessment process. MSDH would also like to thank the University of Southern Mississippi Institute for Disability Studies, Mississippi Community Education Center, and the Family Resource Center of North Mississippi for their support of needs assessment activities.



**MISSISSIPPI**  
STATE DEPARTMENT  
OF HEALTH

*This needs assessment was conducted by faculty and staff from the Applied Evaluation and Assessment Collaborative within the Department of Health Care Organization and Policy at the University of Alabama at Birmingham (UAB) School of Public Health.*

**Julie Preskitt, MSOT, MPH, PhD**

Associate Professor

Director of the Applied Evaluation and Assessment Collaborative

**Anne E. Brisendine, DrPH, CHES**

Science Director

Applied Evaluation and Assessment Collaborative

**Beth Johns, OTR/L, MPH**

Senior Project Director

Applied Evaluation and Assessment Collaborative

**Elizabeth L. Blunck, MPH**

Program Manager

Applied Evaluation and Assessment Collaborative

**Elizabeth Taylor, MSW, MPH**

Program Manager

Applied Evaluation and Assessment Collaborative

**Evelyn Coronado-Guillaumet, MPH**

Consultant

**Honour McDaniel**

MPH Student

**Martha S. Wingate, MPH, DrPH**

Professor and Chair

Health Care Organization and Policy

Applied Evaluation  
and Assessment Collaborative

 THE UNIVERSITY OF ALABAMA AT BIRMINGHAM



**UAB**  
SCHOOL OF  
PUBLIC HEALTH

**UAB** THE UNIVERSITY OF  
ALABAMA AT BIRMINGHAM