

**Maternal and Child
Health Services Title V
Block Grant**

Mississippi

**FY 2024 Application/
FY 2022 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal



MISSISSIPPI STATE DEPARTMENT OF HEALTH

July 7, 2023

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

Dear Mr. Dykton:

The Mississippi State Department of Health (MSDH) is pleased to submit the 2024 Application and 2022 Annual Report for the State Title V Maternal Child Health Block Grant. We are excited to report on the work done over the past year and acknowledge the support the Bureau has provided through technical assistance calls and most recently a site visit to Mississippi. The lessons learned during the last several years has provided us a better foundation for reporting successes and identifying strategies to engage community partnerships. The implementation of these strategies supports the overall improvement of population health over the life cycle.

We look forward to sharing the successes and challenges of the past year. They have enabled us to stretch, grow and help transform Mississippians into change agents within their communities. Should you have any questions or comments, please contact me at phone number 601-576-7472 or email me at: beryl.polk@msdh.ms.gov.

Sincerely,

A handwritten signature in blue ink, appearing to read "Beryl Polk".

Beryl Polk, PhD, CPM, CHP, CCM
Director, Health Services/Title V Director
MS State Department of Health
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601-576-7472

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Equal Opportunity in Employment/Services

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Introduction to Mississippi's Title V Program

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

MSDH's public health system includes policy guidance from the State Board of Health, the State Health Officer, and programmatic/administrative personnel distributed across seven main programmatic divisions, including: Health Administration; Community Health (which includes Health Services); Epidemiology and Communicable Diseases; Health Operations; Health Data and Research; the Public Health Laboratory; and the Public Health Pharmacy. Some of the major operations of MSDH address a wide range of functions, such as communicable disease surveillance, preventive health and health equity, immunizations, nutrition support and supplemental food services, comprehensive reproductive health, health protection, health communications, environmental health, health policy and planning, vital records, public health laboratory, health facilities, licensure and certification, and social services.

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

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

Needs Assessment, Planning, and Reporting Process

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

needs assessment and plan refinement is vital to the success of the MCH program and population health.

2020 Five-Year Needs Assessment

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

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

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

Identified Priorities and Performance Measures

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

Women/Maternal Health

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

Perinatal and Infant Health

- Reduce infant mortality (*NPM 5: Percent of infants placed to sleep A) on their backs B) on a separate approved sleep surface C) without soft objects or loose bedding*)
- Improve access to family-centered care* (*SPM 17: Percent of women, ages 18-44, on Medicaid with a preventive medical visit in the past year*)
- Increase breastfeeding, healthy nutrition, and healthy weight* (*NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months; SPM 12: Percent of women who are enrolled in WIC and initiate breastfeeding*)

Child Health:

- Increase access to timely, appropriate, and consistent health and developmental screenings (*NPM 6: Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening*)

tool in the past year; SPM 3: Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age; SPM 13: Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age; SPM 14: Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit; SPM 15: Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely)

- *Improve access to family-centered care* (SPM 21: Percent of children with and without special healthcare needs who have a medical home)*
- *Increase breastfeeding, healthy nutrition, and healthy weight* (SPM 11: Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile)*
- *Improve oral health* (NPM 13.2: Percent of children, ages 1-17, who had a preventive dental visit in the past year)*

Adolescent Health

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

Children with Special Health Care Needs (CYSHCN)

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

Cross-cutting/Systems Building

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

MCH Program Planning

The MCH Block grant supports health within a life course framework across the MCH population domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, Children and Youth with Special Health Care Needs (CYSHCN), and Cross-cutting/Systems Building. Information gathered through the comprehensive needs assessment process was used by the MCH programs and stakeholders to identify strategies and activities to improve outcomes of MCH populations.

In 2022, after two years of addressing the COVID pandemic and adjusting to multiple transitions with personnel, a new MCH leadership team was established to guide the planning, development, and implementation of the Block Grant. A major goal for this team was to implement a new collaborative process for the development and implementation of the state action plan (SAP) to break down siloed practices and to develop shared strategies and activities to address common priorities. This 2024 application and 2022 annual report is a continuation of this transition from program-focused planning to cross-program and cross-domain planning to refine and implement priority-focused plans with shared objectives, strategies, and activities. Both the annual report and application are organized according to priorities. Although the 2022 annual report still mostly reflects activities of one program addressing related objectives, strategies, and activities, the 2024 application has identified many broad objectives, strategies, and activities that relate to multiple programs, enabling a unified approach to improving health outcomes for women, children, and families.

Performance Reporting

Epidemiologists from the OHDR work with program directors and staff to identify appropriate performance measures, outcome measures and evidence-based / evidence-informed strategies for outcome improvement. Together, epidemiologists and program staff ensure processes are in place for tracking, collecting, and reporting data. The Title V Needs Assessment Coordinator and the Title V State Systems Development Initiative (SSDI) epidemiologists facilitate the tracking and visualization of all measures among the MCH programs. This enables the Title V MCH Director, Title V Needs Assessment Coordinator, Title V and SSDI epidemiologists, MCH staff, and MCH stakeholders to view the overall progress made among all priorities.

Assuring Comprehensive, Coordinated, Family Centered Services

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

Partnerships

The strength of Mississippi's MCH Program lies in its partnerships. MSDH has pursued partnerships of all types using the collective impact framework and through the intentional engagement of families and customers. Examples of MSDH's MCH partners and partnering practices are described below.

MCH Advisory Board:

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

State Agencies and Public Institutions:

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

Community Partners:

Mississippi's Title V Program further diversifies its partnerships through grant-funded activities that align with state priorities. Funded entities include, but are not limited to:

- Federally Qualified Health Centers and Community and School Health Centers
- Professional associations, including the *Mississippi Public Health Association*, *MS Chapter of the American Academy of Pediatrics*, *Mississippi Speech and Hearing Association*, and *Mississippi Head Start Association*

- Mississippi Perinatal Quality Collaborative
- Community organizations, including *Mom.ME.*, *Six Dimensions*, *MS Public Health Institute*, *Teen Health Mississippi*, *Institute for the Advancement of Minority Health*
- Parent Advocacy Centers, including *Mississippi Coalition for Citizens with Disabilities*, the IDEA Parent Training and Information Center, and *Families As Allies*, the Family Voices recipient

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

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

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

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

III.A.3. MCH Success Story

Response to the Jackson area water crisis

In mid-August 2022, the capitol city of Jackson experienced heavy rains and flooding which damaged the O.B. Curtis water treatment plant located near the Ross Barnett Reservoir in the Pearl River basin. With the crippling of this major water treatment plant and malfunction of pumps at the J.H. Fewell water treatment plant, the city was unable to produce sufficient water pressure to serve its residents. For weeks, many residents were unable to access clean, safe water for drinking, cleaning, and bathing in their homes. Even as the pressure was slowly being restored across the system, residents remained under a boil water notice for several more weeks and continued to experience waves of rolling boil water notices until the end of the emergency in November 2022.

The MSDH Offices housing the leadership for its MCH programs is located in Jackson, less than 2 miles from the malfunctioning J.H. Fewell water treatment plant, and was significantly impacted by the water crisis. Not only was the water unsafe for drinking but the pressure was insufficient for functioning facilities, resulting in the temporary closure of the building and the use of portable restrooms after the buildings reopened. Nonetheless, MCH personnel, working remotely as needed, focused on addressing the needs of the women, children, youth, and extended families impacted by this crisis.

The MSDH and MCH programs identified resources where residents could access clean drinking water and posted information for the general public on water safety and locations for bottled water being distributed throughout the city. The MSDH was a major source of information for residents providing ongoing updates and fielding phone calls. Many MCH personnel participated in volunteer efforts to distribute water throughout the impacted communities, even as they themselves were impacted. In addition:

- The Healthy Moms/Healthy Babies program purchased water faucet filters for its enrolled families, and in partnership with the Lead Poisoning Prevention and Healthy Homes (LPPHH) program, then educated enrolled families about lead and its effects on pregnant women and children as well as how to install the filter on to the faucet.
- The service/care coordinators with the First Steps Early Intervention and Children and Youth with Special Health Care Needs (CYSHCN) programs supported enrolled families by addressing their individual needs in accessing bottled water at distribution points and procuring water filters.
- The Oral Health Office worked with the Mississippi Dental Association and Mississippi Dental Society to promote increased dental waterline testing to assure a normal limit of biofilm. Additionally, the Office worked with the Mississippi State Board of Dental Examiners on the status of fluoridation and Regional Oral Health Consultants conducted outreach to promote the use of fluoride varnish applications, as during the repair process, fluoride could not consistently be added to the water.

During the crisis many healthcare providers collaborated to address the health needs of MCH populations. For example, many dentists in other parts of the state, unaffected by the Jackson Water Crisis, offered the use of their dental facility to providers who had to shut theirs down until the City of Jackson made repairs.

III.B. Overview of the State

Demographics, Geography, Economy, and Urbanization

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

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

The residents of Mississippi are dispersed throughout 82 counties and 298 incorporated municipalities. While three-fourths of the state's citizens reside in one of these incorporated places, most of these cities and towns are small. As of July 2022, Jackson, the state's capital and largest city, had a population of 145,995 and the next largest city is Gulfport, with a population estimate of 72,236. The state is predominantly rural, where 65 (79.3%) of the 82 counties are considered rural areas. Mississippi has three standard metropolitan statistical areas (MSA): the Jackson Metropolitan Area (Hinds, Madison, and Rankin Counties); the Hattiesburg area (Forrest and Lamar Counties); and the Gulf Coast Region (Hancock, Harrison, and Jackson Counties). Desoto County, located in North Mississippi, is included in the Memphis, Tennessee MSA. All 82 counties in Mississippi are designated whole or in part as medically underserved areas, according to the Health Resources and Services Administration (HRSA).

Mississippi's population is estimated to be 2,940,057. In comparison to the United States, Mississippi is less racially and ethnically diverse. However, the state has the largest Black / African American population in the United States. Mississippi has slightly higher rates of homeownership and a lack of health insurance coverage. Additionally, Mississippi has a slightly lower percentage of its population with a high school education or higher, a lower employment rate, and a higher rate of children living in poverty. The tables below depict comparison rates between Mississippi and the United States, based on the July 1, 2022 Census Bureau population estimates, for several of these factors.

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

Ethnicity	Mississippi (%)	United States (%)
Hispanic	3.6	19.1
Non-Hispanic	96.4	80.9

Socioeconomic Factors	Mississippi (%)	United States (%)
High school graduate or higher	85.6	88.9
Unemployment rate (July 2021)	3.8	3.5
Homeownership rate	68.9	64.6
Children in poverty (<18 yrs)	28.1	16.8
Persons in poverty (all ages)	19.4	11.6
Persons without health insurance (<65 yrs)	14.2	9.8

Health Status of Mississippi's MCH Population

According to America's Health Rankings, Mississippi ranked 49th in overall health in 2022. Historically, Mississippi has consistently ranked at the bottom for overall health. Similarly, there are several MCH population indicators that continue to have severe challenges, including infant mortality and food insecurity. However, Mississippi shows strength on a few MCH indicators that include a high enrollment level in early childhood education and a low percentage of housing with lead risk. Based on America's Women and Children report, a sub-report of America's Health Rankings, Mississippi ranked 40th overall in Women's Health and 41st overall in Children's Health.

State's Strengths and Challenges

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

Mississippians receive health care from a variety of sources that provide a continuum of care. The health care delivery system in Mississippi includes services for long-term care, care for the aged, and those with intellectual disabilities; mental health care, including psychiatric, chemical dependency, and long-term residential treatment facilities; perinatal care; acute care, including various types of diagnostic and therapeutic services; ambulatory care, including outpatient services and freestanding ambulatory surgical centers; comprehensive medical rehabilitation; home health services; and end stage renal disease facilities. Mississippi has 31 critical access hospitals, 50 rural hospitals with 49 beds or less, 208 Federally Qualified Community Health Centers, and 186 Rural Health Clinics.

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

Despite the health benefits to infants and mothers, Mississippi shows below average rates of breastfeeding. The Center for Disease Control and Prevention's 2022 Breastfeeding Report Card reports that for infants born in 2019 in Mississippi, 69.4% started out receiving some breast milk (compared to 83.2% nationally), 35.7% were breastfeeding at 6 months (compared to 55.8% nationally), 22.2% were breastfeeding at 12 months (compared to

35.9% nationally), 31.1% were exclusively breastfeeding through 3 months (compared to 45.3% nationally), 15.6% were exclusively breastfeeding through 6 months (compared to 24.9% nationally), and 21.2% of breastfed infants received formula before 2 days of age (compared to 19.2% nationally).

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

According to 2022 America's Health Rankings, the percentage of infants exclusively breastfed for six months increased 17%, from 11.1% to 13.0%; tobacco use during pregnancy decreased 13%, from 10.2% to 8.9%; of live births, teen births decreased 11% from 34.8 to 31.0 births per 1,000 females ages 15-19; meningococcal immunization among children ages 13-17 increased 37%, from 46.0% to 63.0%; Tdap immunization among children ages 13-17 increased 31%, from 70.8% to 92.4%; and physical inactivity among women ages 18-44 decreased 20% from 34.4% to 27.6%. These improvements show the progress of our state and Mississippi's desire to improve its health rankings.

Mississippi has also shown steady improvement in education rankings moving from 50th in 2013 to 35th in 2021 according to the Quality Counts National Report. The state maintained its historic gains in 4th grade reading on the 2022 National Assessment of Educational Progress (NAEP), while nationally scores dropped in all four NAEP subjects and grades. Based on information from the Mississippi Department of Education (MDE) statewide results from the 2021-22 Mississippi Academic Assessment Program (MAAP) show student achievement exceeding pre-pandemic levels in English Language Arts (ELA) and science and nearly tying in mathematics. Overall, the percentage of students scoring proficient or advanced reached an all-time high of 42.2% in ELA and 55.9% in science, and reached 47.3% in mathematics, just shy of the pre-pandemic rate of 47.4%.

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

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

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

Despite these strengths and efforts, significant challenges still exist. Mississippi is still ranked last among all states for overall health system according to the Commonwealth Fund. Mississippi ranks 49th for access and affordability, 48th for prevention and treatment, 43rd for avoidable hospital use and costs, 30th for income disparity, and 50th for healthy lives.

Mississippians, including our children, are routinely ranked as the fattest in the country and we lead the nation in high blood pressure, diabetes, and adult inactivity. The Delta region, which is well known for its poverty and rural

characteristics, is at even greater risk for health problems because of lack of accessibility and availability of medical care. An estimated 60% of Delta residents live below the poverty level. In 2021, as part of the Behavioral Risk Factor Surveillance System (BRFSS), 13.1% of Mississippians surveyed said they were unable to see a doctor at some point in the prior twelve months because of cost.

The state's challenges particularly impact the state's most vulnerable residents, including CYSHCN and their families, Medicaid recipients, the working poor, undocumented immigrants, and rural residents. Mississippi has a high percentage of CYSHCN, CYSHCN living in poverty, and more severe health care provider shortages than most states. In addition to those challenges are Medicaid changes to MCOs, closure of the Title V Children's Special Health Services clinic, and the decision not to expand Medicaid within the state of Mississippi. Also, Mississippi still faces challenges because of health care reform with the rising cost of health care. In the absence of any intervention, the burden of high health care costs will worsen, as health care spending per capita in Mississippi is projected to nearly double from 2010 rates.

Akin to challenges for CYSHCN and other vulnerable populations, progress in improving maternal health outcomes is stunted due to inadequate access to obstetric and post-partum care. According to a report released by the March of Dimes in November 2022, more than half of Mississippi counties are considered maternity care deserts. A maternity care desert is one in which there are no hospitals providing obstetric care, no OB-GYNs, and no certified nurse midwives. It is important to note that since the report was released, additional hospitals that had provided obstetric care have closed, further widening the gap between those in need of help and the locations they can access it.

Understanding the composition of the state will help provide a measure to what is occurring within the health care needs of the population. The U.S. Census Quick facts as of July 1, 2022, reported Mississippi's population as 2,940,057, with 51.4% female, 48.6% male. Compared to the nation, a substantially larger percent of the Mississippi population is Black (37.8% vs. 13.6%) and substantially small percentages of the state population are Latinix (3.6% vs. 19.1%) and white (58.8% vs. 75.5%).

State Health Agency Roles, Responsibilities, and Priorities

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

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

Office and Program Organization and Descriptions

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

The Mississippi Breast and Cervical Cancer Program (BCCP) strives for early detection of breast and cervical cancer in those women at highest risk, including the uninsured, the medically underserved, minority, and women 40 and older. These women are more likely to have advanced disease when symptoms appear, reflecting differences in access to screening and care. The program provides education and promotes access to free screenings for breast and cervical cancer provided in partnership with screening providers in all Mississippi counties. BCCP has a broad network of approximately 120 contracted providers offering BCCP-supported services at over 290 sites throughout the state. These providers include federally qualified community health centers, health department clinics, private family physicians and other primary care providers, hospitals, ambulatory surgery centers, surgeons, radiologists, medical oncologists, and laboratories throughout the state. Using a fee-for-service reimbursement model, providers are reimbursed at the Medicare rate for allowable BCCP procedures. With federal (CDC) and matching funds, mammography screening is available through contracted providers to uninsured women between 50 and 64 years of age. Women under 49 years old and younger with positive breast symptoms are eligible for diagnostic screenings. Asymptomatic women 40-49 years old are eligible for screening mammograms only when special funding, such as that from NBCF is available. Timely follow-up and support is provided for all women with clinical findings through their enrolling providers. Timely referral to Medicaid for women diagnosed with cancer is provided directly through the BCCP clinical staff to expedite coverage for treatment.

The Healthy Moms/Healthy Babies of Mississippi program is a Medicaid-reimbursed targeted (perinatal) case management (TCM) program for high-risk pregnant women and their babies less than one year old. HM/HB partners with patients, communities, and medical providers to provide enhanced access to health care, nutritional and psychosocial support, home visits, and health education. The program aims to decrease preterm births, improve maternal health, decrease infant and maternal mortality, and support infant development. Key activities of targeted case management include: securing a medical home for mother and/or her infant, identifying family and community supports, providing referrals for enabling and supportive services such as Medicaid, food stamps (SNAP), WIC, family planning, mental health, transportation, housing, medical services, childcare, employment services, and breastfeeding assistance, providing postpartum home visits to assess the health and condition of mother and infant, and offering health education, such as preparing for the hospital, urgent maternal and postpartum warning signs, depression, anxiety, caring for baby, infant safety, and healthy infant development. The program receives referrals from health department clinics, other MCH-serving programs, birthing hospitals, OB-GYN practices, other health settings, and Medicaid coordinated care organizations (CCOs) and is available to residents of all 82 Mississippi counties.

The Maternal and Infant Health Bureau (MIHB), aims to reduce maternal and infant morbidity and mortality by understanding the causes of deaths through surveillance, review, and abstraction of records for infants, children, and women (pregnancy-related). MIHB further utilizes the information and recommendations gathered through review to engage health systems and communities to implement quality improvement initiatives and prevention strategies. MIHB utilizes strategies such as multidisciplinary review teams with guidance and technical assistance from the National Center for Fatality Review and Prevention (NCFRP) and the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM). Strategies included in the report for the Fetal and Infant Mortality Review (FIMR), Child Death Review (CDR), and Maternal Mortality Review Committee (MMRC) are aligned with processes developed and guided by the NCFRP and the MMRC. Recommendations produced through these actions are carried out by MIHB community and health-setting based partners. MIHB further utilizes strategies such as quality improvement initiatives with guidance from the National Network of Perinatal Quality Collaboratives (NNPQC) and the Alliance for Innovation on Maternal Health (AIM). NNPQC is a partnership

between the CDC and March of Dimes to support state perinatal quality collaboratives in making measurable improvements in statewide health care and health outcomes for mothers and babies. AIM is a national data-driven maternal safety and quality improvement initiative based on proven safety and quality implementation strategies that reduce preventable maternal mortality and severe morbidity.

MSDH continues to provide access to Family Planning/Comprehensive Reproductive Health through its county health department clinics to residents across the state. MSDH is a Medicaid Family Planning Waiver provider and receives reimbursement from the MS Division of Medicaid. The Medicaid FPW is accessible to female and male persons ages 13-44, with family income at or below 194% of the FPL, who are not currently pregnant and who have not had a vasectomy, tubal ligation, or hysterectomy. FPW assists beneficiaries who are not ready to have a child. Under the FPW, MSDH provides physical exams, which may include a medical history with a height weight, and blood pressure, Pap test, and clinical breast exam. Additionally, the clinics provides family planning counseling & education on all birth control methods, including abstinence and natural family planning, testing for pregnancy, HIV, and sexually-transmitted diseases, birth control supplies, contraceptive methods, and pre-conception counseling to help plan future pregnancies. Effective March 31, 2023, MSDH is no longer the Title X federal funding recipient. Patients who desire services that would be covered under Title X (i.e., free, confidential, minor, undocumented individuals, etc.) are referred to a Title X or other provider when MSDH cannot meet their needs.

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

The Genetic Services Bureau houses the Mississippi Newborn Screening, Chronic Congenital Heart Defects (CCHD), and Early Hearing Detection and Intervention (EHDI) Programs and the Birth Defects Registry. MS Code §§ 41-21-201; 41-21-203 requires all newborns to be screened in accordance with the National Recommended Uniform Screening Panel (RUSP). The Genetics Services programs provide short-term follow-up for newborns identified through bloodspot and point of service, ensuring repeat screens are conducted when needed, families are referred to specialists for confirmatory testing, and families of children with identified conditions or risks are connected with long-term follow-up and care/service coordination. These programs partner with birthing hospitals, tertiary clinics, and pediatric facilities statewide as well as internal MSDH field services, CYSHCN, early intervention, and social services. The EHDI program also provides peer-to-peer family support for families of children with confirmed hearing loss as well as access to Deaf/Hard of Hearing role models. The Genetics Services programs ensure all newborns born in Mississippi receive timely newborn screening (i.e., 12-24 hours of birth for hearing screening and 24-48 hours of birth for bloodspot collection and CCHD screen). The NBS program partners with PerkinElmer, the state lab, which receives bloodspot cards, analyzes the samples, and provides results entered in the MSDH electronic health records database, EPIC. The Genetics Services programs also provide education for healthcare and intervention professionals on newborn screening and long-term care and treatment for children with conditions identified at birth. The Genetic Services programs aim to reduce infant mortality and morbidity of Mississippi Newborns with genetic conditions through early detection and treatment and ensure children are provided access to care for follow-up, diagnosis, intervention, and care coordination.

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

coordination programs.

The Mississippi First Steps Early Intervention Program (MSFSEIP) is the Individuals with Disabilities Act (IDEA) Part C program in Mississippi. The MSFSEIP is responsible for coordinating a statewide comprehensive interagency system of early intervention supports and services (EISS) for infants and toddlers under three years of age with a developmental delay or condition likely to lead to a developmental delay and their families. The MSFSEIP coordinates with healthcare providers, early childhood care and education providers, and families across the state to ensure infants and toddlers with identified disabilities and/or developmental delays are identified, evaluated, and receive timely, comprehensive, and family-centered services. The MSFSEIP is composed of a state office, three regional offices, and nine local early intervention programs (LEIPs). All offices participate in public awareness campaigns and outreach to conduct Child Find activities, including promotion of developmental screening, monitoring by primary care and childcare providers, and conducting of developmental screening for infants and toddlers referred from Child Protective Services. The MSFSEIP State Office provides training, guidance, and oversight to the regional offices and LEIPs. The regional offices recruit and form agreements with local providers of early intervention services, such as physical, occupational, and speech therapists, to participate in the EI system. Each LEIP has a Program Coordinator and multiple Service Coordinators who are assigned to provide ongoing support, from intake through transition to school- and/or community-based services, and referrals to participating service providers who educate and support families in understanding their children's special needs and helping them help their children grow, develop, and learn.

The Mississippi LPPHHP was established as a result of the federal law (42 U.S.C. at 1936a) requiring states to screen children enrolled in Medicaid for elevated blood lead levels (EBLLs) as a part of prevention services provided through the Early and Periodic Screening, Diagnosis and Treatment Program (ESPDT). The statewide program provides practical prevention measures through care coordination, education, policy intervention, and risk reduction activities for children and their families. Families of children with a confirmed venous blood lead level (BLL) greater than or equal to 3.5 micrograms per deciliter ($\mu\text{g}/\text{dL}$) receive care coordination services (i.e., telephone counseling, home visit; environmental assessments, lead poisoning prevention, healthy homes assessments, and Sudden Infant Death Syndrome** education; nutritional counseling and referrals) which are designed to identify lead and other environmental home health hazards, and provide recommendations for decreasing hazards. Additionally, as required by the MSDH's Reportable Diseases and Conditions policies and procedures; all laboratories and medical facilities throughout the state are required to report all blood lead levels to MSDH. This data is analyzed to determine the status of lead poisoning and healthy homes issues in the state, and to identify high-risk areas to target education, outreach, and policy interventions.

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is the newest program to be implemented within the MCH system. In May 2023, MSDH was awarded the MIECHV grant. The program is currently under development. Once implemented, the program will provide evidence-based home visiting services to families and children at risk for poor maternal and child health outcomes. Services will include up to weekly personal visits, monthly community educational and networking meetings, regular health and developmental screening, and referrals for additional services and resources as needed.

The Adolescent Health program promotes the health of adolescents by strengthening the state-level public health capacity and infrastructure for their access to preventive care, mental health resources, and other developmentally appropriate services. Recognizing how crucial this developmental period is, given the physical, emotional, and intellectual changes as well as changes in social roles, relationships, and expectations, the program focuses on the elimination of health disparities and inequities that affect young people and advances leadership practices for MCH at the national, state and local levels for adolescence (ages 10-17) and young

adulthood (ages 18-21).

The Children and Youth with Special Healthcare Needs (CYSHCN) program provides family-centered care coordination services for children and youth with special health care needs from birth to 21 years of age. CYSHCN are defined as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally. Care Coordination is provided through a statewide, comprehensive, coordinated, multi-disciplinary, system of care by the health department system and primary care practices for children and youth with special health care needs, their families, and caregivers. Personal contact with the family as soon as possible after diagnosis provides an opportunity to counsel, provide literature, answer questions, initiate referral, establish local medical home and coordinate tertiary center, specialty clinic and/or physician appointments as needed. This service is available to state residents who were born with a special health care need or developed a chronic illness (not due to accident or injury).

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

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a public health program funded and guided by the United States Department of Agriculture (USDA) Food and Nutrition Services (FNS) to safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to healthcare. WIC serves pregnant women, breastfeeding women, postpartum non-breastfeeding women, infants, and children less than five years of age who live in Mississippi and meet income requirements.

WIC provides nutritious foods via a network of retail vendors using an electronic benefit card, referred to as an eWIC card. This includes full-service grocery stores that provide WIC-approved food items and pharmacies that provide special medical formula and WIC-eligible nutritional supplements. MSDH WIC currently authorizes 273 retail vendors across 78 counties, including 104 grocery stores, 157 grocery stores with a pharmacy on site, and 12 free-standing pharmacies. The WIC Shipping and Receiving Unit orders and ships special medical formula and WIC-eligible nutritional supplements to clinics for participants who have access issues. The WIC Breastfeeding Promotion and Support Program focuses on the personal, local, regional, and state advantages of breastfeeding. WIC staff provide breastfeeding information and support to all pregnant and breastfeeding women receiving services from the Mississippi WIC Program to enhance the breastfeeding experience. The MSDH WIC Program serves as an adjunct to good health care by providing peer support, breastfeeding management, information, and assistance throughout the prenatal and postpartum period.

The Office of Oral Health works across agency departments to implement programs to prevent oral diseases. The Office is responsible for assessment, policy and program development, and assurance in the prevention and control of oral diseases. Programs address oral health access and use of services for children and adolescents, adults, families and communities through public health clinics, schools, and licensed medical and dental health providers. Among its many activities, the fluoride program supports communities to adopt community water fluoridation. Additionally, the dental sealants program, Mississippi Seals, provides preventive dental services in schools throughout the state. Oral health screenings, dental sealants, and fluoride varnish applications are provided on-site in schools in collaboration with dental professionals in the community. As a workforce development and capacity building approach, the program offers opportunities for students to shadow and intern with the office to expose them to public health dentistry and statewide oral health disparities. As funding permits, the program also provides Dental Admission Test (DAT) preparations and assistance with applying to dental school. While the program does not offer direct services at county health departments, it employs Regional Oral Health Consultants (ROHCs) who are state

licensed dental hygienists who assist with grass roots implementation of all programs and trainings. The ROHCs strive to improve the oral health of all Mississippians by assisting county health departments to deliver age-appropriate oral health anticipatory guidance and preventive oral health services in each public health district. ROHCs and other team members promote information sharing between health professionals and community stakeholders to educate the public about the importance of good oral health and to reduce the burden of oral disease. The ROHCs also represent the agency, MCH, and the oral health program at schools, health fairs, and other public-facing settings where education and outreach are most needed. The Office of Oral Health is committed to creating a culture of health in Mississippi that includes oral health through oral health promotion, oral disease prevention, oral health surveillance and dental care coordination over one's lifespan.

The MCH Workforce Development Office was established to support workforce development, training, and capacity building to meet the needs of the MSDH Health Service and MCH programs. There are three components within this office: professional development for existing public health personnel; building a pipeline from preservice programs to public health; and providing social service support to Title V and Health Service programs via an integrated public health social work team. The Office is currently responsible for assessing, coordinating, and providing Health Services personnel foundational knowledge surrounding public health, Title V, and MCH and is in development to expand its reach to assess, coordinate, and provide training to other MSDH Offices and external partners throughout the state. The office develops agreements between MSDH and in-state and out-of-state Institutes from Higher Learning to offer internships within MCH programs aligned with student interests.

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

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

State Systems of Care for Underserved and Vulnerable Populations

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

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

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

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

- Health System

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

Mississippi also has 128 hospitals of which there are ninety-five acute care, four psychiatric, one rehabilitation, one OBGYN and ten long-term acute care facilities. Seven counties in our state do not have a hospital: Amite, Benton, Carroll, Humphreys, Issaquena, Itawamba, and Tunica. A shortage of emergency personnel, including medical technicians and equipment is resulting in increased wait times for responses to rural and medical emergencies.

Compared to 2015, we have four comprehensive behavioral health state programs, six intellectual developmental disability regional programs, 2 specialized programs for adolescents and 13 regional centers with county governing authorities.

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

Mississippi's Health Professional Shortage Areas

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

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

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

In 2022, Mississippi had a total of 796,778 Medicaid enrollees providing coverage to 27.7% of the state's population. The state's average length of hospital stay is on par with the national average hospital stay of 5 days. There is only one children's specialty hospital in the state, located on the campus of the University of Mississippi Medical Center

Distribution of Primary Care Physicians, Dentists, and Psychiatrists in MS		
Health Profession Category	% Serving Rural	% Serving Urban (MSAs)
Primary Care Physicians	46% 837 physicians serve 61 rural counties <i>4 rural counties have no primary care physicians</i>	65% 994 physicians serve 17 urban counties <i>all urban counties have primary care physicians</i>
Dentists	6% 68 dentists serve 59 rural counties <i>6 rural county has no dentist</i>	94% 997 dentists serve 17 urban counties <i>all urban counties have dentists</i>
Mental Health (Psychiatric Only)	34% 42 psychiatrists serve 59 rural counties <i>6 rural counties have no psychiatric mental health providers</i>	66% 83 psychiatrists serve 17 urban counties <i>all urban counties have psychiatric mental health providers</i>

While the percentage of Mississippi adults who report being uninsured has dropped since 2013, cost is still the greatest barrier to obtaining health insurance coverage. The price of basic health insurance coverage with reasonable cost-sharing far exceeds the amount people are willing to pay without substantial subsidies. For those Mississippians with low incomes, unaffordable private coverage and lack of access to premium assisted coverage through an employer, the Marketplace, Medicaid, or other source, leave some with no other alternative than to remain uninsured.

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

State Statutes and Other Regulations Impacting MCH/Title V

Newborn Screening Panel

In March 2022, the Mississippi Legislature unanimously passed House Bill 927, amending the comprehensive newborn screening program to align with the Recommended Uniform Screening Panel (RUSP). Under this new state law, the MSDH is required to update the newborn screening panel to include all conditions within three years of inclusion on the RUSP and adopt any rules and regulations needed to accomplish the program or submit a report to the legislature on the status and reasons for the delay. As the Mississippi Panel was already largely compliant with

the RUSP, this law will mainly ensure the panel remains current with the advances in science as new diagnostic tests and treatments for conditions are developed. Mississippi is the eighth state in the nation to adopt RUSP alignment legislation.

Maternal Mortality Review Committee

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

Child Death Review

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

III.C. Needs Assessment FY 2024 Application/FY 2022 Annual Report Update

Needs Assessment Process

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

Needs Assessment Findings

Needs assessment findings revealed several recurring themes across domains highlighting the need for MSDH to align strategies and use resources for the following:

- Improving access to patient- and family-centered care
- Improving health equity for underserved populations
- Decreasing discrimination based on race, class, or gender
- Providing education on mental health issues and improving access to mental health services
- Decreasing provider shortages

Access to Patient- and Family-Centered Care

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

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

Improving Health Equity and Decreasing Discrimination Based on Race, Class, or Gender

The need to promote health equity was also evident from the needs assessment findings. Health equity will increase community capacity to shape outcomes and foster multi-sector collaboration, in turn creating the foundation for a healthy and vibrant community. The Perinatal/Infant Health program has made efforts to address this need through racial equity trainings, focusing on the structural and social dynamics working within health care institutions and communities that prevent optimal births for every woman, particularly Black and indigenous women of color. With trainings on racial equity, social determinants of health inequities, collective impact and advocacy, participants will begin to realize their role within the transformation of those systems.

The MCH Program hosted an implicit bias workshop training for staff. Its purpose was to help staff understand the biases in our everyday life, to discuss how to manage biases, and to understand how biases can affect the level of care for MSDH clients and staff. The workshop provided tools to begin discussions on how to adjust automatic patterns of thinking and to eliminate discriminatory behaviors. It equipped staff the necessary tools to maintain and promote an inclusive and respectful work environment. The workshop training also focused on the topic of patient-centered care and how implicit bias can lead clinicians/and service providers to use personal biases that affect the use of family planning in specific situations or populations (e.g., unmarried adolescents). Since integration of family planning into maternal and child health services is a vast area with many intersections, considering how to address bias is an important element for family planning success.

In addition to trainings, some programs have developed plans and policies addressing health equity within their program. The Early Hearing and Detection Intervention (EHDI) program received a grant through HRSA to establish an Inclusion and Diversity Plan. The purpose of this plan is to promote and foster a culture that values diversity, equity, and inclusion throughout the EHDI program and the diverse communities that the program serves.

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

Mental Health Services and Education on Mental Health Issues

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

To begin to build capacity to address the mental health needs in our state in MCH populations, MCH program personnel have participated in mental health first aid training. In 2021, Adolescent Health Program personnel became certified in mental health first aid. Certified personnel provided statewide training to address mental health needs. In 2022, the CYSHCN personnel also attended Mental Health First Aid training to gain skills and knowledge in recognizing and addressing mental health concerns in CYSHCN youth.

In addition to training, MCH programs have also coordinated workshops and mental services to families. The Maternal and Infant Health Bureau program also facilitated a partnership with MOM.Me to address the mental health

needs in the state. The goal of this collaboration is to:

- Establish a Maternal Mental Health Network
- Conduct health education and outreach
- Provide training to community stakeholders to increase provider knowledge of maternal mental health disorders
- Link women and children to support services

During this collaboration, the Maternal and Infant Health Bureau and MOM.Me hosted a coordinated care program designed to provide the care mothers need. Participants of the program received (1) a one-hour individual session with a therapist; (2) a one-hour weekly group session led by a peer or therapist; (3) a weekly mood assessment conducted by a Care Coordinator via Zoom; and (4) post-program follow-ups for up to six months. The program also hosted a series of virtual workshops on mental health and baby safety.

MOM.Me also offers the same content for fathers to bring awareness to the importance of fathers on maternal mental health and the developmental milestones of their child. Fathers are also educated on postpartum in fathers, infant care, and infant first aid.

More activities related to addressing the mental health needs across the MCH lifespan for MCH populations are being undertaken in the current year and are being planned for the application year. All social workers and service/care coordinators in all MCH programs, including CYSHCN, EI, HMHB assisting MCH personnel who work with infants and toddlers to earn the Infant Family Specialist Endorsement recognized by the Alliance for the Advancement of Infant Mental Health.

Provider Shortages

The impact of provider shortages is inevitably felt throughout the state. Provider shortages impact the health system by lowering the quality of care provided and increasing the number of poor health outcomes. Although Mississippi experiences provider shortages in every medical and health field, the following highlights some particularly challenging shortages.

Newborn Screening and Diagnostic Provider Shortages.

The United States, and Mississippi in particular, is facing a shortage of pediatric audiologists and lacks the genetic specialists to work with families of infants who are found to have conditions identified during newborn screening. This shortage will be difficult to address as training programs are costly, lengthy, and insufficient to address the need. Particularly with pediatric audiologist, reimbursement for working with pediatric populations disincentivizes providers, encouraging them to focus on older, geriatric populations.

Dental Health Provider Shortages.

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

Mississippi's Office of Oral Health developed a Mississippi State Oral Health Plan, 2016-2021. The Plan called for surveillance and assessment of oral health status, which was subsequently addressed by the development of the Mississippi Oral Health Surveillance Plan, 2018-2022. The data collection for the surveillance plan is currently underway, and the results will establish a baseline for oral diseases and resulting health outcomes in Mississippi.

The surveillance activities include dental caries, periodontal disease, cancers of the oral cavity and pharynx and access to care issues occurring over one's lifespan. This information will assist in the placement of new dental providers and public education programs in the areas of the state with the greatest needs. Other benefits of the surveillance process will be an improvement in actionable oral health data for the state and local health providers, more accurate data to report to policy makers, and baseline data to evaluate success.

Mental Health Providers Shortages.

The need for mental health providers across the state is dire. The ratio of mental health providers to population is greater than 1 to 200,000 in the Delta region. It is important to note that the HRSA designation process counts psychiatrists only, and there is a nationwide shortage of psychologists and other mental health professionals. Employing a regionalized approach and counting psychologists and licensed clinical social workers would provide a better assessment of capacity. In partial response to the need for psychiatrists, the Mississippi State Hospital (MSH) added a Psychiatric Residency Program with the first residents having started in July 2021.

Changes in MCH/Title V Program Capacity

Over the past 3 years, MSDH has experienced numerous events that have had a serious impact on staff and services, many of which remain challenging: the impact of COVID-19, including critical staffing shortages; a statewide reassessment and realignment of job classifications; and a continuing drain of skilled public health professionals. These events have made it challenging to recruit and maintain knowledgeable and skilled Title V staff. The Title V Block Grant team is mostly comprised of personnel who have been in their roles for two or fewer years and have recently assumed responsibilities for preparing the Title V application and report.

To recruit and retain qualified MCH staff, MCH works closely with Human Resources to increase efficiencies within the hiring process. Standardized hiring procedures are now in place and additional technical assistance has been provided throughout the hiring process. Proactive strategies have also been employed to publicize vacant positions. Strategies include broadly circulating state vacant positions through established MCH listservs, using additional advertisement and targeted postings, and determining innovative and creative ways to attract and retain a diversified workforce. MCH works with colleges throughout the state to initiate critical conversations to draw student talent.

While MSDH has made limited progress, there is a need for improved recruitment strategies, core competency training, competitive salaries that provide a livable wage, and leadership coaching. From previous workforce development surveys, MSDH has been viewed as bureaucratic, lacking innovation, and under resourced. Job attributes should offer fulfilling, meaningful work, a position that is mission-driven and provides the opportunity to make an impact on their community. MSDH realizes a qualified and competent public health workforce is essential in addressing existing and emerging public health issues. The growing variability of these challenges emphasize the need for adequate core competency training and education of public health professionals. Competitive salaries are needed to attract potential employees, provide a livable wage, encourage low employee turnover, and increase the work environment morale. Leadership coaching provides an inclusive workplace that fosters the development of others and the ability to lead staff toward meeting MSDH's vision, mission, and goals.

To build MCH Program capacity, some leadership staff have been supported to participate in coaching and leadership training programs such as the certified public manager program through the Mississippi Personnel Board and the Advanced Applied Leadership Program through the Else School of Management at Millsaps College.

Partnerships and Collaborations

The Title V/MCH program acknowledges the power of prevention in improving the health and well-being of across the

life course. Health Services initiated a collaboration with the Office of Preventive Health and Health Equity to address the social determinants of health that affect not only Title V/MCH programs but also the health of all Mississippians. Programs in Preventive Health and Health Equity will assist MCH-related strategies around issues such as maternal and infant mortality, developmental screenings, well visits among adolescents, and cross-cutting issues such as mental health, health equity, and disparities. Mississippi's Title V MCH Program continues to partner with numerous entities at the federal, state, and local level to expand its capacity and reach for its MCH population.

The Title V/MCH program also supports the Maternal & Infant Health Bureau (MIHB). Through this support, the MIHB partnered with a local community-based organization, Mom.ME (<https://www.momme.rocks/>), to establish a community-based collaboration and support to expand community knowledge of available services. Mom.ME works to promote maternal mental health literacy to improve the health of women across the life course and create a continuum of care and integrated system of community-based services in women's health.

The Child and Adolescent Health Office partners with Teen Health Mississippi to develop and implement training and technical assistance for youth and youth-serving organizations in Mississippi, guiding providers on how to best support expectant and parenting youth, educate adolescents on sexual and mental health practices, and best practices for implementing youth friendly healthcare, particularly focused on teen populations with health disparities, such as teens of color, teens with English as a second language, teens with disabilities, LGBTQ youth, etc.

Organizational Structure and Leadership Changes

Thomas Dobbs, MD, MPH, served in various capacities since 2007 in Public Health as State Epidemiologist, Deputy State Health Officer, and State Health Officer until July 29, 2022. Dr. Dobbs led the state through one of its most challenging times, the COVID-19 pandemic. In 2022, Dr. Dobbs announced his departure and successor Daniel Edney, MD, FACP, FASAM. Dr. Edney brought years of experience in private practice when he joined MSDH in 2021 as the Deputy State Health Officer and Chief Medical Officer. Dr. Edney was officially announced as the State Health Officer in August 2022. Dr. Edney is a former president of the Mississippi State Medical Association and currently serves as a board member on the Mississippi State Board of Medical Licensure. He has also served as a fellow and laureate for the Mississippi Chapter of the American College of Physicians and a fellow of the American Society of Addiction Medicine.

Dr. Beryl Polk serves as Director of Health Services/Title V under the leadership of the State Health Officer, Dr. Edney. She brings decades of experience in program development, management, and evaluation. Dr. Polk is a Certified Case Manager (CCM), Certified Public Manager (CPM), Licensed Social Worker (LSW), has a MS in Counseling and a PhD in Leadership and Management with an emphasis in program development and evaluation. She has served for 23 years in various roles with MSDH. Dr. Polk provides leadership to more than 300 employees, both directly and indirectly, and across the state through the various offices listed below.

The Division of Health Services houses several programs: Women's Health, Child & Adolescent Health, including Children and Youth with Special Healthcare Needs (CYSHCN), Women Infant and Children (WIC), Oral Health, and MCH Workforce Development.

- Ms. Krista Guynes, MSW, LCSW, is the Director of the Office of Women's Health, which includes the Breast and Cervical Cancer Program, Maternal and Infant Health Bureau, Healthy Moms/Healthy Babies Perinatal Case Management Program, and the Family Planning/Comprehensive Reproductive Health Program. She began serving in this role in 2022.
- Ms. Stacy Callender, SCSP, is the Director of the Office of Child and Adolescent Health, which includes Newborn Screening, the Birth Defects Registry, Early Hearing Detection and Intervention, Early Intervention (Part C), Lead

Prevention and Healthy Homes (LPPHH), Maternal Infant and Early Childhood Home Visiting (MIECHV), Adolescent Health, and Children and Youth with Special Healthcare Needs (CYSHCN) Programs. She began serving in this role in 2021.

- Ms. Valecia Davis, MS, is the Director of the Children with Special Healthcare Needs Program and interim Adolescent Health Director. She has been serving in this role since summer 2022.
- Dr. Jameshya Ballard was appointed Director of WIC in July 2022, when the previous WIC Director retired after more than 30 years of service. Dr. Ballard previously served as State Breastfeeding Coordinator and State Vendor Management Director with the WIC program.
- Dr. Angela Filzen, DDS, is State Dental Director and oversees the Oral Health Office. She has been serving in this capacity since 2017 and works with community-based organizations to increase dental and medical homes for women and children across the state.
- Ms. Danielle Seale, MSW, LCSW, was tasked to lead the MCH Workforce Development Office in 2021, bringing her experiences from more than a decade in public health. In 2022 she was assigned a cadre of Health Services Social Workers to supervise in their social service support of Health Service programs.

New Brand, New Program

Beginning in August 2021, the Perinatal High-Risk Management/Infant Support Services (PHRM/ISS) program that has been in existence at the health department for over 30 years changed to the Healthy Moms/Healthy Babies (HM/HB) of MS program, a nurse case management and home visiting program. To complete the transformation, the program began by developing provider-specific training and orientation for new and existing staff and revamping protocols to implement evidence-based strategies. The HM/HB program developed a recruitment strategy to address the shortage of nurses within the program. The overall goal of the program is to increase capacity, training, and accountability to better serve pregnant women and infants in the state of Mississippi.

Emerging Issues and MCH Program Response

Dobbs Decision

On June 24, 2022, the U.S. Supreme Court officially issued a ruling in the Thomas E. Dobbs, State Health Officer of the Mississippi State Department of Health, et al. v. Jackson Women's Health Organization. In doing so, the Court overturned its 1973 decision of Roe v. Wade. Given the existing challenges Mississippi already experiences with high maternal and infant mortality and morbidity, these rates are predicted to increase as a result of this recent Supreme Court decision and subsequent enforcement of state laws making abortions illegal. As a result, the state's only abortion clinic has closed and restrictions for medication abortions are in effect. Additional pregnancies and births, which would have previously been terminated during pregnancy, are most likely to occur for younger women, single women, women of color, women in under-resourced areas without local family planning services, and women with economic hardships who lack the resources to receive reproductive services out of state.

The MSDH currently estimates the elimination of elective abortions will result in as many as an additional 5,000 births annually, many of which will be unplanned, and for which many women will receive little or no prenatal care. Research has shown repeatedly the negative consequences of inadequate prenatal care for mothers, including three to four times the risk of dying from pregnancy-related complications than those who do receive care, and for infants, including increased rates of prematurity, low birthweight, and infections after birth. As these conditions place infants at increased risk of requiring more advanced neonatal care after delivery, Mississippi expects an increased need for NICU admissions in the coming years.

COVID-19

The COVID-19 pandemic has again laid bare the influence of poverty, race, and ethnicity on the vulnerability to disease and the resulting health disparities. Death rates among Blacks are being disproportionately experienced by younger Blacks and death rates are higher among Native Americans. Since the pandemic began, death rates among Blacks aged 55-64 years are higher than for Blacks aged 65-74, and for whites aged 75-84. Mortality rates

per 100,000 among Blacks in Mississippi was 253.8 (2,050 deaths), twice the rate of white Mississippians (126.4). The mortality rate from COVID-19 among Native Americans in Mississippi was 1,235 / 100,000 (94 deaths), almost 10 times the rate of white mortality. Despite the low number of deaths, the mortality rate from COVID-19 among Native American Mississippians was the highest among the indigenous residents nationwide.

In early 2021, MSDH and health systems partners statewide prioritized vaccine distribution. In October and November 2021, during this reporting period, Mississippi saw its highest rates of COVID and COVID-variant transmissions, infections, hospitalizations, and deaths. In response, the MSDH engaged in targeted campaigns with specific communities, such as engaging with the Hispanic Community to address COVID in October 2021, and began issuing vaccines for children in County Health Departments in November 2021. To improve access to records, Mississippi began participation in MyIR providing online access to immunization records.

As the COVID-19 pandemic began winding down in 2022, MSDH and other health systems stabilized and returned to routine operations. For example, BCCP focused on engaging providers and partners in efforts to return women to breast and cervical cancer screening. This was done by maximizing carryover CDC funding for subgrants with health settings that employed community health workers (CHWs) and patient navigators to provide rapid patient navigation.

Jackson Water Crisis and Lead Lawsuits

As reported under MCH success stories, in mid-August 2022, the capitol city of Jackson experienced heavy rains and flooding which damaged the O.B. Curtis water treatment plant located near the Ross Barnett Reservoir in the Pearl River basin. With the crippling of this major water treatment plant and malfunction of pumps at the J.H. Fewell water treatment plant, the city was unable to produce sufficient water pressure to serve its residents. For weeks, many residents were unable to access clean, safe water for drinking, cleaning, and bathing in their homes. Even as the pressure was slowly being restored across the system, residents remained under a boil water notice for several more weeks and continued to experience waves of rolling boil water notices until the end of the emergency in November 2022.

This presented challenges for MCH program participants in the Jackson area as well as MCH program personnel. The MSDH Offices housing the leadership for its MCH programs, located in Jackson less than 2 miles from the malfunctioning J.H. Fewell water treatment plant, was significantly impacted by the water crisis. Not only was the water unsafe for drinking but the pressure was insufficient for functioning facilities, resulting in the temporary closure of the building and the use of portable restrooms after the buildings reopened. Nonetheless, MCH personnel, working remotely as needed, focused on addressing the needs of the women, children, youth, and extended families impacted by this crisis through helping them access bottled water at distribution points, purchasing water faucet filters, and providing information on updates and education on installing and using filters and protecting young children from lead in water.

Though this event was a specific crisis, the Jackson water system presents an ongoing challenge as years of deferred maintenance and lack of investments in upgrades combined with unique soil conditions that increase the likelihood of breaks in underground water pipes. The MCH programs periodically are called to respond to boil water notices, water outages, and occasional facility shutdowns.

Health Disparities

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

health—are key drivers of health inequities within communities of color, placing those within these populations at greater risk for poor health outcomes.”

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

Maternal Mortality

Maternal mortality has continually plagued the black community in our state. According to the CDC, Black women are three times more likely to die from a pregnancy-related cause than white women. This profound difference is appalling and must be addressed, as 87.5% of pregnancy-related deaths are preventable. Addressing the variation in quality healthcare, underlying chronic conditions, structural racism, and implicit bias will help reduce the black maternal mortality rate.

Undocumented Residents

Immigrant mothers and children are a vulnerable group that faces dangers to their physical and mental health. This stems from immigration policies that include the right to asylum, detention and deportation protocols, regulation of health coverage, and access to both physical and mental health care. These factors can be seen as social determinants for immigrants. As such, the MSDH MCH Program must consider these determinants in ensuring every mother and child has access to quality care despite their citizenship status.

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

[2023 Application/2021 Annual Report – Needs Assessment Update](#)

[2022 Application/2020 Annual Report – Needs Assessment Update](#)

[2021 Application/2019 Annual Report – Needs Assessment Summary](#)

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$9,235,413	\$10,918,076	\$9,228,087	\$9,153,279
State Funds	\$6,926,560	\$6,926,560	\$6,921,066	\$119,623
Local Funds	\$0	\$0	\$0	\$549,527
Other Funds	\$0	\$0	\$0	\$3,171,965
Program Funds	\$774,608	\$774,608	\$273,030	\$3,079,950
SubTotal	\$16,936,581	\$18,619,244	\$16,422,183	\$16,074,344
Other Federal Funds	\$3,811,000	\$4,300,000	\$4,300,000	\$583,281
Total	\$20,747,581	\$22,919,244	\$20,722,183	\$16,657,625
	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$9,278,900	\$9,305,490	\$9,272,183	
State Funds	\$6,959,175	\$366,106	\$731,224	
Local Funds	\$0	\$660,083	\$1,095,262	
Other Funds	\$0	\$5,520,459	\$3,871,552	
Program Funds	\$216,034	\$432,470	\$1,256,100	
SubTotal	\$16,454,109	\$16,284,608	\$16,226,321	
Other Federal Funds	\$4,625,000	\$48,599,460	\$113,758,690	
Total	\$21,079,109	\$64,884,068	\$129,985,011	

	2024	
	Budgeted	Expended
Federal Allocation	\$9,305,490	
State Funds	\$0	
Local Funds	\$1,053,440	
Other Funds	\$5,525,678	
Program Funds	\$400,000	
SubTotal	\$16,284,608	
Other Federal Funds	\$106,139,568	
Total	\$122,424,176	

III.D.1. Expenditures

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

The Title V federal funding, in conjunction with non-federal state monies and other federal funds, are obligated and expended to support Mississippi's priority needs and Title V requirements. Approximately one-third of Title V funding supports Children and Youth with Special Health Care Needs (CYSHCN), and an additional one-third supports the MCH work of departments across the state. The remaining one-third of Title V funding supports other critical MCH priorities such as regional perinatal care systems, lead poisoning prevention, oral health, infant safe sleep and breastfeeding initiatives, reproductive health, infant and maternal mortality reduction strategies, health equity initiatives, and PRAMS.

The Maternal and Child Health Finance Director oversees all MCH budget expenditures. Computer generated cumulative expenditures, transaction listings and spending/receipt plans are available in electronic format for all MCH programs. This information can be accessed by both central and regional office staff. Contract agencies are also audited frequently. MCH program staff provide site visits and program monitoring at contract agencies to ensure compliance with the contract's scope of services. The Mississippi State Department of Health adheres to the policies and procedures developed by the Department of Finance and Administration. These policies can be found on the Department of Finance and Administration website and pertain to the multiple financial functions of the State.

The budget for Mississippi's Title V MCH Block Grant application was developed by MSDH Health Services in cooperation with the Office of Health Administration, Finance and Accounts. The total program expenditures as follow for FY 2022 was \$16,284,608 of which \$9,305,490 (57 %) is Title V and \$6,979,118 (43%) is match provided in-kind by the applicant. Sources of match funds are state and local funds, newborn screening fees, and Medicaid and other Third-Party earnings (as allowed by the MCH Bureau).

Pregnant Women and Infants

Services for pregnant women total program expended were as follows for FY 2022: \$2,814,483 for federal funds (30% of the total federal award); \$5,531,919 for non-federal funds (79% of total non-federal funds).

Child and Adolescent Health

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

Services for the Child and Adolescent Health total program expended were as follows for FY 2022: \$2,824,041 for federal funds (30% of the total federal award), \$664,860 for non-federal funds (10% of total non-federal funds).

Children with Special Health Care Needs

The mission of the Children's Medical Program (CYSHCN) is to develop a statewide system of care for children and youth with special health care needs (CYSHCN) and their families, using resources of the Mississippi State

Department of Health, University Medical Center, community health care providers, community agencies and other available resources. CYSHCN strives to identify barriers and gaps in current health care systems for CYSHCN and assists with resolution.

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

Services for children with special health care total program expended were as follows for FY 2022: \$2,820,943 for federal funds (30 % of the total federal award), \$782,339 for total non-federal funds (11% of total non-federal funds).

Administrative Costs

Administrative costs expended thus far are \$845,947, which is 9% of the total federal grant award. This amount does not exceed the allowable 10 % of the total Title V MCH Block Grant as mandated in OBRA 1989.

Maintenance of Effort

The level of state funds provided for match for FY 2022 is greater than the State's maintenance of effort level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989.

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

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

III.D.2. Budget

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

The Title V MCH Block Grant budget for the FY24 Application allocates equal funds, equivalent to 30% of the total award, for MCH services for pregnant women and others, primary care for children and adolescents, and preventive and maintenance services for CYSHCN, with 10% for administration costs, include accounting and budgeting services and associated administrative support. Preventive and primary care services include policy and procedural oversight, local health department services, pharmacy and laboratory testing, newborn screening (dried blood spot, non-Title V funds; see Other Funds below), and varied family, maternal, and child health initiatives to bolster protective factors and mitigate risk factors. Other services provided include population-based maternal and child health systems coordination, e.g., cross-coordination of providers, specialists, school systems, government agencies, and community partners.

The program budget includes the mandated state match on a 4-to-3 ratio of federal to state funds and meets the maintenance of effort threshold. Sec. 505 (a)(4) of the Social Security Act requires states to maintain the level of funds provided solely by the state for MCH health programs (i.e., state match) at a level at least equal to the level provided by the state in fiscal year 1989. The proposed FY24 budget complies with the state match as below:

- FY24 Anticipated Federal Allocation: \$9,305,490
- FY24 Budgeted State Match: \$6,979,118.

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

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

- National Breast and Cervical Cancer Early Detection Program (NBCCEDP) – These funds assist women to access screenings for breast and cervical cancer. The program works with healthcare providers across the state to expand access to care.
- Preventing Maternal Deaths: Supporting Maternal Mortality Review Committee – The MSDH uses the recommendations from data reports from this committee to implement prevention strategies and reduce the number of deaths among women in the state due to complications before, during, or soon after delivery of an infant.
- State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs) – This funding supports surveillance of children from birth to 72 months of age for elevated blood lead levels. The program makes appropriate referrals for follow-up by infant health programs, provides family education on prevention, and

conducts environmental assessment at the residence or other place most frequently (e.g., childcare, playground, grandparents' home).

- Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA) – This funding supports the identification and serving of infants and toddlers with disabilities from birth to 36 months of age and their families. The program coordinates with other state agencies to provide developmental evaluations, service coordination, and linkage to community based, family centered early intervention services according to an individualized family service plan as needed to improve developmental outcomes. In addition, the program empowers families to understand their rights, their child's disability, and how to help them grow and learn.
- Universal Newborn Hearing Screening and Intervention – This funding supports surveillance of children from birth to 36 months of age for hearing loss. The program works to ensure timely hearing screening, diagnosis, and early intervention.
- Women, Infants, and Children (WIC) – The WIC program coordinates with MCH and other health services programs to maximize the reach of women, infants, and children from birth to 5 years who receive services to reduce food insecurity. Due to its wide reach in Mississippi, the program serves as a main source of referrals to other health programs.
- The Loving Support Peer Counseling Program (WIC: Breastfeeding) – This expands the focus of the WIC program to support women on initiating and sustaining breast feeding, which support infant and child health.
- Maternal, Infant and Early Childhood Homevisiting Grant Program (MIECHV) – These funding support the delivery of evidence-base home visiting to pregnant women and children up to kindergarten who are at risk of poor maternal and child outcomes.

III.E. Five-Year State Action Plan

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

State: Mississippi

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

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

The MSDH MCH Program is responsible for leading and supporting efforts in local communities and across the state to improve the health and wellbeing of pregnant women, infants, children with and without special health care needs, adolescents, and others in the state. To address national and state performance measures, the MSDH MCH Program strategically coordinates activities and efforts with partners and stakeholders to improve health outcomes for the state's MCH population. This strategic alignment is imperative in assuring the greatest impact of improved MCH health outcomes statewide through:

- Access to quality health care for mothers and children, especially for people with low incomes and/or limited availability of care.
- Health promotion efforts that seek to reduce infant mortality and the incidence of preventable diseases, and to increase the number of children appropriately immunized against disease.
- Access to comprehensive prenatal and postnatal care for women.
- Providing access to rehabilitative services for children who need specialized medical care and treatment. Access to preventive and childcare services as well as rehabilitative services for children in need of specialized medical services.
- Providing prenatal, delivery, and postpartum care for low-income, at-risk women.
- Family-centered, community-based systems of coordinated care for children with special healthcare needs.

MSDH maintains a wide range of partnerships with health professionals, Title V Family Delegates, and non-traditional partners who help oversee and implement strategies to address the needs of MCH populations across the life course. These groups take leadership in the agency's steering committee, the MCH advisory board, and with other advisory capacities. The MCH Steering Committee, consisting of Title V core team members, serves as a decision-making body that provides guidance on program-level strategies, guides the direction of Title V efforts, and aids in the identification of additional partnerships and resources at the state and local level. The Steering Committee assisted with the recruitment of members, based on MCH domains, to serve as members on the Maternal and Child Health Advisory Board.

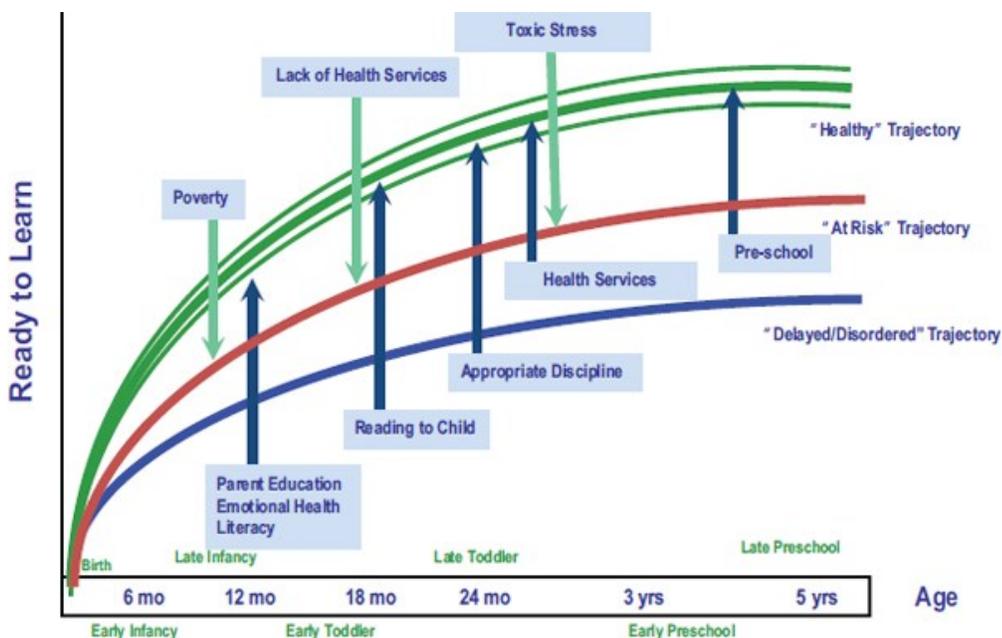
The Maternal and Child Health Advisory Board is composed of 13 members, external partners, medical professionals like pediatricians, family representatives of both children and children and youth complex health care needs, and adolescents. The role of the advisory board is to promote the health and well-being of women, infants, children, children with complex health care needs, and their families. The board advises the Steering Committee on their state priorities by providing MCH/Title V initiatives; reviewing the development, implementation, and adoption of programs, policies, and strategies to ensure integration across sectors at the state and local level; and identifying concerns and gaps in services recognized by families/youth/consumers.

Families and consumers also serve in leadership roles in the CYSHCN program's CYSHCN's Care 2 team and the EHDI program advisory committee. The CYSHCN's Care 2 team consist of care coordinators, community health workers, and CYSHCN caregivers/parents. The role of this team is to enhance care coordination within family-centered medical/dental homes for CYSHCN. More specifically, the CYSHCN Cares 2 initiative promotes team-based care, population-based services, transitioning to adult healthcare providers, and family engagement. Much like the CYSHCN program, the EHDI advisory committee partners with EI providers, parents/families of children who are deaf or hard of hearing, and adults who are DHH. Families serve in this capacity to ensure that their concerns are heard and that the services provided are family centered.

Conceptual Frameworks

Life Course Framework

Public Health uses the life course framework to conceptualize the factors that impact an individual's health across the lifespan and the underlying social, economic, and environmental factors that drive health inequalities. The life course framework can be illustrated with a chart (see figure below) of a timeline from birth through five years of age showing growth curves measuring readiness for learning. There are three trajectories, a "healthy" trajectory, an "at-risk" trajectory, and a "delayed/disordered" trajectory, showing the negative impact of risk factors, such as poverty, lack of health services, and toxic stress, and the positive impacts resiliency factors, such as parent education, emotional health, literacy, reading to child, appropriate discipline, health services, and preschool.



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

Socioecological Model

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

act across multiple levels to be successful.



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

State Health Improvement Plan (SHIP)

To align with the goals of the Title V MCH Block Grant and improve the accountability of performance in Mississippi, on August 26, 2020, the State Health Assessment and Improvement Committee (SHAIC) convened to explore key findings from the four completed SHA processes and identify cross-cutting issues that need to be addressed to make progress towards achieving the vision for *all Mississippians living healthier, longer lives due to a thriving public-health effort supported by active and committed citizens and organizations.*

MSDH began its first-ever State Health Assessment (SHA) and State Health Improvement Plan (SHIP) to determine the state's greatest health needs and identify a strategic approach to addressing the identified MCH priorities. The state health assessment and improvement plan involved the MSDH Senior Advisory Committee, State Health Assessment, and Improvement Committee, MSDH Staff Leadership Team and Community Engagement and Input. The overall process was a collaborative effort that engaged more than 19,000 residents, public health professionals, and community partners across the state.

Findings included:

- *Mississippi is experiencing a public health crisis. In 1996, 19.8% of the adult population was obese. By 2019, the obesity prevalence in our population had increased to 40.8%. If the tide does not change, the percent of obesity in our population will reach over 50% by 2024.*
- *Social determinants of health (SDOH) are the conditions and environments in which people are born, live, learn, work, play, worship, and age. SDOH contribute to health disparities and inequities. In addition to promoting healthy choices, public health organizations and their partners in sectors like education, transportation, and housing can take action to improve the environmental conditions of Mississippians, including people of color, tribal members, and the socioeconomically disadvantaged. The Mississippi State*

Health Assessment Improvement Committee (SHAIC) has identified SDOH as a priority area for Mississippi's State Health Improvement Plan to, "create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.

Using the quantitative and qualitative findings from the SHA, MSDH selected six priority issues across two categories.

Fighting Against Obesity to Manage Chronic Disease

- Decrease Obesity rates through reduction in food insecurities
- Decrease Obesity rates through the promotion of healthy lifestyles

Improving Social Determinants of Health

- Increase access to preventive health services
- Decrease preventive health barriers related to health literacy
- Decrease the proportion of individuals with disabilities who experience barriers to preventive health services
- Decrease the impact implicit bias has on health

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

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

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

Training and Professional Development Needs

Since the beginning of the COVID-19 pandemic, the agency has undergone significant staffing changes that have called for ongoing training for both new and existing staff members to support them in performing effectively in their roles. For programs to serve the community effectively, staff needs at the agency and program level must be addressed. Many programs have begun exploring new methods for ongoing professional development, including the individual coaching, peer coaching, virtual Grand Rounds, virtual conferences, and online credentials.

The Office of Human Resources conducted a 2021 Workforce Training Needs Assessment to further evaluate the training needs required for staff. In addition, the OHS is also in the process of launching a Workforce Development Program for the Maternal and Child Health (MCH) Programs. With the new program, MSDH is looking to improve its programs and MCH health outcomes by:

- Improving cross program communication.
- Enhancing data collection and sharing.
- Promoting staff development and professional benchmarks.
- Expanding availability of quality infrastructure for operations.
- Improving alignment of patient service delivery

Developing a quality MCH Workforce is essential to improving Mississippi's health and well-being. The MSDH needs a diverse, knowledgeable, and motivated public health workforce to serve communities; however, the agency has significant challenges with recruiting and retaining qualified workers, increased retirements, and professional shortages (e.g., nursing). The agency needs to improve training, education, and credentialing of personnel, create an environment promoting employee engagement, increase efficiencies in service delivery, and increase the ethnic diversity of the workforce to reflect the communities served.

According to the most recent MSDH Human Resource internal survey of staff, the average employee has 10.5 years of experience and is 49 years old. Agency employee demographics are 83% female and 17% male and 50.1% Black or African American, 47% Caucasian, 0.94% Asian, 0.79% Hispanic, 0.15% American Indian/Alaska Native, and 0.25% other.

MCH Workforce Development Office

In July 2021, the MCH Workforce Development Office was created to assess, coordinate, and provide Health Service and Title V staff and interns with applicable knowledge about public health, MCH, and health services. With the support of the Title V Learning Journey project from the National Workforce Development Office at University of North Carolina at Chapel Hill, the MCH Workforce Development Office was able to identify a departmental mission and vision statement, three overarching population focus areas, and four values:

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

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

MCH workforce in the state of Mississippi.

Populations: Increase capacity and infrastructure of Health Service's Staff and MSDH; Pipeline from Institutes of Higher Learning to Public Health; and Community partnerships.

Values: Culture & Environment Change; Growing Staff with Joy; Communication; and Leadership Cheerleading.

During the first year, the MCH Workforce Development Office focused on assessing the needs of the current staff. A needs assessment was conducted to determine the demographics and professional development (PD) needs and wishes of Health Service/Title V staff. The survey went to 219 staff members and had a 55% response rate. Of those who responded, 64% were Black or African American, 92% were female, 7% were male and 1% preferred not to answer. The employee age distribution is 15.7% ages 25-34, 28.1% 35-44, 35.5% 45-55, 18.2% 55-64, and 2.5% are 65-70 years of age. Regarding employment status, 89% are full-time employees, 7% are full-time contract employees, 4% are part-time contractors or preferred not to answer. The educational level of the Health Service staff includes: 2% high school degree or GED, 12% 2-year college degree, 46% 4-year college degree, 29% Master's degree, 7% PhD or higher, and 4% preferred not to answer. Among the desired training topics were team building, leadership, communication, critical thinking, customer service, decision making, and problem solving.

To address the variety of learning styles among staff, the MCH Workforce Development Office offers numerous PD opportunities. An educational update email, "Connections: Partnering with You," is sent quarterly and highlights current public health trends, leadership topics, features one MSDH Program each edition, a copy of the upcoming training calendar, and knowledge about other professional development opportunities. The current distribution list includes 260 MSDH staff members. The Training Calendar offers webinar training twice a week, with one track focused on public health based on the MCH Leadership Competencies topics and the others are pulled from the survey topics requested. Over 100 webinars have been provided between April 2022 to March 2023, with 366 participants. Titles include: *The Impact of Coaching on Engagement*, *Declaring Racism as a Public Health Crisis*, *Cognition and Language*, *Cross-Cultural Communication*, *Advancing Equity and Justice by Connecting Evaluation to Strategy*, *Finding Your Voice as a Leader*, *Teamwork: Small Acts, Big Wins*, and *Reimagining a Public Health System to Build an Equitable Tomorrow*.

The *Leadership for All Book Club* was another PD opportunity that garnered 48 participants. Offerings included, *Developing a Leader Within You 2.0* by John Maxwell, *A Leader's Guide to Unconscious Bias* by Pamela Fuller and *Motivational Interviewing* by William R. Miller and Stephen Rollnick. For the self-paced learner, the MSDH Learning Management System (LMS) hosts 18 self-paced training modules from basic computer skills to case management knowledge-based concepts such as *Cultural Humility for Case Managers*, *Reflective Supervision*, and *Home Visiting Safety for Case Managers*. There is also a *Health Service/Title V Programmatic Orientation* module for new staff to watch.

Professional Development Opportunities

Many MCH programs also offered PD in the reporting period.

In 2022, the MSFSEIP and Mississippi State University kicked off the Early Intervention Credential – Level I, an entry-level credential for all individuals working with young children ages birth to 36 months of age who have developmental delays and disabilities and their families in the state. The Level I Early Intervention (EI) Credential is a 240-hour online certification program consisting of 6 modules focusing on: introduction to EI; family-centered practice; IDEA law; evidence-based intervention and instruction; coordination and collaboration; and

professionalism. The MSFEIP also provided workshops on procedures for assessing infant and toddler language development using virtual procedures. The MSFEIP used a Train-the-Trainer approach to ensure the state could sustain these efforts. (See *Child Health Annual Report*)

The MSDH Quality Improvement (QI) Office provides a QI process training to introduce the general benefits and reasoning behind quality improvement, provides the introduction of 11 analytical tools and hands-on group activities. During the reporting period, 128 staff participated in the QI Introduction Training and 62 participated in the QI Intermediate Training. The QI Office partnered with the Mississippi Public Health Institute (MPHI) to obtain two consultants, Lamarr Lewis and Yolanda Pruitt, to provide in-service meetings, called, "Leading Where You Are: Building Connections through Effective Communication," across the state focused on communication methods and effective customer service.

The Office of Tobacco Control provided all funded partners and the Mississippi Tobacco Control stakeholders with information and training regarding tobacco control initiatives that address maternal-child health. Trainings provided included: Two Virtual Tobacco Treatment Specialist Workshops and one Treatment of Tobacco Use During Pregnancy Training. Tobacco cessation trainings were based on the U.S. Public Health Service Guidelines for Tobacco Cessation, and include, pharmacotherapy updates, treating disparate populations, pregnant women, etc. These trainings ensure that staff have a sufficient level of awareness, skills, education, and resources to effectively implement programmatic activities that impact tobacco prevalence among pregnant women and women of child-bearing age.

The Public Health Pharmacy used their Residents to enhance their office PD opportunities. When the Public Health Pharmacy increased the number of pharmacy residents from two to four, the Pharmacy initiated an "every Wednesday" internal training program to offer more consistent training and communication. Offerings included: *departmental policies and procedures, pharmaceutical services processes* (i.e., drug utilization reviews), *navigating specialty HIV medications from procurement to insurance processing to individualized packaging*, and *clinical training*. Residents review or prepare materials for the "every Wednesday" training program.

The Pharmacy Residents enhance the public health infrastructure by working in areas of Specialty Pharmacy Practice (HIV, Tuberculosis, Disease Outbreak), Health Protection (Emergency Planning and Response), Women's Health, MCH, Chronic Diseases, Antibiotic Stewardship, Telehealth, and Community Pharmacy Practices. The Pharmacy residents participate in activities beyond pharmacy staffing, such as academic detailing for the LPPHHP, the pharmacy's opioid program, and antibiotic stewardship, participating in emergency planning and response, assisting with diabetes self-management education and support.

The WIC program houses multiple departments, all of which have individualized professional developmental training needs and goals. The Nutrition office provides professional develop offerings for the MSDH Regional and County level Nutritional staff twice a year. November 9-10, 2021, 29 staff members attended; September 15-16, 2022, 33 staff members attended.

The Breastfeeding Promotion and Support Department focuses on providing education to community partners, including:

- Making an Impact in the Lactation Community – Oct. 6, 2021, a virtual conference sponsored by the Mississippi Breastfeeding Coalition with 130 attendees
- Meet in the Middle: Breastfeeding in the Center of it all – Jan. 26, 2022, a virtual conference sponsored by the Delta Breastfeeding Coalition with 120 attendees.
- Mom and Baby Excel Breastfeeding Conference – Feb. 17, 2022, and March 24, 2022, a 2-day virtual

conference sponsored by Jackson State University.

IBCLC Mentorship and Scholarship Program is an ongoing lactation education program designed to prepare candidates to sit for the lactation consultant exam, with the goal of increasing access to board certified lactation consultants within the WIC population. The WIC Program partnered with the Mississippi Breastfeeding Coalition and MSPHI to implement an International Board of Lactation Consultation (IBCLC) Mentorship and Scholarship program to benefit 20 WIC peer counselors. Peer counselors received assistance with training and study materials. A total of 23 individuals participated. Of these 23, 8 are new IBCLCs, 6 are awaiting test results, and 9 are eligible to take the exam in September 2023.

The WIC Vendor Management Department is responsible for providing yearly training to the contractual vendors who assist with the Supplemental Nutrition program. There were 271 vendors trained in FFY '22. One training was held, and it was non-interactive. MSDH WIC Vendor Management Unit sent out training newsletters. All vendors verified receipt and understanding on or before September 1, 2022.

The Mississippi Public Health Association (MPHA) assisted in developing a needs assessment of HM/HB nurses, MSDH nursing leadership, social workers, social work leadership, and nutritionists and collaborating with the University of MS Medical Center (UMMC) School of Nursing faculty to create standardized procedures of care for nurses to use for the revamped Healthy Moms/Healthy Babies program consistent with the goals and aims of the HM/HB program, evidence-based public health nursing practice, MS Medicaid specifications, and MSDH policy. MPHA also partnered with UMMC to develop a 12 module-based training program for nurses in the HM/HB program modeled after the Association of Women's Health, Obstetrics, and Neonatal Nursing as well as best practice procedures from other states, including: Anatomy and Physiology of the Pregnant Woman, Care During Pregnancy, Education of the Patient, Family and Team Member, Family Planning During the Postpartum Period, Gestational Onset Problems in Pregnancy, Newborn Assessment, Newborn Potpourri, Personal Safety with Home Visits, Planning Care for Childbirth, Postpartum Depression, Postpartum Care, Pregnancy with Pregestational Problems, Social Determinants of Health, Substance Use and Abuse.

To meet the needs of the HM/HB social workers, Dr. Brenda Sumrall Smith assisted in developing and conducted standardized training with MSDH HM/HB staff in Spring 2022 based on a social work education needs assessment. Dr. Sumrall Smith, a Licensed Clinical Social Worker (SW), Licensed Marriage and Family Therapist, and Board-Certified Diplomate in Clinical SW, has over 46 years of experience in SW in healthcare and retired as Director of Social Work for UMMC, where she also served as a clinical instructor on the faculty and on UMMC's Ethics Advisory Committee. Dr. Smith was a long-time Board member of the multi-disciplinary National Perinatal Association and is a past president of the National Association of Perinatal Social Workers. The training included topics on Perinatal Psychosocial Assessment, Postpartum Depression and Edinburg Scale, Understanding Complications in Pregnancy, Helping Families Cope with Common Infant Complications, Grief in the Perinatal Period-Helping Clients, Understanding Perinatal Terminology. About 50 internal and external Nurses, Social Workers, Nutritionists participated in each training course. Training was live, recorded and posted for future use on the MSDH LMS. HM/HB staff participated in trainings about tobacco cessation and pregnancy, Syphilis treatment and updates for pregnant women and infants.

The Office of Oral Health completed employee PD, trainings for health care providers and community trainings. The employee PD focused on knowledge and skills regarding oral health subjects, new information and research updates. The Office of Oral Health provided community members trainings on the following topics such as: Dental Hygiene 101, Cavity Free in MS Oral Health, and Cultural Competence training. The Office continues to encourage and expose elementary to post baccalaureate students to numerous careers in dentistry. Team members provided information during career fairs stressing the role of oral health in overall health and well-being and the need for more

dental professionals.

The MCH Workforce Development Office participated in the 2022 Exploratory Workforce Learning Journey with the National MCH Workforce Development Center. The Mississippi team was interested in developing a multiyear strategic plan creating a roadmap to ensure activities build upon each other and align with the needs and strengths of public health staff, develop an orientation for new employees and students surrounding public health, Title V and MCH, and assessing staff knowledge through the dissemination of a survey to identify the gaps in knowledge and skills of the MCH staff. The Mississippi team participated in all three phases of the Learning Journey between January 2022 to March 2023. The team participated in monthly skill building sessions where tools and resources were shared, participated in individual and group coaching sessions, and accomplished the three proposed projects. August 2021, the National MCH Workforce Development Center hosted a half a day learning session for Title V staff, exposing them to such tools as Appreciative Inquiry, Dreaming/Visioning, and System Support mapping. The following day and a half were set aside for technical support in developing the 1-3 year strategic plan, vision, and overarching umbrella of programmatic values.

With the assistance of the National MCH Workforce Development Center, Centers of Excellence in MCH, two interns were hosted by the MCH Workforce Development Office summer 2022. They were able to analyze the MCH Workforce Development Office survey of professional development topics requested by Health Service/Title V staff. During the one-year anniversary celebration of the MCH Workforce Development Office, staff participated in a questionnaire regarding their interest in professional development opportunities covering the MCH 12 competencies. The top 3 choices were communication, interdisciplinary/ interprofessional team building, and developing others through teaching, coaching, and mentoring. The results of both surveys serve as a baseline regarding the professional development opportunities provided on the monthly training calendar.

The MSDH has numerous departments and programs which utilize social workers in providing a broad array of micro, mezzo, and macro services. The MSDH MCH Workforce Development Director (LCSW) is the representative responsible for serving as the Social Work continuing education (CE) coordinator and follows all guidelines set forth in the Mississippi Board of Examiners for Social Work and Marriage and Family Therapists' Social Work Continuing Education Guide for CE Providers along with nine (9) MSDH SWs who volunteer to be part of the Internal Review Committee. As an approved Designated Provider (DP) of Social Work CE, MSDH offers Social Workers CE opportunities they would otherwise be obligated to obtain through outside sources often at their personal expense. Social workers must renew their licenses every two years and are required to submit evidence of having earned 40 hours of continuing education. From October 2020 to July 2022, MSDH as a designated provider of Social Work Continuing Education sponsored 67 offerings and granted over 1,114 hours of continuing education at little to no cost to the social workers. This is a valuable service MSDH can provide its social workers and others throughout the state with an interest in public health.

MSDH encourages growth of employees through a variety of professional development opportunities. Yearly, MSDH mandates training for all MSDH employees which includes annual HIPAA, Privacy Policy Training, and IT Security Policy training. Staff members are encouraged and were able to attend and/or present at the following national conference, CityMatCH Annual Conference, American Academy of Pediatrics and National Conference and Exhibition, AMCHP, and American Society of Health System Pharmacist (ASHP) and Training. In addition, staff members participate in programs such as CityLeaders, AMCHP Leadership Labs, and national boards such as Workforce and Leadership Development Committee AMCHP.

Pipeline from Institutes of Higher (IHLs) Learning

There are several ways that MSDH is working on developing a “pipeline from IHLs” to Public Health. To provide internships, there needs to be an agreement between MSDH and the IHLs. Since October 2021, the agency has obtained 35 in-state Memorandums of Understanding and 15 out-of-state Memorandums of Understanding with IHLs. Health Service programs were able to host seventeen plus interns from disciplines of Public Health, Social Work, Dentistry, and Pharmacy. The MCH Workforce Development Office and the MSDH Human Resources Department began creating guidance for Health Service Programs surrounding internships. These documents are in pilot stage before moving towards agency approval.

The Office of Oral Health continues to encourage and expose students (elementary, middle school, high school, college, and post baccalaureate) to numerous careers in dentistry. Team members continued to provide information during career fairs stressing the role of oral health in overall health and well-being and the need for more dental professionals. The Oral Health Program had two interns, one from Jackson State University who was pursuing a master’s degree in public health with an emphasis in Epidemiology. This student completed over 300 hours and focused his work on reviewing and evaluating Mississippi Pregnancy Risks Assessment Monitoring Systems data from 2016-2019. The student was an international dentist from India who had strong interest in maternal child health outcomes related to oral health. The goal of reviewing this data was to look at reported dental visits while pregnant to identify opportunities to educate on the safety and importance of pregnant women seeing a dentist. Not only did this student complete his master’s degree program but he was accepted into a Public Health Residency Program with the University of Rochester. A returning intern was from Tougaloo College, was the Tougaloo Heart Health Ambassador and Mississippi Rural Dental Scholarship Scholar recipient. This student focused on oral health, cardiovascular disease implications, population health, and public health dentistry. This intern is interested in pursuing a career in dentistry, has completed her degree with a Bachelor of Science in Biology and is now enrolled in the Master of Science Program at Meharry Medical College, School of Graduate Studies and Research. With successful completion of this program, she plans to matriculate into the Doctor of Dental Surgery program at Meharry.

The Oral Health Program continues to partner with the University of Mississippi Medical School, School of Dentistry to provide funding for third- and fourth-year dental students to do clinical rotations in underserved and underinsured communities. Additionally, college and post baccalaureate students interested in Scholarship opportunities were also offered information on the Princeton Review DAT program, and financial opportunities available to assist with dental school admission (DAT) testing fees and application to dental school offered through the Office of Oral Health. Twelve students participated in this dental admissions test scholarship program where, with leveraged funds, scholarships totaling a little over 7,000.00 were provided to support dental school admission preparation and efforts.

The Children and Youth with Special Health Care Needs hosted two social work students. One was Jackson State University, Schools of Social Work – Bachelor level, and the other from the University of Southern Mississippi, Schools of Social Work – Master’s level.

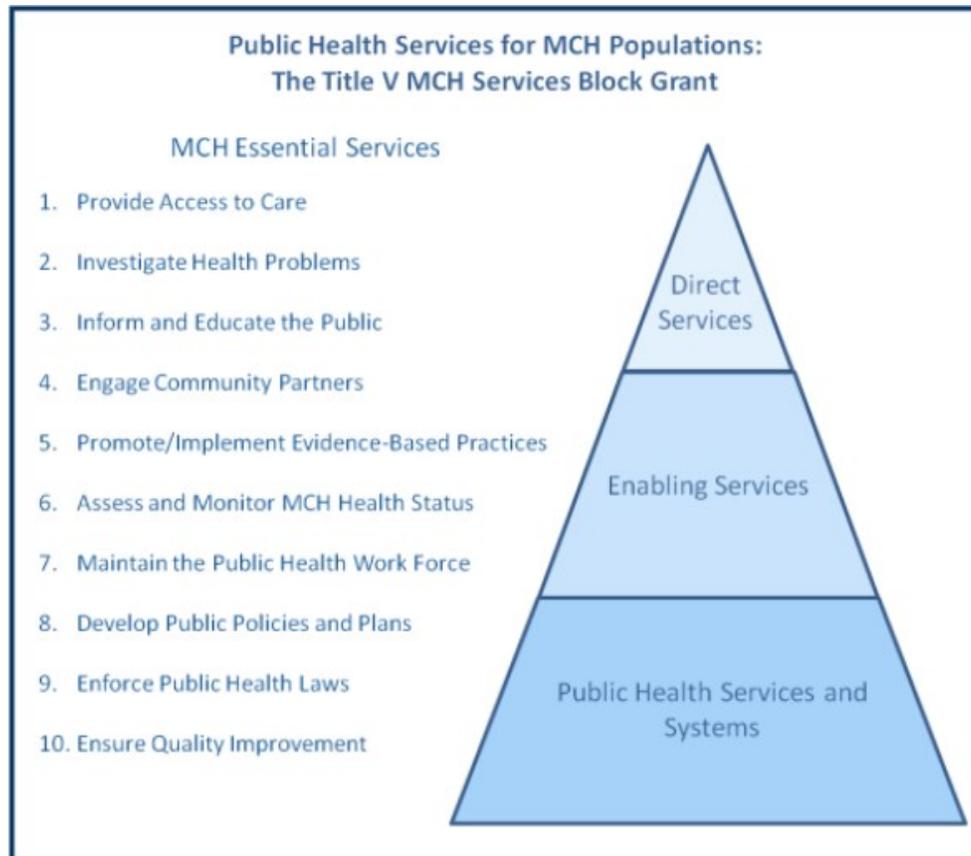
The MCH Workforce Development Office hosted two virtual interns through the National MCH Workforce Development Center, Centers of Excellence in MCH. One intern was from University of California, Berkeley working on her Bachelor of Arts in Public Health and the other was from University of Illinois at Chicago working on her Master of Public Health with a focus on Maternal Health. They provided increase to staff capacity by disseminating and analyzing the MCH Workforce Development Office Needs Assessment July 2022. In addition, they were able to create a catalog of national training. The interns reviewed videos, self-paced modules, recordings and pdf slides and compiled data including: length, recommendation for others, and main takeaways. All content was published from 2017- 2022.

This catalog represents the compilation of MCH-focused training to address professional development topics

around leadership, cultural competence, equity and inclusive health practices. Data came from the following four National Public Health and Public Health-MCH-focused portals: MCH Navigator, Region IV Public Health Training Center, Tennessee Public Health Training Center, and CityMatCH. Trainings fall under the following categories: Leadership – Conflict Negotiation, Leadership – Concepts and Theories, Leadership – Developing Self and Others, Communication, MCH Conceptual Models, Cultural Competency, Equity and Inclusion, and Working with Communities and Systems.

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

MSDH recognizes family/consumer engagement as a pivotal component in establishing family-centered programs and policies to improve maternal and child health outcomes across all populations. MCH programs have implemented family/consumer strategies at the state and local levels in alignment with MCH services.



Mississippi's MCH programs continue to strive towards giving families a voice in all levels of program implementation through:

- Parent feedback survey that assesses services provided by MCH Programs;
- Family/consumer public input survey;
- Contractual relationships with family organizations such as Family as Allies;
- Outreach, mentoring, and training offered to families;
- Focus groups to gather input for various MCH programs;
- Parents hired as parent consultants; and
- Family representatives on the Mississippi Early Hearing Detection & Intervention Advisory Council, Mississippi Genetics Advisory Committee, CYSHCN Leadership Team.

Parent Feedback

MCH programs have utilized various social media platforms to educate and strengthen family voices throughout their work. Programs such as Oral Health, Early Hearing Detection and Intervention, and Breast and Cervical Cancer have used social media to disseminate information, especially during health observances. Oral health highlighted many health observances and used this opportunity to educate the public on the connection to oral health. The Office of

Oral Health focuses on the months of February (National Children’s Dental Health Month), March (World Oral Health Day), April (Oral Cancer Awareness Month), and October (Dental Hygiene Month).

Outreach and Education

MS-BCCP is broad and inclusive. Beyond the state-level program staff, it includes all enrolling, screening, and diagnostic providers across the state, as well as community partners who link participants with those providers through individual interactions, group meetings, and larger community events. MS-BCCP depends heavily on the collaboration of this entire network sharing an equal lift to reach women, provide information and education about breast and cervical cancer and screening, explore their fears and reservations, assess their barriers and needs, provide solutions and resources, and directly care for them through their own systems. Daily, these providers and partners see women in their clinics, hospitals, and imaging centers. They encounter them in their churches, community centers, and other shared spaces where they live, work, and play. Their experiences will be as varied and diverse as the women they serve. MS-BCCP collaborates exclusively with subgrantee partners who employ patient navigators, community health workers, and/or patient health advocates to help women work through their direct needs and their reservations about screening. These partner staff speak the patient's language literally and figuratively to assure all barriers to screening have been explored and not just those typically addressed with tangible assistance. These subgrantees have been strategically selected and are located among the most vulnerable areas of Mississippi. MS-BCCP also partners with the Mississippi Comprehensive Cancer Control Program (MCCCP) Leadership Steering Committee and the Partnership for Comprehensive Cancer Control (MP3C) through the active participation on their annual conference planning committee and the Cancer Survivors Educational Conference.

Additionally, among the diverse staff within the MS-BCCP program, we have a breast cancer survivor, who routinely provides insight on how information, messaging, etc. might be perceived or received among women in the high-priority populations.

The Maternal and Infant Health Bureau continued its partnership with Six Dimensions, LLC consulting group to conduct maternal health awareness and provide outreach events in the community to better understand women’s birthing experiences, especially those who suffered severe maternal morbidity during their birthing experience. Six Dimensions utilized the Laboring with Hope documentary (Laboring with Hope is a short documentary that addresses the national maternal mortality crisis among Black women. The film is used as a public health strategy to support improving Black maternal health outcomes), Facebook Live discussions, and other events to build a safe space for women to share experiences and what services they wish were available and or could have had access to while pregnant. The findings from these discussions helps the MSPQC work to address clinical gaps and identify community-based partnerships and resources to help women prenatally and postpartum. Key findings from these sessions included:

- Identifying strategies for women to navigate the system for better birthing experiences.
- Listening to, trusting, and respecting the perspectives of black mothers and other pregnant people. Providing education and space for support people to be actively involved throughout the perinatal period. Supporting doula care for parents who are interested in expanding their support team.
- Providing education on perinatal conditions that can affect mothers such as fibroids, miscarriage, and postpartum health.
- Addressing perinatal mental health through education.
- Connecting mothers with the necessary supportive resources in a timely and cohesive manner. Assisting mothers in exploring options for managing labor.
- Providing evidence-based information on delivery options available. Creating community resources guides for expecting families

- Developing and disseminating and advocacy guide to help empower families when making perinatal decisions.

The key findings from events held in partnership with Six Dimensions, LLC provided an avenue for the Maternal and Infant Health Bureau to address many of the clinical gaps identified through the MS Perinatal Quality Collaborative and the Maternal Mortality Review Committee.

The Office of Oral Health has also used family engagement practices to build protective factors against poor dental health through education and outreach. With federal allowance of virtual WIC certifications due to the COVID 19 pandemic, the Office of Oral Health modified outreach efforts with the WIC program by working more intimately with the nutritionists and clerks to provide oral health aides, education, age-appropriate toothbrush and toothpaste, and floss.

The Office of Oral Health worked with the WIC team to ensure harmony in maintaining oral health services currently being offered. During the grant reporting period, our office provided oral health services to:

June 2022

- Wayne County WIC -50 ORAL HEALTH kits for kids, 50 ORAL HEALTH kits for adults.
- Bolivar County Health Department (WIC Nutritionist) – 24 infant oral health kits and 2 “Baby Teeth are Important” posters.
- Sunflower County Health Department (WIC Nurse) – 18 infant oral health kits and 25 ‘Healthy Mouth for Your Baby” literature.

September 2022

- Clarke County WIC – 50 finger toothbrushes, 50 adult toothbrushes, 25 child activity books, and 50 “Wiping Out the Mouth” handouts.
- Leake County WIC – 4 dental referrals to Hispanic parents (Translation services are needed.)
- Smith County WIC – 5 participants and 2 dental referrals

Our office also worked with other MSDH and community partners to provide oral health kits and education to children and mothers outside of the WIC program. These activities were:

November 2021

- Washington County Health Department – 12 adult toothbrush kits, 8 children’s toothbrush kits, 10 infant rings, 30 kids toothpaste, 30 oral health education booklets.
- Sunflower County Health Department – 72 adult toothbrushes, 144 youth toothbrushes, 40 floss, 40 oral health education booklets.

December 2021

- Greenville High School (864 adult toothbrushes, 864 teen oral health education booklets.
- McWillie Elementary (Carolling event) – 16 children’s toothbrushes, 3 adult toothbrushes.
- Akin Elementary – 357 youth toothbrushes, 160 oral health education booklets.
- Boyd Elementary – 3557 youth toothbrushes, 160 oral health education booklets.
- Tunica County Health Department – 30 adult oral health kits, 8 children’s oral health kits.
- Tate County Health Department – 30 adult toothbrushes, 30 youth toothbrushes, 15 kids toothbrushes, 5 infant rings, 20 finger brushes.
- Desoto Health Department – 24 adult toothbrushes, 30 adult toothpaste, 15 kids toothbrushes, 5 infant rings, 20 finger rings.

- Sunflower County (Rulleville) – 10 adult oral health kits, 10 youth toothbrushes.

January 2022

- Alcorn County Health Department- 50 adult toothbrushes, 25 finger brushes.
- Prentiss County Health Department – 25 finger brushes, 20 oral health education booklets.
- Union County Health Department – 50 adult toothbrushes, 20 adult toothpaste, 20 floss, 50 youth toothbrushes, 20 kids toothpaste, 20 infant ring toothbrushes, 25 finger brushes.
- Marshall County Health Department – 50 adult toothbrushes, 20 adult toothpaste, 20 floss, 50 youth toothbrushes, 20 kids toothpaste, 20 infant rings, 25 finger toothbrushes.
- Desoto County (Olive Branch) – 50 adult toothbrushes, 20 adult toothpaste, 20 floss, 50 youth toothbrushes, 20 kids toothpaste, 20 infant rings toothbrush, 25 finger brushes.

February 2022

- Jackson County Landry's Land of Learning (16 adult and 80 youth kits.) February 2021
- Madison County Madison Crossing Elementary K-5th grade students (provided 675 ORAL HEALTH kits)
- Forrest County oral health training to teachers 23 at Forest Head Start. 160 ORAL HEALTH kits were provided to those children attending Head Start virtually that had not seen a dentist.

June 2022

- Legacy Village Oral Health Presentation (youth and infants presentation) - 10 infant oral health kits (contains ring toothbrush and toothpaste), 25 youth oral health kit (contains ring toothbrush, flossers, and toothpaste).

September 2022

- Clarke County Wellness Clinic for Pregnant Women – finger brushes, oral health education brochures, and 50 adult toothbrushes.
- Choctaw Health Center (medical clinic) – 50 toddler brushes and 50 adult brushes.
- MSDH Healthy Moms Healthy Babies (50 participants) – 50 adult toothbrushes, 50 finger toothbrushes, and 50 child toothbrushes.
- Jackson County MSDH Healthy Moms Healthy Babies – 24 infant/toddler toothbrushes, 12 adult toothbrushes,
- Harrison County MSDH Healthy Moms Healthy Babies – 24 infant/toddler toothbrushes, 12 adult toothbrushes.
- Hancock County MSDH Healthy Moms Healthy Babies – 12 infant/toddler toothbrushes and 12 adult toothbrushes.
- Pearl River County MSDH Healthy Moms Healthy Babies – 12 infant/toddler toothbrushes and 12 adult toothbrushes,
- George County MSDH Healthy Moms Healthy Babies – 24 infant/toddler toothbrushes and 24 adult toothbrushes.
- Hispanic Festival 1st Annual Event (Forrest County) – 125 adult, 50 child toothbrushes and 100 floss.

In addition to using education and outreach to build protective factors, other programs have used this opportunity to link families to necessary services. OTC provided the Baby & Me Tobacco Free Program MS Telehealth Referral Training to Northeast MS telehealth counties: Chickasaw, Itawamba, Pontotoc, Calhoun, Monroe, Lee, Union, Benton, Marshall, Union, Tippah, Alcorn, Prentiss, Tishomingo, Lafayette. Through this approach, the program was able to complete an intake for 641 women between the ages of 18-44.

The CYSCN program is committed to the foundational principle of empowering families to be leaders in their healthcare decisions. The Parent Outreach Coordinator works with Parent Liaisons within our CYSHCN partner organizations on ways to support families by hosting monthly webinar sessions on topics of choice as decided by the

Parent Liaisons. These sessions allow for a free flow of conversations and address questions or concerns that parents and our transitioning CYSHCN may have themselves.

The CYSHCN team also conducted outreach via health fair or panel participation across the region providing information and supports to families. Some activities were:

November 2021

- CYSHCN Cohort Partnership Training

January 2022

- CYSHCN Cohort Partnership Training

February 2022

- Family Healthcare Center Tougaloo College, Jackson
- Jackson Hinds Comprehensive Health Center, Jackson

March 2022

- MS Centers for Advanced Medicine, Jackson
- G.A. Carmichael Health Care Center, Canton
- Family Health Care Center, Laurel
- Yalobusha Health Clinic
- Youth Mental Health First Aid, Gulfport

April 2022

- Sickle Cell Health Fair, Summitt
- JSU School of Public Health, Ridgeland
- Aaron E. Henry Health Clinic, Lexington

May 2022

- Family Engagement Symposium, Jackson
- CYSHCN Partnership Clinic Learning Session, Jackson

June 2022

- Help Me Grow Health Fair, Madison

July 2022

- Health Homs/Health Babies Kickoff, Raymond
- Young Adult Mental Health First Aid, Madison

Advisory Committees

Maternal and Child Health Advisory Board

The Maternal and Child Health Advisory Board assists all MCH programs by:

- Reviewing the development, implementation, and adoption of programs, policies, and strategies to ensure integration across agencies and systems
- Advising on methods of integration at the local and state level
- Advising use of block grant funds to address needs in local communities based on state measures and

supported by data

- Assisting in the development of information on MCH services and activities to ensure information is created in a culturally, literacy-level, and linguistic manner

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

State Interagency Coordinating Council (SICC)

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

EHDI-MS Advisory Committee

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

Genetics Advisory Committee

The Genetics Advisory Committee (GAC) provides recommendations to the MSDH and Board of Health regarding rules, regulations, and procedures governing the operation of newborn screening and birth defects, including adoption of conditions to the Mississippi Newborn Screening Panel. The committee meets twice annually and is comprised of 13 volunteer members, including national experts, clinicians, consumers, parents, advocates, and partner agency representatives. Although the passage of HB 927 in 2022 requires the Mississippi Newborn Screening Panel to include all Recommended Uniform Screening Panel (RUSP) conditions within three years of adoption, the GAC supports the NBS Program in development and implementation of guidance and education for healthcare providers and families on current and conditions newly added to the RUSP, identifying and sharing testing and treatment options, guidance on public awareness and prevention efforts, and recommendations on newborn screening fees.

LPPHHP Advisory Board

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

requirements for screening, testing, follow-up, and reporting.

Community Water Fluoridation Advisory Board Committee

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

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

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

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

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

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

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

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

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

The Health Data and Research and Vital Records and Public Health Statistics epidemiologists partnered with the Chief Health Data, Operations and Research Officer and Data Governance Director to participate in the ASTHO DREAM Learning Collaborative to create a small numbers policy and avoid erasure in MCH data reporting. The MCH epidemiologists and research biostatisticians participated in AMCHP, ASTHO, HRSA/MCHB and CSTE live in-person and virtual and archived trainings and peer learning opportunities. The team is also actively involved in the MSDH Grand Rounds and several presented projects and analyses during the grant year.

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

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

Goals and Activities

Goal 1: Build and expand state MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation

SSDI supports building Mississippi's MCH data capacity to support Title V program efforts and contributes to data driven decision making in public health and clinical programs. This includes needs assessment and Title V MCH Block Grant data support, identification of structural and process measures for Title V program and supporting MCH programs to develop State Performance Measures (SPMs) to address priority needs. To meet this goal, the agency focused on the following activities:

- Providing data support to MCH programs, for the Title V Block Grant application and reporting processes
- Establishing and reviewing performance measures and developing and reviewing structural and process strategy measures;
- Supporting a statewide Needs Assessment for the Title V Block Grant
- Providing data and technical support for timely and accurate submission of the Title V MCH Block Grant.

The 2020 Title V Maternal and Child Health Comprehensive Needs Assessment collected and captured vital perceptions of mothers, providers, adolescents, children, children and youth with special health care needs and their families. The surveys, key informant interviews, and information from focus groups allowed MSDH to have a general picture of the disparities and needs across MCH populations in the state. These data informed MSDH's efforts to adjust and realign its MCH priorities to compensate for shifting population and resource needs and create new state MCH priorities.

The Title V/SSDI workgroup developed MCH partnerships to address aspects of data availability and use through data linkage. The successful Pregnancy Risk Assessment Monitoring System (PRAMS) data and newborn screening data are still working proof of concept data linkage available for MCH data analysts to understand the linkage process and data requirements. The work group worked with internal and external partners to initiate all necessary MOU that will allow them to work together to close the data gap and access the data elements necessary to meet the Minimum or Core Datasets (M/CDS). To meet M/CDS, an assessment was conducted to evaluate Mississippi's capacity for reporting on the M/C Indicators. Most of the data were captured through the Office of Vital Statistics, Electronic Health Records from EPIC and the Mississippi Division of Medicaid. Therefore, the SSDI team worked on expanding their partnerships with these stakeholders.

Goal 2: Advance the development and utilization of linked information systems between key MCH datasets in the state

During previous grant cycles, the agency was able to renew existing MOUs with the Division of Medicaid, expand internal partnerships with the Office of Vital Records and Statistics for the linkage of birth records and program data such as lead poisoning prevention, newborn screening and maternal mortality data, and PRAMS to access essential

data about women before, during and just after pregnancy. For the current grant cycle, Health Services will continue to improve collaboration with internal and external partners. The goals are to identify existing data gaps to meet the Minimum or Core Datasets (M/CDS), initiate all necessary MOUs to close data gaps and access the data elements necessary to meet the M/CDS, implement a new data linkage between birth and death records and hospital discharge data or Medicaid eligibility data; and improve the availability and timeliness of linked MCH data reporting and the utilization.

In previous years, the SSDI epidemiologists supported efforts to obtain, access, and make available M/CDS through various sources, many of which are used for the Title V Needs Assessment and other reporting activities. To meet M/CDS, an assessment of Mississippi's capacity for reporting on the M/C Indicators was conducted. Much of the data are captured through the Office of Vital Statistics and the Mississippi Division of Medicaid (DOM), the major MCH stakeholders. To expand SSDI partnerships with the Office of Vital Statistics, no MOU was required; however, to capture data from DOM renewing the existing MOU was needed, which has been concluded. For the coming year, SSDI/MCH epidemiologists will continue to analyze both unlinked and linked data sets as needed to support programmatic efforts. MSDH will maintain the data sharing agreement with DOM and increase collaboration with internal and external partners to assess data gaps.

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

The epidemiologists in OHDR and Vital Records and Health Statistics are also working with the LPPHH program to conduct a risk analysis and to produce a GIS supported data visualization to identify the lead exposure risk in the state. The title V/SSDI team are developing a plan for additional data needs assessments to be conducted by the epidemiology staff in the OHDR, and epidemiology staff serving MCH programs throughout the agency.

Goal 3: Support program evaluation activities around the National Performance Measures that contribute to building the evidence base for the Title V MCH Block Grant program

Evaluation is an essential part of the evidenced-based public health evaluation process. Health Services and OHDR recognize the need to create and implement proper tools to effectively evaluate MCH programs. Through performance measurement, Title V/SSDI epidemiologists can collect valuable data that can help improve MCH service delivery and client results. However, performance measurement data cannot necessarily answer all questions about how a program is working or how results were achieved. The MCH program staff and epidemiologists track, monitor, and measure programs' activities and effectiveness.

In the previous year, the SSDI epidemiologist and State Title V Director worked to develop and implement data collection methods to monitor and evaluate MCH program activities (impact evaluation) more effectively. The first phase of development involved utilizing a tool from the Colorado Department of Health to quarterly monitor and track MCH program activities. The reports are submitted quarterly by programs and provide a detailed description of

program activities. The spreadsheet was developed to assist programs with the collection of data to determine the impact of programmatic activities. This tool allowed Title V workgroup to track, monitor and evaluate activities around the NPMs that contribute to building the evidence base for the Title V MCH Block Grant program. This evaluation tool is no longer in use, but we recognize the importance of conducting ongoing assessment activities as well as provide an understanding of how to evaluate progress made towards performance measures, identify new and emerging issues, and examine the state's capacity to implement MCH programs. The MCH epidemiologists and SSDI epidemiologist will continue to meet with MCH program staff and track and monitor the status of each activity pertaining to each NPM and SPM within MCH programs.

MCH epidemiologists and SSDI epidemiologist are developing a systematic method of program evaluation and identifying key indicators for evaluation. This evaluation includes identifying surveys or other data collection instruments that help with tracking and evaluation and meeting quarterly to review the status of each activity pertaining to each NPM. The team intends to develop a plan to conduct and complete the state Title V needs assessment and coordinate training for MCH staff on the importance of ongoing evaluation and needs assessment activities.

The MSDH SSDI program plans to engage with epidemiology and program staff, and the MSDH Health Information Technology offices to update the reporting tool used for programs to submit quarterly reports on block grant activities and strategies. A streamlined reporting system that is accessible to programs and MCH Title V Block grant leadership will facilitate data collection and data use for informed decision-making and evaluation. The MCH Title V Block Grant leadership has forged a renewed partnership with the OHDR, including the OHIT, ODG, Epic (electronic health record), and HDR. A cross-functional team of 19 staff from the offices met weekly to review, analyze and report on the Title V performance measures. The team plans to present recommendations for the Title V MCH Block Grant's ongoing Needs Assessment and will serve as a standing workgroup to evaluate program activities, identify key indicators, identify systematic approaches to evaluation, and develop tools for program needs. The Needs Assessment Coordinator, MCH Title V Director, and PRAMS/SSDI supervisor will be able to engage with MCH leadership on a quarterly basis and provide training where necessary, ensuring all program staff has the tools and information desired for informed decision-making and evaluation. MCH program staff are leveraging their connections with the CDC Maternal and Child Health Epidemiology Program Team have participated twice in the past two years in the CDC-Harvard Evaluation Practicum. In the most recent year, the LPPHH participated in the Practicum, and a comprehensive evaluation plan was developed for the program.

Goal 4: Use of Minimum/Core Dataset (M/CDS) Indicators

The M/CDS Indicators project is an opportunity for the SSDI program to continue data capacity efforts. Currently, the MCH indicators described are not in a comprehensive, singular data source workbook, but the SSDI program is able to advance the use of indicators by the SSDI staff participating in the MCH Title V Block grant reporting process, the MCH Needs Assessment, and by providing ongoing data support to MCH program. Considering this use, some of the ways in which the SSDI program advanced the use of the M/CDS indicators include:

1. Providing the MCH Block Grant program with program-relevant data

The SSDI / MCH Epidemiologist worked with the MCH Title V Director to guide program reporting for the MCH Title V Block grant. This reporting process took place over several months, with large meetings of MCH Office Directors and leadership to discuss the reporting needs and MCH data. The SSDI / MCH Epidemiologist worked with programs and was available for individual technical assistance.

2. Develop internal MCH partnerships to address aspects of data availability and use

The SSDI program sought to increase collaboration with partners internally and externally to develop the M/CDS Indicators during the last grant cycle. The intent was to understand gaps in data access and identify the potential for formal partnerships to increase data access. In addition to the DOM's renewed MOU during the last grant cycle, additional MOUs are being developed.

Goal 5: Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming.

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

The agency has been working alongside the Association of State and Territorial Health Officers (ASTHO) and our Data Road Map for Racial Equity Advancement in MCH (DREAM) Learning Community to develop or enhance MSDH's policies and practices for data gathering, management, and sharing in ways that more effectively promote racial equity in public health. One of the policies written provides a uniform process for sharing small numbers in public health data. To ensure privacy, reports released by MSDH oftentimes have had to suppress or group data points reflecting smaller populations in the state. However, with this new policy, the hope is that an agency-reviewed standard for releasing small numbers will encourage more granularity in data reports and, therefore, shed light on how smaller populations in the state are affected by public health issues. (This standard is to be used only in the absence of another small numbers requirement imposed by the federal government or a separate data-sharing agreement.)

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

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

Increasing Data Capacity Efforts

The Offices of Health Data, Operations and Research conducted activities throughout several offices which support MCH data capacity enhancement activities. The Office of Data Governance provides legal oversight in the sharing and use of MSDH data within and outside the agency. In 2020 the office launched an online data request process for internal and external requesters to easily submit data requests. In 2021 MSDH Institutional Review Board (IRB) functions moved to the office to better coordinate the research and data capacity of the agency. This has enhanced the utilization of data and improved data capacity related to MSDH data. In 2022, the office was a part of a team throughout Health Data, Operations and Research that is participating in the ASTHO DREAM Learning Collaborative to create small numbers policy and avoid erasure in data reporting.

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

Personnel in this office, in collaboration with staff in other Health Data, Operations, and Research Offices, are participating in the FDA grant awarded to the University of Mississippi Medical Center to establish a perinatal COVID-19 databank.

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

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

The Office of Vital Records and Public Health Statistics provides registration, amendment, issuance, and

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

CSTE Applied Epidemiology Fellow

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

Along with the other projects mentioned, the fellow's major project is to work on the Perinatal Periods of Risk for Mississippi. This project will initially identify the overall state, race, and geographical-specific fetal-infant mortality and excess mortality rates over several years to highlight high-risk groups and the disparities that can be found in each. The second phase of this project will identify specific risks such as SIDS, congenital abnormalities, perinatal conditions, injury, etc. that are more prevalent in each community to better tailor prevention efforts by internal and external partners. Finally, with the remaining time left in the fellowship, the fellow looks forward to working with the PRAMS (Pregnancy Risk Assessment Monitoring System) survey, the Child Death Review, and any other MCH opportunities that come along. Also, the fellow anticipates the chance to present findings from the above projects at different conferences/meetings in the coming year.

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

Disasters impact all Mississippians and are particularly difficult for our most vulnerable populations, including those who are challenged whether physically or mentally (vision impaired, cognitive disorders, mobility limited), limited or non-English speaking, geographically or culturally isolated, weakened elderly, pregnant women, and children. The state of Mississippi encompasses an area of 48,432 square miles with 82 counties. The coastline of Mississippi is a short 44 miles across three counties—Hancock, Harrison and Jackson. This area and adjacent inland counties are vulnerable to the threat of tropical depressions, hurricanes, and storm surge and much of the state is vulnerable to other extreme weather, water and climate-related emergencies. The most recent examples of emergency preparation and response are the on-going COVID-19 pandemic, critical disruptions in water plant and water line operations in both the City of Jackson and the City of Vicksburg, massive flooding in the Delta as well as the Pearl River in and around the City of Jackson, severe cold and ice storms across the state, an EF3 tornado in the southeast area of the state, and Hurricane Sandy. Mississippi's public health preparedness is an excellent model of public-private-volunteer cooperation.

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

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

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

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

Mississippi's Title V MCH Block Grant programs have made very intentional efforts to address the cross-cutting needs of the MCH population, knowing that these partnerships and collaborations are the keys that will impact a system level change. Understanding the interconnectedness of these needs, aligns the scope of work needed to improve the Mississippi's MCH populations health outcomes. Recently the Office of Health Services finetuned the states' priorities to include cross-cutting needs such as health equity and mental health. The MCH programs have utilized their partnerships to expand outreach efforts, improve linkage to direct care services, and strengthened care coordination as well as infrastructure building service outside and within the agency. Mississippi has been faced with several challenges including an over-burden health care system, provider shortage, and the crippling effects of COVID-19 pandemic on the physical, mental, economic, and wellbeing of the maternal and child health populations and their families. Access to care to comprehensive health services, equal employment opportunities, fair and safe housing, and racial injustice are some of the leading social determinants of health that continue to impact the health outcomes of our populations. Education and outreach continue to serve as the backbone of much of the work conducted by the Office of Health Services. Education and outreach strategies are used to strengthen the knowledge and capability of families to make healthy, informed decisions regarding the health of their families and community.

The Office of Tobacco Control (OTC) has used its collaboration with the Community Health Center Association of Mississippi (CHCAMS) to address the social and behavioral issues of smoking in women during their pregnancy. Smoking during pregnancy has been proven to cause developmental delays, low birth rate, and an increased risk of SIDS. Through a sub-grant agreement, the program has implemented the Baby & Me-Tobacco Free Program. The Baby & Me-Tobacco Free Program is aimed to reduce the burden of tobacco use among women during the prenatal and postpartum period. The program has been implemented in eleven Mississippi Community Health Centers. The program uses a cessation support design specific to pregnant women. This design is multi-pronged and successfully target low socioeconomic groups by combining brief cessation counseling with bio-maker feedback, while offering practical incentives such as positive reinforcement to maintain smoking cessation. The OTC provides funding, technical assistance, evaluation, and oversight for the partnership / collaboration. The CHCAMS manages the implementation and day-to-day operation of the program through their Memoranda of Agreement with the participating FQHCs. OTC's project manager and the CHCAMS's project director meet regularly to discuss barriers, tactics, and data to determine the best methods to reach and serve Mississippi's pregnant population that are burdened by tobacco use.

To address the issues of safe housing, the Lead Poisoning Prevention and Healthy Homes Program (LPPHHP), through a collaboration with the University of Mississippi, has provided lead testing of the water in homes of children with blood lead levels between 5-14. LPPHHP used this opportunity to increase the identification of children exposed to lead and increase the referrals within their programs, as well as referrals to the Early Intervention and CYSHCN programs based on the level of exposure and the services needed. During the reporting period, 5,418 Medicaid-enrolled children were tested for lead at one to two years of age, 573 children less than 72 months of age identified with an elevated blood lead level, 28 children with a blood lead level of 10 or higher were referred to Early Intervention Services, and 17 were referred to CYSHCN. LPPHHP staff also hosted eight events in which they provided education to more than 500 families regarding the source of lead contamination, signs and symptoms of lead poisonings, and resources available to them. LPPHHP also partners with Green and Healthy Homes to strengthen capacity-building activities, workforce training, community engagement, and funding to reduce lead hazard in alignment with CDC guidelines.

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

The MSDH Title V program has a longstanding, collaborative relationship with the Division of Medicaid (DOM) to ensure all MCH populations have access to the resources and services needed to maintain a healthy life. Mississippi's Medicaid program is one of the largest insurers in the state, serving one out of every four Mississippians through regular Medicaid, the Children's Health Insurance Program (CHIP), or Medicaid's coordinated care program, MississippiCAN. Over 25% of Mississippians identified as low-income (below the federal poverty level) are enrolled in Medicaid. Of the 796,778 Medicaid enrollees, 64.6% of enrollees were contracted through managed care organizations (MCO) and Primary Care Case Management (PCCM), with the remaining 35.4% of enrollees receiving services through the traditional fee-for-service (FFS) structure.

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

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

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

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

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

State Action Plan Introduction

Accomplishing MCH/Title V Goals and Mission

Mississippi's MCH/Title V Program broadly supports and works to improve the health of the maternal and child population in the state. This is done by identifying priority needs and working with partners to leverage program capacity to meet those needs, which ultimately improves health outcomes for women, children, and families across the state. The MCH/Title V Program collaborates with internal and external partners from local to federal levels to assure that all programs serving these populations can be strategically aligned statewide. This strategic alignment is imperative for using resources efficiently and assuring the greatest impact.

Addressing the MCH Priorities

The MCH Block grant supports health within a life course framework across the MCH population domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, Children and Youth with Special Health Care Needs (CYSHCN), and Cross-cutting/Systems Building. Information gathered through the comprehensive needs assessment process was used by the MCH programs and stakeholders to identify strategies and activities to improve outcomes of MCH populations.

After the completion of the most recent Five-Year Needs Assessment begun in 2019, the MCH Block Grant Team determined based on feedback from previous grant reviews the State Action Plan (SAP) development process needed to be revamped to be more collaborative. This effort was intended to break down siloed practices and increase collective efforts across programs; however, due to the COVID pandemic, staff were stretched to cover more responsibilities as other MSDH staff were diverted to address the public health response. Program personnel found sustaining their programs in addition to collaborative planning exceptionally challenging. As COVID testing and vaccinations became more widely available and the state began returning to more normal operations, almost the entire existing MCH Block Grant Team changed positions or left the agency.

In 2022, a new MCH leadership team was established to guide the planning, development, and implementation of the Block Grant. A major goal for this team was to implement a new collaborative process for the development and execution of the SAP to identify shared strategies and activities to address common priorities. This 2024 application and 2022 annual report is a continuation of this transition from program-focused planning to cross-program and cross-domain planning to refine and implement priority-focused plans with shared objectives, strategies, and activities. Both the annual report and application are organized according to priorities. Although the 2022 annual report still mostly reflects activities of one program addressing related objectives, strategies, and activities, the 2024 application has identified many broad objectives, strategies, and activities that relate to multiple programs, enabling a unified approach to improving health outcomes for women, children, and families.

Identified MCH Priorities

As a result of the Five-Year Needs Assessment process, Mississippi's MCH Programs and stakeholders, including community organizations, clinical providers, advocates, and families, identified critical priorities for each of the key MCH populations as well as additional Cross-cutting/Systems Building needs. Priority needs identified for more than one MCH population are indicated with an “**” symbol.

Women/Maternal Health:

- Reduce maternal morbidity and mortality

- Improve access to care*
- Improve oral health*

Perinatal and Infant Health:

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

Child Health:

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

Adolescent Health:

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

Children with Special Health Care Needs (CYSHCN):

- Assure medical homes for CYSHCN

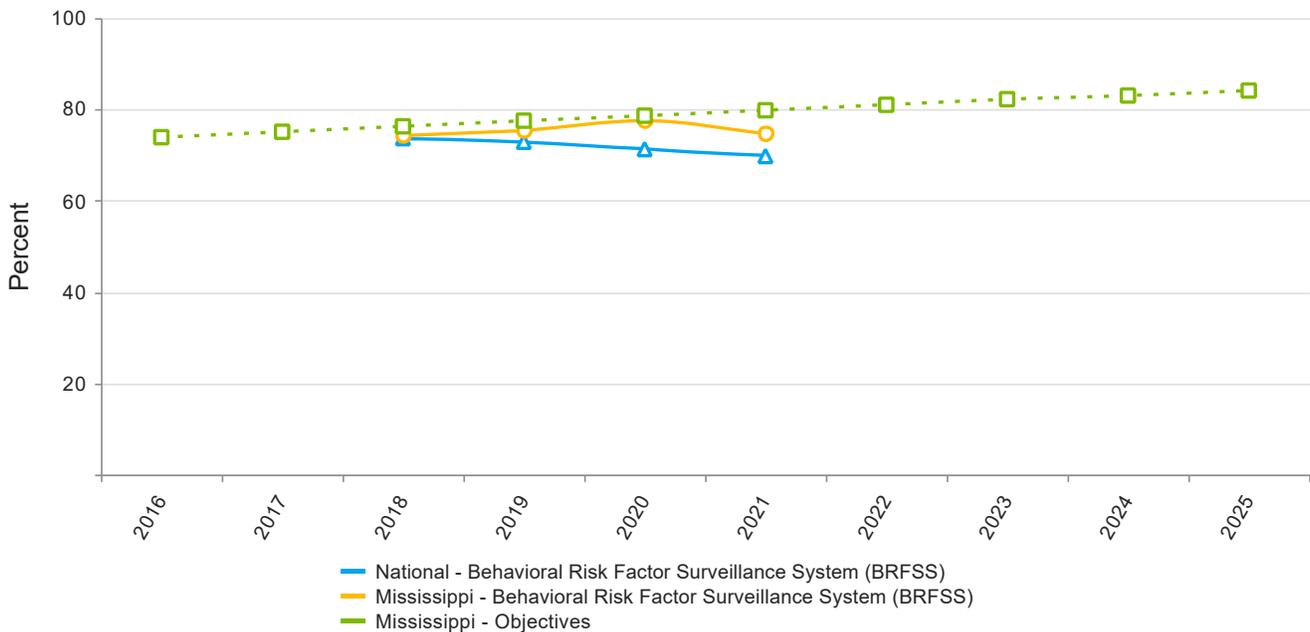
Cross-cutting/Systems Building:

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

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2018	2019	2020	2021	2022
Annual Objective			78.5	79.7	80.9
Annual Indicator		74.2	75.4	77.5	74.7
Numerator		389,320	390,297	403,215	379,846
Denominator		524,486	517,720	520,497	508,347
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

i Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives

	2023	2024	2025
Annual Objective	82.1	82.9	84.0

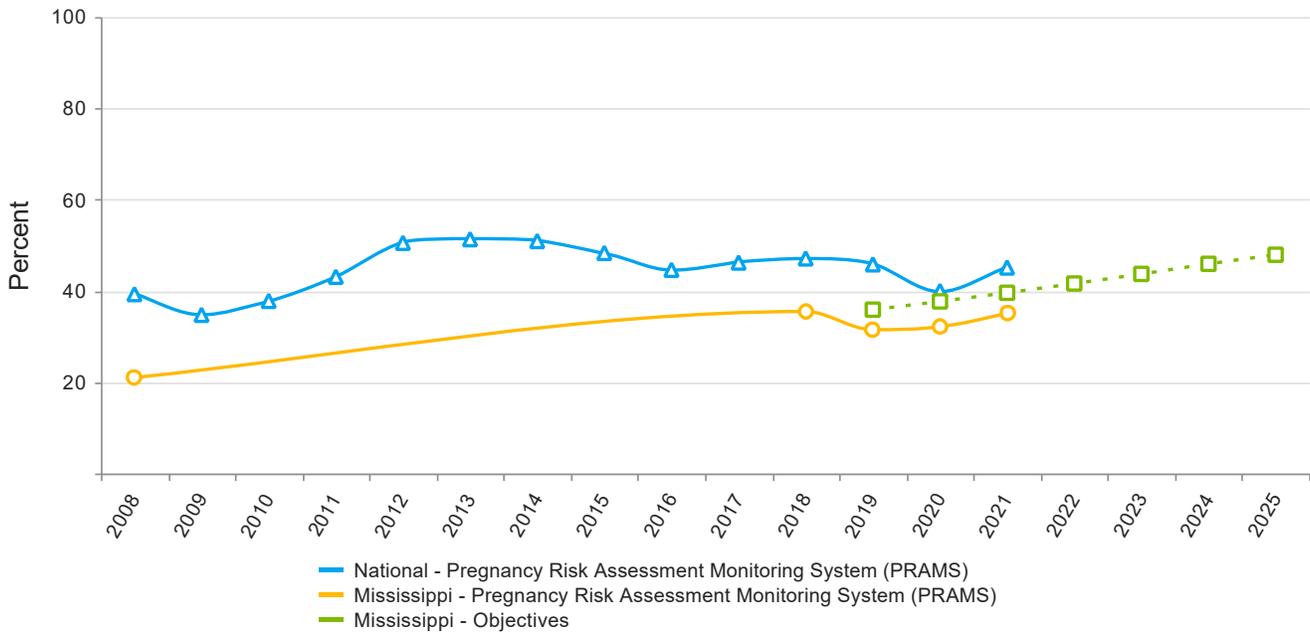
Evidence-Based or –Informed Strategy Measures

ESM 1.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy

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

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	125.0	150.0

**NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives**



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	2019	2020	2021	2022
Annual Objective		35.9	37.7	39.6	41.6
Annual Indicator	21.2	35.4	31.6	32.1	35.3
Numerator	7,953	12,028	10,696	10,493	11,307
Denominator	37,556	33,953	33,881	32,729	31,993
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2008	2018	2019	2020	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		35.9	37.7	39.6	41.6
Annual Indicator	34.2	35.4	31.6	32.1	35.3
Numerator	11,784	12,028	10,696	10,493	11,307
Denominator	34,483	33,953	33,881	32,729	31,993
Data Source	MS PRAMS				
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	43.7	45.9	47.9

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Number of pregnant and postpartum women who received oral health education

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		600	650	700	750
Annual Indicator		409	347	0	1,000
Numerator					
Denominator					
Data Source		MSDH Office of Oral Health - REDCAP			
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	800.0	850.0	1,000.0

State Performance Measures

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

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

Annual Objectives			
	2023	2024	2025
Annual Objective	2.2	2.1	2.0

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

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

Annual Objectives			
	2023	2024	2025
Annual Objective	28.5	25.7	23.1

State Action Plan Table

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

Priority Need

Improve Oral Health

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

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

Strategies

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

ESMs

Status

ESM 13.1.1 - Number of pregnant and postpartum women who received oral health education Active

ESM 13.1.2 - Number of WIC sites where oral health education is given to program participants by ROHCs Inactive

ESM 13.1.3 - Number of pregnant women who saw the dentist post referral Inactive

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

Improve Access to Care

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

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

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

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

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

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

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

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

Strategies

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

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

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

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

ESMs	Status
ESM 1.1 - Number of community group and activities program attends and partners with	Inactive
ESM 1.2 - Number of engaged users viewing social media messages delivered by MSDH social sites promoting women's preventive health services	Inactive
ESM 1.3 - Number of social media message months promoting women's preventive health services	Inactive
ESM 1.4 - Number of strategies or measures for racial equity related policy, practices and systems changes implemented at the program, division and department level.	Inactive
ESM 1.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Reduce Maternal Morbidity and Mortality

SPM

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

Objectives

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

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

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

Strategies

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

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

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

Priority Need

Reduce Maternal Morbidity and Mortality

SPM

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

Objectives

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

Strategies

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

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

Women/Maternal Health - Annual Report

Women/Maternal Health
Annual Report - FY2022

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

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

The following section outlines strategies and activities implemented between 10/1/2021-9/30/2022 to meet the objectives and show improvement on the measures related to women's and maternal health:

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

NPMs, NOMs, SPM, and ESMs:

- NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year
- SPM 5 - Percent of Women ages 40-64 yrs. old screened for cervical cancer.
- ESM 1.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy.

Objective: By September 30, 2020, increase awareness activities related to the Office of Women's Health programs from 50 to 60.

Objective: By September 30, 2020, increase the number of women and infants participating in a case management program (PHRM/ISS) from baseline to by 1%.

Objective: By September 30, 2020, increase the number of outside MSDH referrals for the case management program (PHRM/ISS) from baseline to 1%.

Objective: By September 30, 2020, the Office of Women's Health will increase the number of users viewing the social media message delivered by MSDH social sites promoting women's preventive health services from baseline to 2%.

Strategy: The Office of Women's Health Director, PHRM/ISS Director, Fatherhood Coordinator, and Outreach Coordinators will work with internal MSDH and External MSDH partners to identify opportunities for collaboration.

Activities: Office of Women's Health program staff continue to have a strong visible presence with several community-focused events and collaborative opportunities. These opportunities allow staff to provide information and resource materials regarding the BCCP, Family Planning Waiver, Healthy Moms/Healthy Babies, and Maternal and Infant Health Bureau programs, as well as others under the Office of Health Services, emphasizing services available to both external stakeholders and potentially eligible participants. Throughout the reporting period, the staff across multiple programs collaborated with community organizations, businesses, and other

stakeholders statewide. These organizations included FQHC's, colleges and universities, faith-based organizations, hospitals, MS-BCCP screening providers, social service providers, grassroots organizations, and others in direct contact with the target population. To increase awareness and knowledge of Maternal/Women's Health programs at the community level, MSDH staff participated in **76** outreach, engagement, or technical assistance activities throughout this reporting period. These activities included onsite and virtual training, conferences, community forums, roundtable discussions, workshops, and other events. Several staff in the Office of Women's Health are cross trained to provide outreach for multiple MCH programs, public awareness activities are rarely exclusive to a single program. Often, multiple programs are represented when an outreach activity is executed. Some of these activities are detailed as follows:

- October 2021 – Worksite Wellness promotional table on the MSDH Campus and Jackson Medical Mall across multiple dates– 88 participants (BCCP, Family Planning)
- December 7, 2021 – Virtual Lunch-n-Learn hosted by Mary Bird Perkins Cancer Center – 11 participants (BCCP)
- January 11, 2022 – Virtual meeting with Magnolia Medical Foundation to discuss partnership (BCCP, Family Planning)
- January 11, 2022 – Virtual presentation for the Community Health Advisory Network (Pearl, MS) – 7 participants (BCCP, Family Planning)
- January 19, 2022 – Virtual meeting with Boat People SOS (MS Gulf Coast) to discuss partnership (BCCP, Family Planning)
- January 2022 – Virtual subgrantee orientations/technical assistance with Delta Health Center and Mary Bird Perkins Cancer Center (BCCP)
- February 2022 – Virtual subgrantee orientations/technical assistance with Plan A Health, Singing River Hospital (BCCP)
- February 3, 2022 – Virtual Lunch-n-Learn hosted by Mary Bird Perkins Cancer Center – 11 participants (BCCP)
- February 9, 2022 – Virtual outreach presentation to Harbor House Chemical Dependency Center – 3 participants (BCCP, Family Planning, HM/HB)
- February 16, 2022 – Virtual presentation to Institute for the Advancement of Minority Health – 11 participants (BCCP)
- March 2022 – Virtual subgrantee orientation/technical assistance with Family Health Care Clinic (BCCP)
- March 5, 2022 – 19th Annual Hope Conference (Virtual) “Lighting the Way to Cancer Survivorship” – 257 participants (BCCP)
- March 14, 2022 – Virtual Lunch-n-Learn hosted by Mary Bird Perkins Cancer Center – 18 participants (BCCP)
- March 18, 2022 – Onsite technical assistance to Plan A Health – 6 participants (BCCP)
- March 21, 2022 – Canton Community Health Action Network – Virtual presentation by St. Dominic's Hospital Patient Navigator on breast and cervical cancer screening, diagnostic, and treatment resources – 16 participants (BCCP)
- March 23, 2022 – Outreach planning meeting with Flowood Women's Facility Chaplain (BCCP, Family Planning)
- March 26, 2022 – UMMC See, Test, and Treat – 31 uninsured patients with abnormal screening mammogram or pap results were referred to the BCCP table and given a provider in their county to schedule diagnostic follow-up with a BCCP provider (BCCP)
- March 29, 2022 – Mississippi HPV Summit (Virtual) – 140 participants (BCCP, Family Planning)
- April 4, 2022 – MSDH Public Health District IV (Virtual) Provider technical assistance training – 39 participants (BCCP)

- April 21-22, 2022 – MS Perinatal Quality Collaborative (Virtual/Onsite) – (BCCP, Family Planning, HM/HB, MIHB)
- May 10, 2022 – MSDH Public Health District VI (Onsite) Provider technical assistance training – 14 participants (BCCP)
- June 1, 2022 – Jackson Free Clinic (Virtual) Partnership Discussion – 5 participants (BCCP)
- June 15, 2022 – Virtual Lunch-n-Learn hosted by Mary Bird Perkins Cancer Center – 18 participants (BCCP)
- July 12, 2022 – Technical assistance site visit with Jackson Hinds Comprehensive Health Center – 14 participants (BCCP)
- July 15, 2022 – HM/HB Program Rebrand Kick-Off – 98 participants (BCCP, Family Planning, HM/HB, MIHB)
- July 20, 2022 – UMMC Medical Residency Students – resource awareness presentation – 14 participants (BCCP)
- July 30, 2022 – Community Resource Day at MS Department of Corrections Satellite Facility in Flowood, MS – 161 participants (BCCP, Family Planning)
- August 12, 2022 – Making Strides Against Breast Cancer Luncheon – 300 participants (BCCP)
- August 20, 2022 – UMMC See, Test, and Treat –uninsured patients with abnormal screening mammogram or pap results were referred to the BCCP table and given a provider in their county to schedule diagnostic follow-up with a BCCP provider (BCCP) – 19 participants referred to BCCP
- August 25, 2022 – Partnership planning meeting with MS Public Health Institute re: collaboration on MCH programs, services, and activities (BCCP, Family Planning, HM/HB)
- September 1, 2022 – Virtual Lunch-n-Learn hosted by Mary Bird Perkins Cancer Center – 9 participants (BCCP)
- September 1, 2022 – UMMC Medical Residency Students – resource awareness presentation – 9 participants (BCCP)
- September 16, 2022 – New BCCP Provider Orientation with Jackson Free Clinic (Virtual) – 10 participants (BCCP)
- September 22, 2022 – Susan G. Komen Organization – 2022 Navigation Nation Summit – all BCCP staff participated

Note: Strategies and activities for attending professional conferences, meetings and engagement with providers continued to be hampered in this reporting period because of COVID-19 impacts. Many events were conducted virtually, which did not allow for the same level of engagement as onsite interactions.

Strategy: The PHRM/ISS program promotes a 2 to 4 weeks post-partum medical visit with all women and discusses inter-conception care with parenting women.

Activities: The Mississippi State Department of Health (MSDH) implemented the Perinatal High Risk Case Management Program (PHRM/ISS) in every county of MS for over 34 years. The program provided clinic and home-based perinatal case management to pregnant women and infants, using a multi-disciplinary team of a nurse, social worker, and nutritionist. This case management program was largely sustained by program revenue generated from billing Medicaid for eligible patients. Following amendments to the Medicaid Administrative Code for Maternity Services, Part 222, Chapter 2: Perinatal High-Risk Management and Infant Services in 2020, the program has subsequently revised its model to a nurse-led case management model. Effective July 2022, the historic perinatal case management program was rejuvenated and rebranded as the Healthy Moms/Healthy Babies Program of Mississippi (HM/HB). This new family support program’s mission is focused on partnering with families and communities to ensure all Mississippi moms and babies have a safe birthing experience and healthy infant development. The program aims to decrease preterm births, improve maternal health, decrease

infant mortality, and support infant physical and mental development. Its target population remains high risk pregnant women through 60 days post-partum and high-risk infants through 12 months old.

The HM/HB program partners with the medical home and community to provide care coordination and home visiting services to assist expectant women of all reproductive ages and infants up to one year of age who have identified health risks. HM/HB provides comprehensive and coordinated maternity and infant targeted case management services aiming to reduce the maternal and infant mortality and morbidity rates in the state of Mississippi. The care management model consists of assessment, education, empowerment and support, linkages to other services, management of high-risk behavior and response to the social determinants of health (SDOH) that may have an impact on birth outcomes. Patients and families shall receive culturally sensitive, compassionate, non-judgmental care and services in the HM/HB program. HM/HB exists to address the following:

- Ensuring that all HM/HB staff and HM/HB Extended Service Providers are trained in maternal early warning signs, post-birth warning signs, and postpartum depression.
- Ensure that HM/HB patients and families are connected to social services and mental health services for psychosocial support and/or substance use treatment.
- Ensure that HM/HB patients and their families feel heard and empowered about how to advocate for their health.
- Ensure that HM/HB patients are educated about maternal early warning signs (dangers in pregnancy), post-birth warning signs, and postpartum depression.
- Ensure that HM/HB patients have a medical home and follow up on appointments.
- Ensure that HM/HB patients are screened for social stressors including any social determinants of health.
- Ensure HM/HB patients/caregivers are educated about family planning and are connected to resources as needed.
- Ensure that pregnant women, caregivers of infants and their families are educated about the risks in pregnancy and in infancy.
- Ensuring that HM/HB patients are assisted in receiving access to insurance coverage.
- Educate pregnant women and parents about the benefits of breastfeeding and connecting them to lactation support as needed.
- Promoting smoking cessation and encouraging patients and families to reduce secondhand smoke exposure.
- Provide safe sleep education to pregnant women, parents, and families and refer to safe sleep resources as needed.

Strategic planning began in August 2021 to develop provider specific training and orientation to new and existing staff. Protocols were developed and evidence-based strategies are in the implementation stage to revamp a program that has been in existence at the health department for over 30 years. The HM/HB program developed a recruitment strategy to address the shortage of nurses within the program. The overall goal is to increase capacity, training, and accountability to better serve pregnant women and infants in the state of MS.

To combat the growing maternal and infant health crisis in the state of Mississippi, the MS State Department of Health, Healthy Moms/Healthy Babies program wanted to equip their staff and internal partners with the resources and training needed to assist pregnant women and their families. From October 2021 to January 2022, HM/HB partnered with the MSDH Maternal and Infant Health Bureau to offer a Maternal and Infant Health virtual training series. The first training was the Maternal and Infant Health Training Session 1- Getting to Know our MCH Teams. This training gave an opportunity for HM/HB, the Maternal and Infant Health Bureau, and The

Maternal Child Health Block Grant Team to provide introductions, talk about the purpose of their programs or bureaus and how the systems can collaborate. Session 2 was called Maternal Morbidity and Mortality in Mississippi. This session provided information about the drivers for maternal mortality and its disparities. Also, maternal mortality definitions were provided as well as a discussion on the maternal mortality review process. Session 3's topic was Infant Mortality in MS which included discussions on infant morbidity and mortality data, definitions, and description of the child death review panel. Session 4's topic was Maternal Hypertension-What Every MCH Professional Should Know. Session 5 is Predicting and Preventing Preterm Birth in MS and the last training, Session 6, was Supporting the NICU Graduate. The training series had an average of 60 participants in each training session. All sessions were recorded. And videos can be found on Health Stream, MSDH's learning management system.

In prior years, PHRM/ISS program utilized a data management system to capture required performance measure data including information on the participants, interventions, and birth outcomes, which allowed for real-time analysis of service delivery, quality assurance, and research analysis. The database was developed for each individual county health department site throughout the state and structured to collect demographic information for participants and their infants, including age, race, ethnicity, contraceptive/birth control choices, information concerning the number and types of referrals and direct services provided, and other programmatic information monthly. The database was updated June 2020 to include a data point exclusive to interconception care. Starting in 2021, the former data system became obsolete and was replaced with the MSDH electronic health record, which allows for data extraction when a case manager has input information for discrete data fields. Unlike the prior data system, there presently is not a single data point in the EHR exclusive to the HM/HB program where data can be reliably extracted for analysis of the postpartum home visit and medical visit. Instead, there are multiple points at which this data can be entered, including narrative progress notes, which makes for less reliable reporting. The program is prioritizing improvement in this area for the remainder of CY2023.

Strategy: The PHRM/ISS case management program develops relationships with external partners to increase referrals to the program.

Activities: The HM/HB program experienced a major downward turn in referrals and new enrollments throughout the COVID pandemic. Starting in January 2022, the HM/HB program had 402 enrolled patients. In February 2022, there was increase in HM/HB central office program staffing that helped equip the resources needed to re-launch the program. In March 2022, branding and collateral work began with MSDH Communications Department to develop marketing information and brochures. By May 2022 the program branding was completed with a new logo, vision, mission, and values. The month of May was also a crucial time to where HM/HB was able to kick off nurse recruitment for HM/HB case management. The Healthy Moms/Healthy Babies of MS held an all-day program convening on July 15, 2022, in Raymond, MS. The purpose of the convening was to kick-off the new program, share the new promotional materials, reveal visions and goals and to provide training to staff. It was MSDH's way of unveiling its new strategy for addressing maternal child health in the state of Mississippi. The agenda for the convening included 4 guests representing the Voice of MS Families discussing their challenges with pregnancy and with birth of infant and development. The MSDH State Health Officer and CDC Epidemiology Assignee presented on the "State of Maternal and Infant Health in MS". The HM/HB program director discussed HM/HB New Program and New Practices which included the incoming State Health Officer sharing his vision for MS. Lunch guest speakers included: a Pediatrician, OB-GYN, and Public Health Nurse to discuss topics and solutions concerning Maternal and Infant Health. Breakout sessions included topics about patient-centered care to Social Workers, Nurses, and Nutritionists. Birthing doulas also came with some of their clients and discussed the services they provide. Over 100 participants registered and participated including some who attended virtually. Staff testimonials included that the convening was refreshing, gave them hope, and a new perspective on

maternal and infant health. Afterwards, HM/HB teamed up with a veteran perinatal social worker to prepare to provide 10 training courses to HM/HB staff about maternal and infant case management and mental health. And HM/HB also teamed up with the MS Public Health Association to develop Nurse training modules for HM/HB nurse case management team. During the convening, the HM/HB director encouraged MSDH staff to “Give Me 5...For the Next 5 Months”. This included: 5 to 10 minutes every morning to set your day and focus, 5 to 10 new enrollments each month, 5 days to provide first contact attempt, and 5 community/provider outreach each month. HM/HB new enrollments jumped from 38 for July 2022 to 120 in August of 2022. For the rest of the year of 2022, MSDH saw an increase in participants of HM/HB. This number of enrolled patients steadily climbed month-to-month reaching 596 by the end of September 2022.

Throughout the reporting period, the Office of Women’s Health program staff networked and collaborated to leverage additional formal and informal partnerships for programmatic referrals and continuity of care with community health centers/FQHCs, delivering hospitals, OB/GYN offices, pediatricians, and managed care organizations, in addition to community-based, faith-based, and other youth-serving organizations. The program tracks several referral sources sent to the program administrative office for recording and processing.

During the reporting period, there were 1,266 referrals processed across these multiple referral sources, returning the program to pre-COVID referral numbers. While referral numbers have improved over the past year, there is still much work to be done on enrolling patients. Most referrals do not result in an enrollment into the program. Internal quality improvement initiatives are underway to improve this.

The following table shows the numbers of patients served by fiscal year, as well as the number of professional visits recorded related to PHRM/ISS – HM/HB. The program will continue monitoring and reporting to MSDH Senior Leadership and the Division of Medicaid on a monthly basis for the foreseeable future.

Measure	FY18	FY19	FY20	FY21	FY22	FY23
Unduplicated maternity patients served	1,960	2,206	2,190	1,136	794	912
Maternity professional visits received (with nurse, social worker, or dietician)	10,636	8,378	15,395	4,051	2,721	5,065
Unduplicated infant patients served	1,471	1,484	1,454	897	719	495
Infant professional visits received (with nurse, social worker, or dietician)	8,218	5,192	8,544	3,513	2,638	3,245

Strategy: The Office of Women's Health will identify similar promotional themes surrounding well woman visits and health exams for internal MSDH and external MSDH partners to promote the social media posting by MSDH.

Activities: The MS-BCCP program initiated a cervical cancer awareness social media campaign through the MSDH Office of Communications to run through January 2022. In September 2022, the Outreach Coordinator prepared a work request for a social media campaign to run through October 2022, which promoted breast cancer screening and early detection.

During October 2021, the importance of screening and early detection was further promoted by community health partners and participating providers. Many partners used their own internal and organic resources, such as business and organization social media outlets, to encourage uptake of screening services. Southeast

Mississippi Rural Health Initiative, Inc., Aaron E. Henry Community Health Center, East Central MS Healthcare, Inc., and Coastal Family Health Center used Facebook as an outlet to bring awareness to the availability of free breast screening services in the month of October 2021. Numerous other providers and health systems across Mississippi took to their own social media platforms and local news outlets to promote screenings and early detection throughout the year, some even referring to MS-BCCP as a resource for women without insurance or other means to pay for services.

Objective: *By June 30, 2022, increase screening rates among the African American, Hispanic, Asian and American Indian communities to identify never or rarely screen women and link them to services.*

Objective: *By June 30, 2022, re-engage with the MS Department of Corrections (MDOC) to provide staff and incarcerated women with education on the importance of screenings and resources available.*

Strategy: Facilitate sub-grant agreements with Health Systems Partners (JHCHC, FHCC) and Community-Clinical Linkage partners (Plan A, Singing River Health Systems, North Sunflower Health System) to support activities that increase screening rates among these underserved groups of women.

Activities: A competitive RFP was developed to recruit subgrantee partners for FY2022 and was posted to the website in late August 2021. Seven applications were returned. Reviews were scheduled for early October 2021 and would lead to five competitive proposals being funded through June 30, 2022. The FY2022 subgrantees were located different areas of the state and were strategically positioned and working to reach underserved women. Some activities planned included expansion of patient navigator services to additional sites, addition of community health workers in under-reaching counties, and mobile screening and mobile mammography events in areas of the state with both low MS-BCCP enrollment, increased incidence for cancer, and higher vulnerability. The FY2022 subgrantees were Jackson Hinds Comprehensive Health Center, Family Health Care Clinic, Plan A Health, Mary Bird Perkins Cancer Center, and Delta Health Center. Collectively, these subgrantees enrolled 1,100 unduplicated women residing in 47.5% (n=39) counties in MS-BCCP during the reporting period. These enrollees accounted for 31% of all women enrolled (n=3,569). Among subgrantee enrollees, 49% (n=543) were new (no prior enrollments in any year) to the program. Collectively, these women received a total of 3,564 program-supported breast and/or cervical cancer screening and/or diagnostic activities.

For FY2023, the subgrantee request for proposals (RFP) public facing announcement, closed September 30, 2022, and produced 14 applications from organizations from health systems and community-bases partners. A report on these subgrantees will be provided in the next MCH Block Grant report.

FY2022 MS-BCCP program data for the reporting period reflects that among 3,590 participants served, 51.5% were Black/African American women, 32.4% white women, 1.9% American Indian/Native Alaskan, Asian, or Pacific Islander women, and 0.5% were two or more races. For 13.7% of participants, no race was indicated, representing a major area for programmatic data quality improvement. Fifteen point eight percent (15.8%) of enrollees indicated their ethnicity was Hispanic, 81.1% non-Hispanic, and for 3% no response was recorded. With the race of nearly 14% and ethnicity of 3% of the participant population undetermined, the program cannot accurately determine its progress in achieving its targets for serving priority populations. However, based on available data, the program presently falls short of targets set in prior years.

Strategy: Consult with Institute for the Advancement of Minority Health on strategies and best practices for engaging underserved populations. Explore opportunities for partnership.

Activities: There was no activity for this strategy during the reporting period.

Strategy: Initiate contact with Flowood Correctional Facility and other minimum-security settings, which house women for brief periods (6-18 months) to explore interest in providing virtual education to staff and inmate population on breast and cervical health and BCCP services. Plan logistics accordingly. Pursue MOU for sustainability.

Activities: On March 22, 2022, the BCCP Outreach Coordinator completed orientation at the MDOC Flowood Women's Facility. This is a requirement for any outside agency who wishes to visit the facility to interact with or provide educational programming to the inmates.

PRIORITY: Maternal Morbidity and Mortality

Nearly all the strategies and activities for this priority were carried out by the Maternal and Infant Health Bureau (MIHB), which aims to reduce maternal and infant morbidity and mortality by understanding the causes of deaths through surveillance, review, and abstraction of records for infants, children, and women (pregnancy-related). MIHB further utilizes the information and recommendations gathered through review to engage health systems and communities to implement quality improvement initiatives and prevention strategies.

MIHB utilizes strategies such as multidisciplinary review teams with guidance and technical assistance from the National Center for Fatality Review and Prevention (NCFRP) and the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM). Strategies included in the report for the FIMR, CDR, and Maternal Mortality Review Committee (MMRC) are aligned with processes developed and guided by the NCFRP and the MMRC.

MIHB utilizes strategies such as quality improvement initiatives with guidance from the National Network of Perinatal Quality Collaboratives (NNPQC) and the Alliance for Innovation on Maternal Health (AIM). NNPQC is a partnership between the CDC and March of Dimes to support state perinatal quality collaboratives in making measurable improvements in statewide health care and health outcomes for mothers and babies. AIM is a national data-driven maternal safety and quality improvement initiative based on proven safety and quality implementation strategies that reduce preventable maternal mortality and severe morbidity. MSPQC utilizes best practices and evidence-based guidance from NNPQC and AIM.

It is important to note that 4 of 5 of the former MIHB staff separated from the agency in August through October 2022. It has taken this Bureau months to stabilize with new staff seeking to build on the work of those in former leadership positions. However, there have been multiple challenges to do so, notably due to the inability to plan for succession with the former staff. Additionally, accessing reports and data that would inform this report has been challenging. While certain OWH staff do have access to the former staff members' emails and have been able to construct information for this report, many strategies would have been better informed by information contained in data files that can no longer be accessed. This has been an important lesson learned and has been shared across the broader MCH workforce. Notably, the Office of Health Services leadership has since provided direction and instruction for all staff related to succession planning, continuity of work during vacancies, and the archival of important records and artifacts for perpetuity in more broadly accessible platforms.

NPMs, NOMs, SPM, and ESMs:

- SPM 2 - Reduce Maternal Mortality Rates and Disparities by promoting best practices in clinical care and strengthening the Maternal Mortality Review Committee (MMRC) efforts.
- SPM 4 - Percent of women ages 15-44 years old that use family planning services

Objective: *By September 30, 2021 increase the percent of cases reviewed by the Mississippi Maternal Mortality and Morbidity Review Committee within one year of maternal death.*

Objective: *By September 30th, 2022, build an infrastructure to address birth equity among Maternal and Infant Health Bureau staff, hospitals participating in MSPQC Quality Improvement Initiatives and the Maternal Mortality Review Committee.*

Objective: *By September 30th, 2022, increase the number of MSPQC hospitals participating the Initiative to Support Vaginal Births caesarean reduction project from 5 hospitals to 9 hospitals.*

Objective: *By May 30th, 2022, conduct at least 2 Maternal Mortality Review Committee meetings.*

Objective: *By September 30th, 2022, increase Maternal Mortality informant interview participation rates for 2019 cases from 60% to 70%.*

Objective: *By August 30th, 2022, conduct at least six community outreach events to address maternal mortality disparities and promote Maternal Mortality Review Committee recommendations.*

Strategy: Review all deaths potentially related to pregnancy within two years of the date of death.

Strategy: Identify, abstract, and review maternal deaths up to 365 days postpartum.

Activities: Maternal deaths are identified within a year of the end of pregnancy on a routine basis in collaboration with Mississippi Department of Health Office of Vital Statics. Birth and death certificates are the primary source for identify maternal deaths. The Maternal Mortality Review Committee identified maternal deaths through a structured multistep process including:

1. Pregnancy checkbox on death certificates
2. Death codes and descriptive terms
3. Linkages to birth and fetal death certificates
4. Review of news, social media

Once maternal deaths were identified, The MMRC abstractor called the institution or health system to establish a point of contact. Once contact was initiated, a letter describing the records request was sent. An allotted grace period of 7-10 days is given to receive records before follow-up correspondence is initiated. Follow-up correspondence is conducted at least three times before indicating the missing components of the medical record. Once records are completed, they are securely transferred to the MMRC Nurse Abstractor for review of the record and development of the case summaries in preparation for the review meeting. An additional component of the abstraction process occurs with the MMRC Social Worker through the informant interview process. The informant interview process allows additional context on social determinants of health that could have impacted the pregnancy. The MMRC Social Worker utilized the medical records to obtain contact information for families. If case abstraction did not yield usable contact information, MMR Social Worker utilized extensive online searches, online obituaries, social media searches, and utilized information found on legitimate/reputable news outlets. During the CDC ERASE Maternal Mortality reporting period of 4/1/2021 – 3/31/2022, 39 cases of maternal death were abstracted for review. decisions forms are completed during the meetings with input from MMRC members. During the December 2021 MMRC meetings, the use of zoom polls was piloted to capture pregnancy-relatedness, contributing factors, preventability, and the chance to alter

outcomes. This assisted with reducing the amount of time spent discussing each case and targeted the discussions on areas where consensus was not reached. The use of zoom polls also provided more time to complete the contributing factors and recommendations for action section of the committee decision form. Zoom polls were very helpful during uncomfortable discussions about the contribution of racism, where at times during open discussion some members felt silenced by others and the committee leadership could not determine the level of agreement on the decision.

Maternal Mortality Review meetings are conducted with a multidisciplinary member committee consisting of clinical and non-clinical disciplines and organizations with representation from multiple regions of the state, gender, and racial diversity. Meetings are generally hosted quarterly; however, the schedule fluctuated due to the peak periods in COVID-19 cases.

MMRC meetings were conducted on:

- December 16-17, 2021
- July 19, 2022
- September 30, 2022

Strategy: Document committee decisions consistent with guidance documents no later than two years from the date of death.

Activities: Committee decision forms were completed for all cases reviewed during the study period and entered in MMRIA. Completing the committee decisions form in real-time during the meetings was a time-consuming process especially when consensus was not reached amongst MMRC members, and few offered concrete decisions. It is typical for committee members to offer few recommendations as this appears to be an area where committee members struggle the most. Additional facilitation strategies will be employed in future meetings to further reduce the time spent discussing each case and more on developing recommendations for action.

Strategy: Enter all review committee decisions (documentation consistent with guidance) into MMRIA within 30 days of completing the review of death.

Activities: While committee decisions forms were entered for all the cases reviewed, there were delays in entering completed committee decision forms when there was lack of consensus on some points of the form or when recommendations were not provided in the manner requested by CDC (who/what/when). Existing committee decisions have been revised to meet the requested format and committee members have been educated on the desired format for recommendations. In the future, MMRC administrative support staff will work to enter decisions directly into MMRIA rather than transcribe from a PDF to MMRIA at a later date to ensure complete entry within 30 days.

Strategy: Perform data quality assurance checks for completeness within 90 days of completing the review.

Activities: While initially performed outside of 90 days, the MMRC reviewed cases for completeness and made corrections based upon those reviews. A special request to the CDC to open closed cases is necessary to make updates, corrections, or modifications, but that process has been fast. All staff who contribute to case abstraction have access to MMRIA and can work together to ensure data completeness and accuracy. Two additional staff have been trained on MMRIA and now all those contributing to abstraction and analysis have access and work together to ensure completeness and accuracy. Both independently and based upon prompts from the CDC,

MIHB has been assessing data completeness within this last quarter. There are plans to standardize the timing and process of data quality assurance and work closely with the CDC to update locked cases.

The Maternal Mortality Report for 2017-2019 deaths was prepared starting in August 2022. However, due to turnover in 4 of 5 positions with the MIHB occurring August through October in 2022, the report could not be completed until January 2023. The most recent Maternal Mortality Report can be reviewed at <https://msdh.ms.gov/page/resources/19612.pdf>

Strategy: Increase the number of informant interviews that assist the Maternal Mortality Review Committee in understanding the family's perspective of the mother preceding death.

Activities: Informant interviews became a formal process of the MMRC in 2020. The MMRC contracted with Therapy Plus, LLC to conduct key informant interviews and outreach to next of kin and families. The completed informant interview case summaries are shared during the case reviews. Therapy Plus provided a report relative to the informant interviews conducted on 2018 deaths. For 2018 cases, 60% of the cases assigned resulted in a successful Informant Interview. The 40% of cases that were not interviewed, were primarily not completed because of inaccurate contact information for the next of kin, or lack of accurate contact information for surviving family members in the medical record. This often left no viable means of successfully contacting the family. For 2018, Informants were most likely to be a woman. The mother or sister of the decedent was most likely to participate as an Informant. Overall, mothers are more likely to be an Informant, even when the decedent was married at the time of death. For 2018 cases, the contact information listed on the death certificate or in the abstraction medical record had a high probability of being inaccurate. There is an increased likelihood that family members/next of kin could have moved or changed phone numbers within the amount of lapsed time between the death and attempted contact of the next of kin by the MMR Social Worker. Therapy Plus also provided a report on all 2019 death cases related to informant interviews. **The participation rate had risen to 82%.**

The Informant Interviewer shared the following key takeaways:

- Most families with viable contact information in the medical record elected to participate in the informant interview process. A non-interview was primarily a result of a lack of medical records or inaccurate contact information for the next of kin. Conducting Informant Interviews on cases outside of "real time", continue to present challenges.
- In 2019, participants were overwhelmingly likely to be a female relative. The mother of the deceased was most likely to participate in the informant interview process. These are similar trends observed in 2018 interviews. However, 2019 experienced more male participation from spouses/partners, fathers, and male children of the deceased (versus that of 2018). Also, Informants were most likely to be the caregiver to the deceased's surviving child(ren).
- Cases classified as a homicide continue to be difficult to process for interviews. Several factors contributed to this dynamic for the 2019 group. Of the 2019 homicide cases, many of the family members that were contacted reported that their loved one's case had not yet gone to trial. Due to the pandemic, the Mississippi court system experienced a backlog of cases due to shutdowns and limit setting procedures to prevent the spread of COVID. Many family members expressed fear of retaliation or interference with the pending court case if they participated despite being informed of confidentiality measures.

Strategy: Partner with a national organization to provide training, assessments, and technical assistance in building a strategic plan to address birth equity.

Activities: MSPQC decided not to enter into a contractual agreement with the National Birth Equity Collaborative

to conduct the Birth Equity Assessment, focus groups and interviews during the reporting period. In lieu of conducting these activities, MSPQC is partnering with the Obstetric Initiative to distribute the Labor Culture Survey (LCS) to hospitals to measure the micro culture of labor and delivery units as well as identify opportunities to encourage attitudes around vaginal birth. MSPQC had planned to distribute the Labor Culture Survey (LCS). The Labor Culture Survey is a tool designed to measure individual attitudes and beliefs and labor and delivery unit culture related to cesarean overuse. The LCS tool consists of 29 items and six subscales: Best Practices to Reduce Cesarean Overuse, Fear of Vaginal Birth, Unit Microculture, Physician Oversight, Maternal Agency, and Cesarean Safety. By using the LCS, MSPQC will be able to better facilitate the implementation of the I-Support Initiatives specifically targeting attitudes, unit norms, knowledge deficits, communication gaps, and behaviors. The LCS officially opened for responses in September 2021 and the oversight of the project stayed with MSPQC, which transitioned to being housed and administered by the MS Public Health Institute (MSPHI) in September 2022.

Strategy: Provide evidenced based training to MSPQC birthing hospitals to reduce severe maternal morbidity.

Strategy: Provide guidance to hospitals on reducing nulliparous, term singleton, vertex (NTSV) caesarean rate.

Activities: The Mississippi Perinatal Quality Collaborative (MSPQC) is a statewide partnership that promotes evidence-based quality improvement initiatives at the hospital and community level to improve birth outcomes across Mississippi. MSPQC relies on collaborative data-driven projects to address specific drivers of maternal and neonatal morbidity and mortality. These projects are selected by participating members across the state who work to develop, disseminate, and successfully implement best practices in all clinical settings caring for mothers and infants. Working collaboratively, the MSPQC comprises three divisions: (1) Neonatal, (2) Obstetric, and (3) Family Engagement and Support. During the reporting period, the MSPQC provided monthly technical assistance and training to participating MSPQC hospitals.

The Alliance for Innovation on Maternal Health (AIM) is a data-driven maternal safety quality improvement initiative that collaborates with the Mississippi Perinatal Quality Collaborative to implement strategies to reduce preventable maternal mortality and severe morbidity. In prior reporting periods, MSPQC utilized the AIM Severe Hypertension in Pregnancy safety bundle to provide a structured and standardized approach for delivering well-established, evidence-based practices to be implemented with complete consistency, for every patient, every time. After several months of successful implementation with participating hospitals, this bundle was considered “in maintenance.” During the reporting period, the MSPQC’s focus shifted to other AIM bundles, notably the I-Support Reduction of Primary C-Section and I-Support Intended Vaginal Birth bundles. During the reporting period, 36 hospitals actively participated in AIM activities. Patient safety bundles are driven by the findings of the MMRC and the relationship between the MMRC and MSPQC along with the support of third-party payers is critical to the successful implementation of data driven recommendations.

Monthly conference calls/webinars for I-Support Vaginal Births/Reduction of Primary C-Section were led by the MSPQC I-Support Lead, Dr. Janice Scaggs, a certified nurse midwife and nurse practitioner, and were held on the following dates. Due to incomplete data, a report on the number of participants is not immediately available:

- October 19, 2021 – 19 participants
- November 2, 2021 – in lieu of I-Support content, participants received presentation “Promoting Physiologic Humility During Birth and Labor”: participant count unable to be obtained.
- December 21, 2021 – 8 participants
- February 15, 2022 – 34 participants; guest presenter, Dr. Lisa Law
- March 15, 2022 – 42 participants; guest presenter, Dr. Nicole Carson

- April 12, 2022 – 20 participants

MSPQC hosted its Annual Conference on April 21-22, 2022. The conference was offered in-person at the Sheraton Flowood the Refuge Center & Conference Center and virtually. Only hospital teams could attend the conference in-person, all other programs and community-based partners were asked to attend virtually due to COVID-19. The conference had educational two tracks: Neonatal and Maternal. The Neonatal track was held on April 21, 2022, and the Maternal Track was held on April 22, 2022. Additionally, a Spinning Babies pre-conference workshop was hosted on April 21, 2022. As part of the conference, a workshop supported by MS Blue Cross Blue Shield entitled “Spinning Babies” was offered to 38 participants. At the event, there were 37 onsite participants and 40 virtual participants. On April 22, 2022, the MSPQC officially announced its statewide launch of the I-Support Intended Vaginal Births AIM bundle. Facilitation of the I-Support Vaginal Births is coordinated in partnership with Blue Cross Blue Shield of Mississippi Provider Partnerships & Health Management. Over the next several months, the MSPQC developed a tool kit, which was sent to all participating hospitals and included labor positioning handouts, badge cards, posters, birthing balls, and other useful tools and resources.

Monthly conference calls/webinars for I-Support Intended Vaginal Births were also led by Dr. Janice Scaggs through August 2022. A new lead, Sara Humbert, also a certified nurse midwife assumed the facilitator role in September 2022.

- May 13, 2022 – 11 participants (Statewide Kick-Off)
- June 7, 2022 – 47 participants
- July 5, 2022 – *due to inaccessible data file, the participant count is not available*
- August 2, 2022 – *due to inaccessible date file, the participant county is not available*

To support AIM bundle implementation momentum, Blue Cross Blue Shield hosted regional meetings with participating hospitals. In these meetings, I-Support bundles and “Spinning Babies” education was offered to participants. These meetings were held as follows:

- July 19, 2022 – Indianola, MS – I-Support (6 hospital teams), “Spinning Babies” (36 participants)
- July 27-28, 2022 – Pascagoula, MS – I-Support (9 hospital teams), “Spinning Babies” (32 participants)
- August 4-5, 2022 – Oxford, MS – I-Support (9 hospital teams), “Spinning Babies” (32 participants)

MSPQC partners with AAFP to conduct hands-on Advanced Life Support in Obstetrics courses to nursing staff in Mississippi. MSPQC Project Director, Lead Nurse Midwife for the I-Support Project and contract nurse consultant are trained facilitators for this course. MSPQC is working to increase not only the number of nurses trained in the state but the number of ALSO instructors. To improve the response to obstetric emergencies, MSPQC hosted Advanced Life Support in Obstetrics (ALSO) simulation training. ALSO is an evidence-based, interprofessional, and multidisciplinary training program that equips the entire maternity care team with skills to effectively manage obstetric emergencies. Training is conducted with hospitals upon request.

Training was conducted with hospitals on the following dates:

- October 12, 2021: 11 participants
- November 5, 2021: 10 participants
- January 29, 2022: 14 participants (ALSO Instructor Course)
- February 25, 2022: 7 participants and 5 instructor candidates
- June 23-24, 2022: 10 participants

Strategy: Provide education on the treatment of severe maternal hypertension.

Activities: MSPQC utilizes the AIM Severe Hypertension in Pregnancy safety bundle to provide a structured and standardized approach for delivering well-established, evidence-based practices to be implemented with complete consistency, for every patient, every time. Conference calls and webinars for Severe Maternal Hypertension are conducted to provide continual guidance, knowledge sharing, and technical assistance to hospital teams. Additionally, one-on-one quarterly calls are held in conjunction with Blue Cross Blue Shield of MS to discuss unique challenges and barriers teams face with implementing maternal safety standards and to provide additional resources. Conference calls and webinars were held on the following dates:

- February 8, 2022: 72 participants
- February 22, 2022: 43 participants
- March 29, 2022: 42 participants

After several months of successful implementation with participating hospitals, this bundle, along with the obstetric hemorrhage bundle, were considered “in maintenance” in March 2022 and no additional specific efforts were dedicated here.

During the reporting period, MSPQC partnered with the Preeclampsia Foundation to distribute blood pressure cuff kits to health systems for home monitoring of pregnant and postpartum women with hypertension/preeclampsia. MSPQC purchased and distribute 450 Cuff Kits to 9 clinics and hospitals. Participating clinics and hospitals provided the Cuff Kits to women who are currently pregnant or have given birth within the last 6 weeks and who were unable to purchase a home blood pressure monitor.

Distribution of the blood pressure cuffs were prioritized based on highest risk, including a higher medical risk (hypertension, history of preeclampsia, obese plus age over 35, and autoimmune disorders) and population-level risk (Black, Native American, and rural). The cuff kits included automatic blood pressure monitors and a variety of educational tools that explain how and why to take your blood pressure, what the numbers mean, and when to seek help. A REDCap survey was developed to track demographics of individuals receiving Cuff Kits. Additionally, sites were given guidance on how to identify, educate and enter data. During the reporting period, 109 Cuff Kits were disseminated. Dissemination of Cuff Kits to women was a slow process. The Preeclampsia Foundation lacked an implementation guide that provided guidance on how to roll-out the Cuff Kit community. MSPQC developed a process and hosted a kick-off webinar with instructions on eligibility, diagnosis, and data entry but some facilities faced greater difficulty creating internal processes to capture and enter the data in REDCap. Out of the 109 participants, 104 were Black, 4 were White, and 1 was left blank. The majority (89%) had Medicaid.

**DIAGNOSED CONDITIONS AMONG WOMEN WHO RECEIVED
A BLOOD PRESSURE CUFF**

RACE	COUNT (PERCENT)
	N=109
Pre-Eclampsia	51 (46.8%)
Gestational Hypertension	10 (9.2%)
Chronic Hypertension	33 (30.3%)
History of Pre-Eclampsia	19 (17.4%)
Obesity	15 (13.8%)
Cardiovascular Disease	1 (<1%)
Other Diagnosis	5 (4.6%)

NOTE: Participants could choose more than one condition

Strategy: Implement community outreach events to address maternal mortality disparities and promote clinical recommendations of the MMRC.

Activities: During this project period, a contract was renewed with Six Dimensions, LLC to conduct outreach events to bring awareness to maternal mortality, disparities, and strategies to prevent maternal deaths. One key process in raising awareness was to identify partners working to reduce maternal mortality. This provided opportunities to leverage resources and deliver consistent messaging to the community. Additionally, it provided opportunities for interacting with women prenatally and postpartum to provide education and create a safe space for women to share lived experiences that further shaped the work and recommendations of the MMRC and the MSPQC. Information pertaining to partners is securely stored in a spreadsheet and utilized to distribute resources and information.

During this reporting period, Six Dimension LLC. Partnered with 23 organizations. Six Dimensions hosted six virtual screenings of the Laboring with Hope documentary. Laboring with Hope is a film created by Six Dimensions, LLC. that talks about loss, grief, and the hope for change. The film addresses maternal morbidity and mortality among Black women and the racial and structural biases that create barriers to health among Black women. Screenings were hosted on the following dates.

- October 26, 2021: 118 participants
- November 15, 2021: 974 participants
- January 26, 2022: 25 participants
- February 23, 2022: 25 participants

A partnership was established with Six Dimensions, LLC to assist with raising awareness on Maternal Morbidity and Mortality issues in Mississippi. During the reporting period the following outreach events and presentations were conducted.

- October 18, 2021: Motherhood 101 Discussion/Presentation with expecting and new mothers - 12 participants
- October 25, 2021: Documentation for Patient Advocacy: (Facebook Live Event) –Reached 1026
- October 27, 2021: Maternal Health Discussion with the MS Worker’s Center for Human Rights -parent & worker circle participants -18 participants
- November 17, 2021: Not Just the Baby Blues (Facebook Live Discussion) - Reached 710
- November 30, 2021: Motherhood Discussion- Labor & Delivery stories, breastfeeding support, and postpartum discussion -14 participants
- December 13, 2021: Mama’s Mental Health Matters Too (Facebook Live Event) - Reached 406
- December 16, 2021: Coping with Holiday Stress & Anxiety Parenting Seminar -Zoom - 40 participants
- January 25, 2022: Training on Health Equity in Reproductive Health - 20 participants
- January 27, 2022: Supporting COVID-Positive Pregnant and Parent People - 296 participants
- February 2, 2022: Educational session - 10 participants
- February 9, 2022: Maternal Health & Medicaid Expansion- Jackson MS Alumnae Chapter of Delta Sigma Theta -356 views
- February 17, 2022: Breastfeeding Excellence Conference-Jackson State University - 78 participants
- February 22, 2022: NICHQ presentation about shared decision making for Black mothers - 80 participants
- March 5, 2022: Educational and training workshop for doulas -12 participants
- March 31, 2022: Nutrition education for mothers and expecting mothers -5 participants

During this reporting period the following promotional and educational items were developed by Six Dimensions in part using support from MS MMRC subawards.

- Pregnancy Journal
- Actions Steps Visual
- Let's Talk Motherhood Graphic Recording Part 1
- Let's Talk Motherhood Graphic Recording Part 2
- Laboring with Hope Screening & Discussion Graphic Recording

The pregnancy journal and the Actions Steps Visual are specific products that were developed to address the needs of mothers, based on their feedback.

During the reporting period, MIHB renewed a contract with Mom.ME, a non-profit community-based organization to provide maternal support services to pregnant and postpartum women. Mom.ME provided the following eClasses and workshops during this reporting period.

- October 30, 2021: OctoberFest Community Health Fair - 105 participants
- January 13, 2022: Car Seat Safety Class - 8 participants
- January 19, 2022: Labor & Delivery Class - 8 participants
- February 23, 2022: Promising Partnerships to Address Maternal Mortality Webinar (presented on HRSA Region IV webinar)
- April 14, 2022 – “Building for Liberation Centering Black Mamas, Black Families, and Black Systems of Care” Black Maternal Health Conference – 24 participants
- October 1, 2022 – “The Art of Storytelling” – partnership with the Aerial View

Mom.ME also conducted peer mentor trainings for mothers wanting to take an active role in offering support to women enrolled in the Mom.ME Cares pilot program. Peer mentors are recruited and identified through outreach and participation in the Mom.ME Cares program. Two peer mentor training courses were conducted during the reporting period. Five women were trained on how to answer the Mom.ME Peer Support phone line that is available 24 hours. The warm line offers individuals an opportunity to talk to someone who truly understands their struggles. Participants were trained on how to keep all calls confidential unless given permission to disclose information to Mom.ME staff, actively listen to the callers, be empathetic of their issues, empower the individuals, and how to share their story and journey to help encourage them on their path to wellness and recovery. On February 19, 2022, an additional training was hosted to discuss how to communicate with mothers enrolled in the Mom.ME Cares program, identify when a mother is in crisis, and processes for scheduling meetups with mothers and families. Four women received this training. Mom.ME also sponsored a professional training that was facilitated by Postpartum Support International (PSI) on Perinatal Mood Disorders: Components of Care. The training was held on June 8-9, 2022. The two-day course provided guidance and assisted individuals with building skills to assess and treat perinatal mood disorders. Additionally, Mom.ME staff and volunteers have participated in a variety of trainings to continually improve and provide appropriately tailored services to pregnant and postpartum women. During the reporting period, Mom.ME staff and volunteers have participated in the following trainings:

- October 2-3, 2021: Champions for Change Summit hosted by the Voices and Preeclampsia Foundation
- October 6, 2021: Lactation Conference
- October 26, 2021: Mother-Infant Attachment: Promoting Connections in the Perinatal Period
- February 21, 2022: A Maternal Mental Health Crisis: PMADs in the Pandemic Seminar

Cohort Two started October 1, 2021. At the end of this project period, Mom.ME Cares has received 35 referrals from medical providers and successfully enrolled 11 women in the program. As of March 2022, 15 support group meetings had been held with 8-10 mothers attending each session.

During the reporting period, Mom.ME also expanded its reach in partnering with Plan A Health and the Diaper Bank of the Delta to provide community-based mobile and mental health screenings, postpartum care, baby weight and length measurements, and tangible high-need items at “birth2baby” events. These events were held on:

- May 13, 2022 – West Point, MS

Mom.ME hired a web designer to assist with rebranding the website. The redesign made the website more user friendly and a one-stop shop for pregnant and postpartum women setting assistance. The website went live May 21, 2021, with an integrated referral system for any provider, community worker, etc. to refer women to Mom.ME Cares program, support groups, and workshops. Rebranding and redesign incorporated a referral system for providers, community, etc. to refer women to Mom.ME Cares program and other services. Mom.ME worked with its web designer throughout the reporting period on a provider directory that will showcase practitioners referring to the Mom.ME Cares program. This update is anticipated to be completed and added to the website by June 2022. Further, Mom.ME. hired a production company to develop a video to bring awareness to Perinatal Mood Disorders. In efforts to appropriately capture the lived experiences of women, those participating in the Mom.ME Cares pilot program were encouraged to share their story and how they benefitted from the program. Six women agreed to participate in the development of the video, however, only two of the six stories were utilized due to the narrative and length of time. Mom.ME edited the video to make a PSA to share across social media platforms and other media outlets to raise awareness about maternal mental health. Mom.ME also released the PSA on television as a commercial. The PSA aired for 45 days within a 50-mile radius of Jackson, MS.

Objective: By March 2022, Title X clinics will increase the number of family planning and preventive health services users by 5.35% (37,000 users) from baseline of 35,120 users CY 2019.

Objective: By March 31, 2022, the Family Planning Program will establish formal partnerships with at least 20 community-based and faith-based organizations to increase utilization of family planning services.

Strategy: Collaborate with MSDH regional staff to develop promotional strategies to increase family planning users.

Strategy: Collaborate with partners to provide reproductive health training to the community.

Activities: During the Title X project grant period (April 1, 2019 – March 31, 2022), MSDH served as the sole Title X grantee in Mississippi. During that timeframe, MSDH contracted with Federally Qualified Health Centers (FQHCs), also known as delegate agencies to increase community awareness of access to the MSDH Family Planning program services offered. The delegate agencies included Aaron E. Henry Community Health Centers (5 sites), G. A. Carmichael Health Centers (3 sites), Northeast Mississippi Health Care Centers (3 sites), Family Health Care (5 sites), Jackson State University, Jackson Hinds Comprehensive Health Centers, Open Arms Healthcare Center, Dr. Arenia C. Mallory Healthcare, Southeast Mississippi Rural Health Inc, East Central Mississippi Healthnet and University of MS Medical Center. At the local level, community partners are more likely to be a referral source or provide in-kind or low-cost services to family planning patients in need. The contract with delegate agencies ended when the MSDH Family Program was no longer a Title X grantee and entered in the No-Cost Extension cycle which began on April 1, 2022, and ended March 31, 2023.

Title X family planning program provided services to:

- 35, 120 unduplicated users from 01/2019 – 12/2019
- 30,891 unduplicated users from 01/2020 – 12/2020

- 13,623 unduplicated users from 01/2021 – 12/2021
- 20,839 unduplicated users from 01/2022 – 12/2022

These reported data show a decrease in users for 2020, 2021 and 2022 from 2019 due to COVID-19 and changes in clinical operations for MSDH and Title X delegates.

During the reporting period and through March 2022, efforts were made to involve additional FQHC clinic sites as 20 delegate agencies. The Title X program manager, responsible primarily for work with delegates agencies, developed an efficient process to monitor FQHC quarterly reports to ensure compliance. The program Nurse consultant continued to provide clinical staff technical assistance on proper documentation needed for family planning visits in EPIC. Program staff met with the Office of Communicable Disease, which includes the STD/HIV program to ensure that Title X patients received Family Planning Waiver information and condoms funded by the Title X services.

Telehealth has a great potential for expansion of access to Family Planning services, particularly in areas that are more likely to experience reproductive health disparities. Conditions under COVID-19 provided an added incentive to introduce telehealth as an alternative healthcare solution. In March 2020, MSDH initiated the COVID-19 Guidance for patient care. This included screening via telephone for the corona virus, then assessing family planning needs, offering either a scheduled face to face appointment or providing immediate delivery of birth control supplies via curbside (in parked car). The COVID-19 Guidance for patient care continued to be used at MSDH county health departments. Telehealth protocols were developed specifically for Family Planning to include both MSDH health departments and Delegate Agency Health Clinics. Several Telehealth meetings were conducted in the process to get the Family Planning program onboarded with MSDH's EHR, EPIC. The program worked with the EHR to develop a telehealth tool within the EHR to identify program's telehealth visits.

Family Planning continued to collaborate with STD/HIV services by providing Family Planning Waiver materials and condoms as requested by that program. Continuous efforts were made to ensure the integration of literacy, age appropriate and cultural/ linguistic materials are included in all preconception health messages and outreach activities. Educational materials were translated into other languages and disseminated to each county health department and Title X delegate agencies to provide clinicians with tools to better educate the clients served.

MSDH continued to train MCH/FP Coordinators to ensure the understanding of preconception health care and how to best emphasize the benefits of family planning services throughout the life span of the client. Every client (female and male) of reproductive age received education and counseling around preconception and inter-conception care along with information about all forms of contraception that is consistent with their reproductive life plan and risk of pregnancy. The orientation process for new clinic staff is managed at the district/regional clinic levels. The program staff provided technical assistance to ensure clinic staff receive appropriate annual updates. MSDH Family Planning staff attended monthly program meetings. Each meeting included education and information on various Title project program topics, updates, and staff training, allowing staff to stay up to date on program and professional information and changes as needed. The Family Planning program continued to partner with local non-profit organizations and FQHCs to expand family planning services across the state.

The MSDH Title X FP program ended on March 31, 2023. The program continued to operate under No Cost Extension (NCE) funds from April 1, 2022, to March 31, 2023. Under the NCE funds, the program continued to provide family planning services to all MSDH Title X clients and work on improving the overall management and administration of the Family Planning program. Areas of improvement included improving administrative functions, fiscal oversight and responsibility, contraceptive access, high quality family planning services and increasing collaborations and partnerships. As the NCE period has closed, MSDH continues exploring

possibilities and opportunities to partner with Converge, the current Title X grantee for Mississippi since April 1, 2022. This includes supporting patients who need the enhanced services and protections offered under Title X to gain access to provide within Converge network. Further, MSDH clinics have been aggressively implementing a statewide project known as "Operation Going Gold" since August 2022. Under this project, MSDH clinic staff have been trained in the most efficient and effective processes to support patients in applying for the Family Planning Waiver. Since August 2022, all MSDH clinics have provided patients with direct, one-on-one assistance to make application for the waiver, and have provided intentional patient-level follow-up, reminders, calls, etc. to assure patients are linked and enrolled in this important resource to allow them to continue receiving family planning services at no out-of-pocket cost to them.

PRIORITY: Oral Health

NPMs, NOMs, SPM, and ESMs:

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

Objective: *By September 30th, 2022, increase the number of pregnant women who have a dental visit during pregnancy from 29.5% to 45% (by 10.5%).*

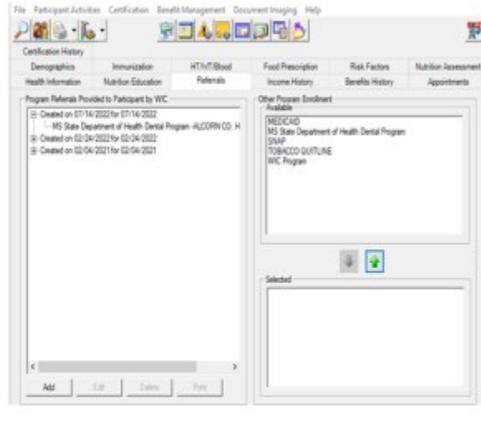
Strategy: The MSDH's Offices of Oral Health and WIC will collaborate to offer oral health education to WIC participants by Regional Oral Health Consultants (ROHCs).

Activities: The Office of Oral Health worked with the WIC team to ensure harmony in maintaining the oral health services currently being offered. During the grant reporting period, our office provided oral health services to several WIC sites throughout Mississippi as well as hygiene kits, finger brushes, training brushes, and brochures in both English and Spanish. The Office participated in routine WIC regional meetings to update WIC team members on program updates. Additionally, throughout this reporting period, ROHCs participated in quarterly WIC nutritionist meetings to share program updates and trouble shoot any region specific challenges. In September 2022, the Program Director also shared updates with the WIC team, including staffing updates of ROHCs and the new referral system in SPIRIT and REDCAP provided through their team.

Additionally, since this reporting period, we have updated the documentation tools in the WIC SPIRIT portal to allow the WIC nutritionist or clerk to identify if the participant received oral health education or if a hygiene kit was disseminated. This was needed with the extended virtual certification of WIC participants. These new tools and data from them will be shared in the next annual report.

WIC AND ORAL HEALTH: ENHANCED COLLABORATION

- Referrals (REDCAP)
- Dental Care Coordination
- Oral Health Messages on WIC app



Strategy: Provide oral health education to expectant mothers on the importance of proper oral health during pregnancy and postpartum.

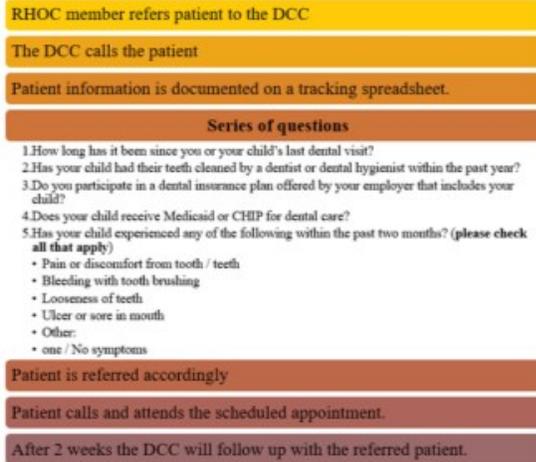
Activities: Over this reporting period, Oral Health personnel continued to amplify messages on the safety and importance of seeing a dentist during pregnancy. In working with our WIC participants, Healthy Moms-Healthy Babies program, community baby showers hosted by faith-based entities and local insurance carriers, we provided oral health education to 1186 expectant mothers and/or those who were post-partum. We utilized educational materials from the Healthy Smiles from the Start, Dental Care Tips for Mom and Baby brochure launched by the Alliance of the American Dental Association, American Dental Association and the Henry Schein Cares program. Additional resources shared were those from the National Maternal and Child Oral Health Resource Center. With these educational materials, each mother was given toothbrush aids for herself (toothbrush, floss and toothpaste) and age-appropriate toothbrush aids for infants and toddlers (finger brushes/scissor brushes or teething ring toothbrushes).

Strategy: Provide regionally specific dental referral names and phone numbers to expectant mothers of dentists in the community where they can schedule routine exams and dental procedures during and after pregnancy

Activities: While our agency does not provide direct dental services at local county health departments, we have dental hygienists with the office of oral health located throughout the state to assist with our oral health promotion, oral disease prevention, dental care coordination and oral surveillance efforts over a lifespan. During this reporting period, the program director shared updates to the regional oral health consultant map (which details the counties each ROHC serves) and introduced our dental care coordination process to maternal child health staff throughout the state (at several meetings). Generally, the regional oral health consultants do not have access to the patients seen in the various departments and are not apart of the electronic health record, EPIC, where this information can be captured. As such, we rely heavily on internal and external team members to share this information with our dental care coordinator or local ROHC for follow up with the patients. We are waiting for oral health questions and assessments to be rolled out through all agency programs by way of EPIC; however, we are unsure of when this will take place. In the interim, an excel spreadsheet is utilized to capture dental referrals (internally and externally) and document outcome of the follow up with the patients. The below graphs depict this process:

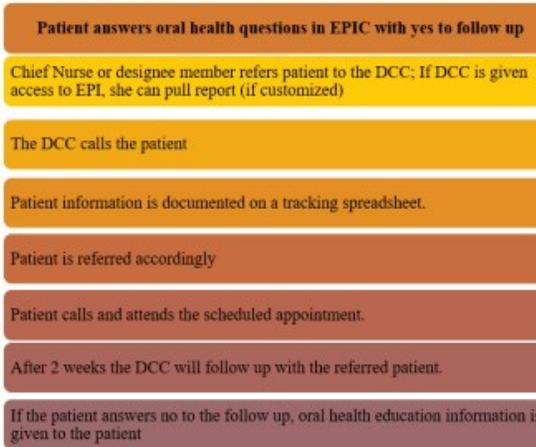
DENTAL CARE COORDINATOR (DCC): INTERNAL PROCESS

Internal = Office of Oral Health (OOH)
External = Referrals from Outside



DENTAL CARE COORDINATOR (DCC): EXTERNAL PROCESS

Internal = Office of Oral Health (OOH)
External = Referrals from Outside



Strategy: Work with Physician Assistants (PA's) to provide screenings, varnish, and develop a systematic referral system to ensure dental visits for preventive care.

Activities: Physician Assistants have been one of three non-dental provider types (nurse practitioners, medical webdoctors) we have worked to recruit for our Cavity Free in Mississippi program where we train providers on the importance of oral health assessments and fluoride varnish application in medical settings. As an incentive, these provider groups received additional reimbursement from Medicaid for the oral assessment and fluoride varnish application on children 0-3, if they are not reimbursed based on an encounter rate. While we have had some difficulty recruiting physician assistants, we have worked with medical doctors and nurse practitioners to train on the Cavity Free in Mississippi program. During the grant reporting period, Cavity Free in Mississippi trainings and supplies were provided in Smith County and Wayne County at Family Health Center of Laurel (15), in Wayne County at Waynesboro Family Medicine (5) in Jones County at Calhoun Medical Clinic (3) in Clarke County at Deloach Family Clinic (1), in Bolivar County at Healthy Living Medical Center LLC (3), in Clay County at West Point Children's Clinic (6) in Harrison County at Lighthouse Pediatrics, in Franklin County at Caring Hands Children's Clinic-Meadville, in Lawrence County at Caring Hands Children's Clinic-Monticello, in Lincoln County at Milestones Pediatric Clinic, in Simpson County at Pedz Clinic, and Hancock County at Children's International Pediatrics. A total of fifty-four 54 medical providers and staff were trained, representing twelve counties.

Additionally, medical providers received fifty (50) .25 gram of 5% sodium fluoride varnish, educational pamphlets

on fluoride varnish, and a list of dental suppliers and products. During the grant reporting period, at least two thousand and seven hundred (2, 700) .25 grams of 5% sodium fluoride varnish were provided to non-dental providers implement this program in their clinics.

Also, as a part of our provider recruitment efforts, folders were created and provided to non-dental providers. These folders included a flyer about the program, a letter from the program director sharing the importance of oral health assessment and fluoride varnish in the medical home, a white paper on fluoride varnish in the primary care setting by the American Academy of Pediatrics, and billing information. We hope to gain more data from the providers going forward on implementation efforts and impact.

Strategy: Monitor provider patient utilization to track Fluoride varnish, utilization, provider participation, number of referrals, and number of follow-up care to dental homes.

Activities: One of our strategies towards increasing the number of children receiving oral health assessments and fluoride varnish in a primary care setting was to increase the number of persons trained on our Cavity Free in Mississippi Curriculum. As part of this collaboration, we evaluated the training tool, documents associated and created an evaluation tool to follow up with the trainers of the curriculum for feedback and monitoring of program implementation. We also incorporated a cold call tracker log where Regional Oral Health Consultants document when they reach out to a provider (office) and what feedback they receive. Ultimately, we were testing whether updates to the training log and training tools would provide ease of documentation and tracking with follow up by the ROHCs to providers who participated in the training. Increasing follow up was hoped to generate more opportunities to assist providers with challenges of implementing the process to perform the oral assessment and fluoride varnish.

The Office of Oral Health hopes to utilize this centralized tool to follow up with providers over time to better address their training needs and implementation progress of the oral health assessment and fluoride varnish application in their healthcare system.

As part of the Advancing Prevention and Reducing Childhood Caries initiative we participated in, teams were given training on oral health drivers and change ideas that could further our efforts:

Oral Health Change Ideas

Primary driver	Secondary driver	Change ideas	Lead measures	References
State agency leadership and other stakeholder collaboration	Engaging with health systems and stakeholders	<ul style="list-style-type: none"> • Facilitate relationships between primary care providers and dental providers to advance oral health¹⁷ <ul style="list-style-type: none"> • Host "Dining with Dentists" events to bring dental and medical professionals in a community or region together² • Offer interdisciplinary trainings that involve both medical and dental residents³ • Offer trainings and information to health systems on the importance of addressing oral health in primary care^{4,5} <ul style="list-style-type: none"> • Offer interactive seminars (with associated CME credits) on the relationship between oral health and overall health, and the related role of primary care providers • Outline suggested redesigns to clinical workflows to better accommodate fluoride varnish application in primary care practice • Develop and disseminate oral health educational materials, including fact sheets, to primary care providers, that emphasize the importance of addressing oral health in primary care • NEW! Provide information on ordering fluoride varnish and develop a resource on recommended oral health supplies for medical exam rooms <ul style="list-style-type: none"> • Consider using AAP's list of Oral Health Supplies for the Exam Room²⁷ • NEW! Engage state dental and primary care societies and oral health coalitions as active partners in program improvement²⁸ • NEW! Collaborate with the state's Maternal and Child Health Program to advance oral health integration; see ASTDO's Issue Brief on this topic for examples²⁹ 	<ul style="list-style-type: none"> • # of events held, - 1 - O • # of participants - 2 - CS • # of provider materials - 3 - E • # of materials disseminated - 4 - E - 5 - O - 37 - O - 38 - E - 39 - E, CS 	

Our Aim Statement for this project was: By December 31, 2022, the Magnolia state will increase fluoride varnish applications by non-dental providers for Medicaid and CHIP beneficiaries ages 1-5 to 18, 128 by assisting non dental providers in primary care settings with incorporating an oral health assessment and fluoride varnish application during EPDST screenings.

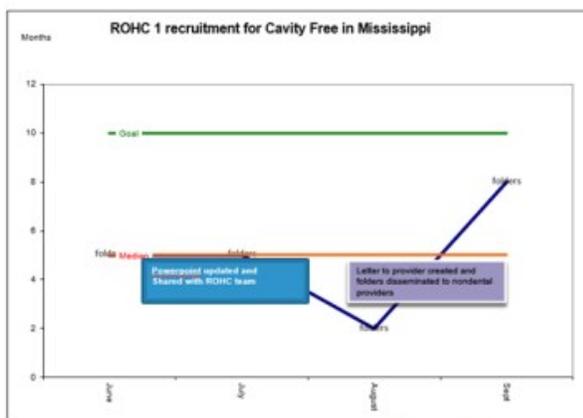
- We utilized this framework and learned the following lessons from PDSAs of our training process and tools:
- (1) A change in the Cavity Free in Mississippi Training Tracker log that provided a tab per ROHC as opposed to all ROHC entries being on one spreadsheet, was helpful to the ROHC team in keeping up and inputting their information about non dental provider recruitment efforts.
 - (2) Some recommendations were made regarding the training itself and it was updated to reflect provider and ROHC feedback.
 - (3) The Cavity Free in Mississippi flyer and medical provider application was reviewed by our pediatric consultant.
 - (4) A cold call log was created and used by ROHCs to document follow up with non-dental providers in their counties of coverage.
 - (5) Providers trained don't often report back on data of those trained, so we will be updating the medical provider application which asks for preliminary office demographic data. The staff will be trained in its use. Our dental director drafted a letter to send to each provider and these are used with other information in recruitment efforts.

RUN CHART: Recruitment-Cavity Free in Mississippi

Vertical Axis Label: Months
 Graph Label:
 ROHC 1 recruitment for Cavity Free in Mississippi

Date / Observation	Value	Median	Goal
June	5	5	10
July	5	5	10
August	2	5	10
Sept	8	5	10

Actual Trainings conducted:
 July 20, 2022
 August 4 and 5, 2022



We now have a better system to monitor which providers not only had the training but those who have implemented it. We continue to have some challenges with retrieving data back from those providers trained on the number of constituents benefiting from the program. We are exploring ways to enhance these efforts.

Strategy: Build connections and strengthen opportunities with state programs, dental schools, dental hygiene programs, private practice and community-based organizations

Activities: Our office continues to build relations throughout the state with various stakeholders to strengthen our work in the community we serve. We received notification from the National Maternal and Child Oral Health Resource Center that our state oral health program was selected to participate in the Integrating Oral Health Care and Primary Care Learning Collaborative: A State and Local Partnership. In this collaborative, The Office of Oral Health has been working to better integrate the interprofessional oral health core clinical competencies within a local community health center who provides prenatal care to its patients (G A Carmichael Family Health Center). May 2022, we begin working with GA Carmichael Family Health Center. The purpose of this collaboration is to expand access to integrated preventive oral health care for the maternal and child health population by providing high quality oral health technical assistance, training, and resources. Mississippi is one of 9 states participating in this learning collaborative. As a framework, we are utilizing the Interprofessional Oral Health Core Clinical

Domains: Risk assessment, oral health evaluation, preventive interventions, communication, and education and interprofessional collaborative practices as defined in the US Department of Health and Human Services, Health Resources and Services Administration, Feb 2014 white paper "Integration of Oral Health and Primary Care Practice".

Project measures are:

Domain 1: Risk Assessment

- Percentage of pregnant women who received an oral health risk assessment during a first or second trimester visit by a primary care team member.

Domain 2: Oral Health Evaluation

- Percentage of pregnant women who received an oral health screening during a first and/or second trimester visit by a primary care team member.

Domain 3: Preventive Intervention

- Percentage of pregnant women who received a fluoride varnish application during pregnancy by a primary care team member.

Domain 4: Communication and Education

- Percentage of pregnant women who received oral health education during pregnancy by a primary care team member.

Domain 5: Interprofessional Collaborative Practice

- Percentage of pregnant women who received a dental referral during a first and/or second trimester by a primary care team member.
- Percentage of pregnant women who received a dental referral for urgent needs during a first and/or second trimester visit by a primary care team.
- Number of pregnant women who received a documented dental referral who had an initial oral health visit during the month.
- Number of pregnant women who received a documented dental referral for urgent needs who had an initial oral health visit during the month.

We are monthly tracking GA Carmichael's progress having created oral health assessment tools, identified oral health education to disseminate and refining a process of referral from the OB/GYN team to the dental.

This is just one example of how our work at the local and state with GA Carmichael to improve systems of care for the integration of oral health with the OB/GYN department is impactful to the community in reducing oral health disparities and championing the need for comprehensive dental benefits for all ages.

Strategy: Increase oral health awareness by distributing educational materials geared towards public and health professionals.

Activities: In January of 2022 we expanded our work with the Office of Preventive Health to assist with their efforts in the GO NAPSACC and MS Better Together Program. We have maintained rich relationships with the MS Head start Association and other private daycare centers in the state for decades. Go NAPSACC's provider tools guide childcare providers through 5 simple steps to make healthy changes to their programs. These steps

include Assess, Plan, Take Action, Learn More, Keep it Up.

The model focuses on seven easy to use modules that address topics that are essential to the health of young children:

- Child Nutrition
- Breastfeeding and Infant Feeding
- Farm to ECE
- Oral Health
- Infant and Child Physical Activity
- Outdoor Play and Learning
- Screen Time

During this reporting period, Regional Oral Health Consultants completed the training to provide technical assistance to centers who do not have policies in place at their facilities regarding oral health inclusion and best practices. We have distributed information about this program at conferences with Head start and Daycare centers, community events and the like.

Additionally, during this reporting period, we attended conferences like the 35th Community Health Association of Mississippi where we participated as a vendor and our program director presented on Dental Provider Roles in Providing Vaccination and Social Assessment Use in Dental Clinic Settings.

Similarly, our ROHCs participated in numerous meetings, health fairs and community outreach opportunities where they shared literature on the importance of oral health to overall health and well-being. Some topics highlighted included: the benefits of community water fluoridation; oral health and diabetes, oral health and cardiovascular disease, oral health and aging, oral health and pregnancy, and oral health and substance abuse and misuse (opioids and vaping).

Women/Maternal Health - Application Year

**Women/Maternal Health
Application Year - FY2024**

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

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

NPMs, NOMs, SPM, and ESMs:

- NPM 1: Percent of women, ages 18-44, with a preventive medical visit in the past year

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

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

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

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

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

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

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

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

Activity: Extend existing or select by competitive RFP, subgrantees, including health systems or community-based partners, to execute specific activities for recruitment, referral, enrollment, direct services, and participant navigation to address SDOHs of MCH program participants that improve women's/maternal health.

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

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

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

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

external partners to increase referrals to the program.

Activity: Identify 3-4 potential healthcare settings, community-based, faith-based, social, volunteer service organizations, homeless/domestic violence shelters, residential programs, treatment programs, housing complexes, etc. to outreach per quarter. Request opportunities to share information with “gatekeepers” of (i.e., community health workers, patient navigators, care coordinators, case managers, faith leaders, non-profit social service workers, helpers, etc.) or to the target population.

Activity: Optimize MSDH electronic health record (Epic) and other platforms to create referral management processes and templates for use by external and internal referral sources to home visiting/case management programs.

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

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

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

Activity: Submit work requests to the Office of Communications to promote CDC/HRSA/other approved messaging related to women’s health issues etc. Prepare social media post schedules and templates for observance months/days.

Activity: Maximize available funding and in-kind support to develop or enhance direct health education approaches for consumers of MCH-serving programs focused on improving women’s health issues (i.e., breast and cervical cancer screening, well-woman/preventive health visits [WISEWOMAN if funded])

PRIORITY: Maternal Morbidity and Mortality

NPMs, NOMs, SPM, and ESMs:

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

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

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

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

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

Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in

providing services geared toward improving maternal mortality based on MMRC recommendations.

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

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

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

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

Activity: Streamline referral process for pregnant women with positive syphilis findings to home visiting/case management program.

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

Activity: Support the uptake/maintenance/continued implementation of AIMS Safety Bundles (i.e., severe maternal hypertension, obstetric hemorrhage, and reduction of primary caesarean births) in birthing hospitals and other health systems.

Activity: Support the launch/uptake of new AIMS Safety Bundles (i.e., postpartum discharge transitions, perinatal mental health) in birthing hospitals and other health systems.

Activity: Host the Annual Maternal Health Symposium to support future strategic planning on maternal health issues and mortality/morbidity prevention approaches.

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

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

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

Activity: Extend existing or select by competitive RFP, subgrantees, including health systems or community-based partners, to execute specific activities for providing health promotion, health education, and health equity-focused activities that improve maternal health (prenatal, perinatal, postpartum, and/or interconception).

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

Activity: Submit work requests to the Office of Communications to promote CDC/HRSA/other approved

messaging related to maternal health issues (prenatal, perinatal, postpartum, and/or interconception) etc.
Prepare social media post schedules and templates for observance months/days.

Activity: Maximize available funding and in-kind support to develop or enhance direct health education approaches for consumers of MCH-serving programs focused on improving maternal health issues.

PRIORITY: Oral Health

NPMs, NOMs, SPM, and ESMs:

- NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

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

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

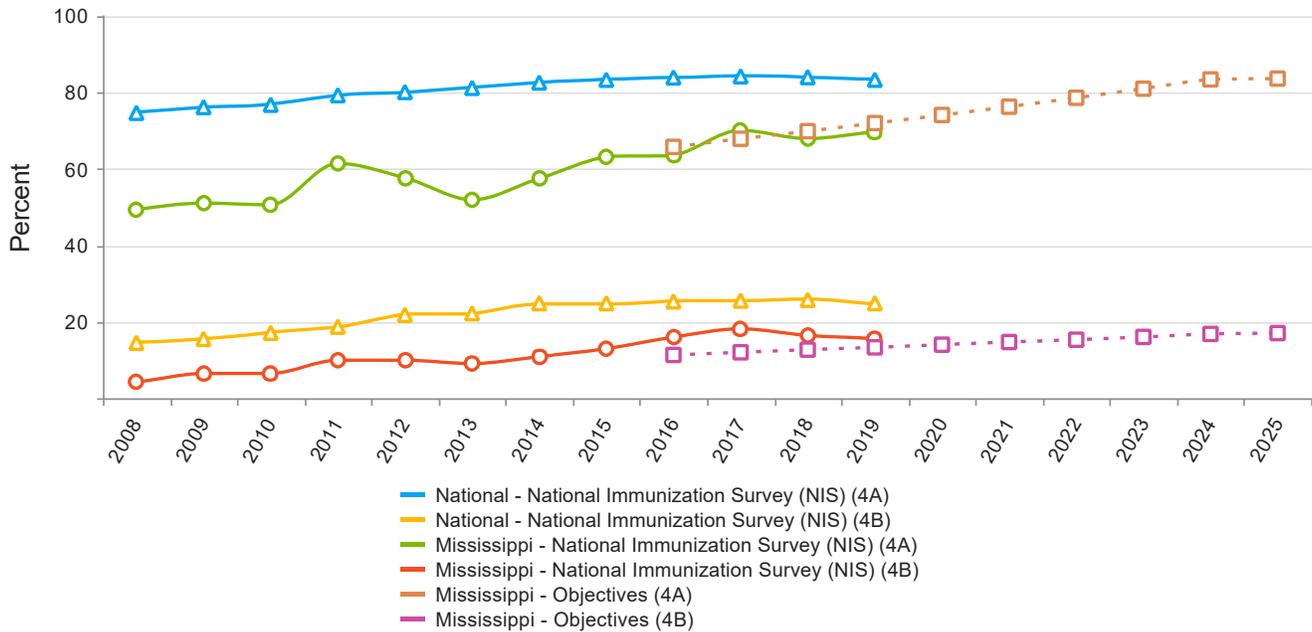
Activity: Implement oral health promotion and messaging through eWIC app

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

Perinatal/Infant Health

National Performance Measures

**NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives**



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	2019	2020	2021	2022
Annual Objective	69.8	71.9	74	76.2	78.5
Annual Indicator	63.2	63.4	70.0	68.0	69.4
Numerator	22,091	22,722	22,777	21,999	23,474
Denominator	34,981	35,813	32,539	32,351	33,806
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	80.9	83.3	83.5

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	2019	2020	2021	2022
Annual Objective	12.8	13.4	14.1	14.8	15.4
Annual Indicator	13.0	16.0	18.1	16.4	15.6
Numerator	4,455	5,507	5,651	5,200	5,053
Denominator	34,243	34,464	31,217	31,729	32,343
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	16.1	16.9	17.1

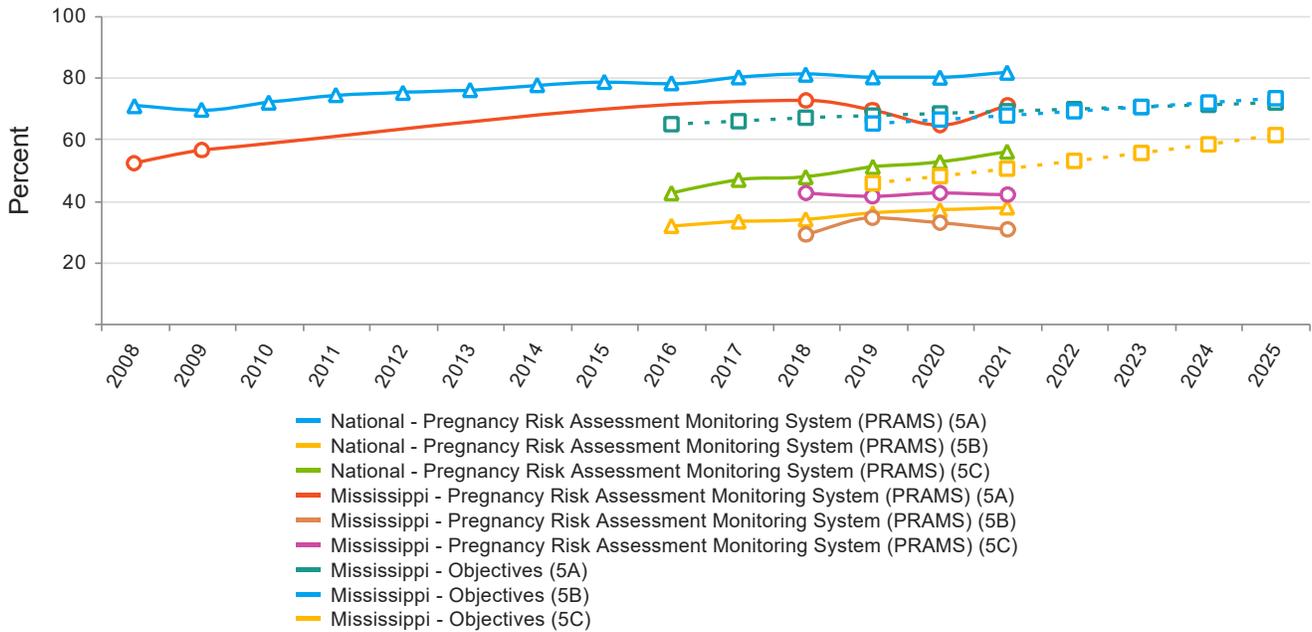
Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	3	4	5	6	24
Annual Indicator	11	18	21	22	25
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	Baby Friendly USA			
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	26.0	28.0	30.0

**NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Indicators and Annual Objectives**



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	2019	2020	2021	2022
Annual Objective	66.8	67.5	68.2	68.9	69.6
Annual Indicator	56.1	72.2	69.4	64.3	70.7
Numerator	21,733	23,861	22,384	20,451	21,727
Denominator	38,760	33,042	32,256	31,790	30,728
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2009	2018	2019	2020	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	66.8	67.5	68.2	68.9	69.6
Annual Indicator	63.6	72.2			
Numerator	21,016	23,861			
Denominator	33,023	33,042			
Data Source	MS PRAMS	MS PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	2024	2025
Annual Objective	70.3	71.0	71.7

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

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

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		64.9	66.2	67.5	68.9
Annual Indicator	63.6	28.8			
Numerator	21,016	9,167			
Denominator	33,023	31,841			
Data Source	MS PRAMS	MS PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	2024	2025
Annual Objective	70.3	71.7	73.1

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

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

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		45.6	47.9	50.3	52.8
Annual Indicator	43.4	42.3			
Numerator	15,145	13,523			
Denominator	34,882	31,973			
Data Source	MS PRAMS	MS PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	2024	2025
Annual Objective	55.4	58.2	61.2

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals

Measure Status:				Active	
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	25,000	20,200	20,450	20,700	21,000
Annual Indicator	20,000	10,000	14,880	9,560	11,863
Numerator					
Denominator					
Data Source	MSDH Infant Health Program				
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	21,250.0	21,500.0	21,500.0

State Performance Measures

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

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	49.3	54
Numerator		11,007
Denominator		20,401
Data Source	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	51.0	51.5	52.0

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

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

Annual Objectives			
	2023	2024	2025
Annual Objective	78.5	79.0	79.5

State Action Plan Table

State Action Plan Table (Mississippi) - Perinatal/Infant Health - Entry 1

Priority Need

Increase Breastfeeding, Healthy Nutrition and Healthy Weight

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

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

Strategies

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

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

ESMs

Status

ESM 4.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

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

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

Priority Need

Reduce Infant Mortality

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

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

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

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

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

Strategies

MIHB will provide the administrative support for the death case abstraction, exploration, and determination process to fidelity for all maternal deaths through the Child Death Review Panel and FIMR

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

ESMs

Status

ESM 5.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

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

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

Priority Need

Improve Access to Family-Centered Care

SPM

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

Objectives

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

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

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

Strategies

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

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

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

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

Priority Need

Increase Breastfeeding, Healthy Nutrition and Healthy Weight

SPM

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

Objectives

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

Strategies

Partner with other MCH-serving program on Community Innovation and Outreach (CIAO) project activities

Perinatal/Infant Health
Annual Report - FY2022

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

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

The following section outlines strategies and activities implemented between 10/1/2021-9/30/2022 to meet the objectives and show improvement on the measures related to perinatal and infant health:

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

NPMs, NOMs, SPM, and ESMs:

- NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
- SPM 1 - Percentage of women who smoke in the last three months of pregnancy.
- NOM 9.1 - Infant mortality rate per 1,000 live births
- NOM 9.3 - Post neonatal mortality rate per 1,000 live births
- NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
- ESM 1.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy.
- ESM 5.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals

Objective: By September 30th, 2020, expand safe sleep outreach from 6 to 9 new community partners.

Objective: By April 30th, 2020, increase the number of likes and or reactions to the Safe Sleep Mississippi Facebook page from 0 to at least 500.

Objective: By September 30th, 2020, increase the number of trainings given to professionals on infant safe sleep guidelines from 2 to 4.

Objective: By August 30th, 2021, increase the number of birthing hospitals supporting and participating in the Mississippi Perinatal Quality Collaboratives QI Initiatives from 33 to 37.

Objective: By September 30th, 2021, reduce primary cesarean deliveries among low-risk mothers (NTSV) rate by 10% among 5 participating hospitals.

Objective: By May 30th, 2022, produce a document that highlights the findings, success, and challenges of the FIMR program regarding reducing infant mortality in a local context.

Objective: By September 30th, 2022, increase the number of families educated about infant safe sleep practices from 162 by 50%.

Objective: By March 30th, 2020, establish a system for tracking activities and success of FIMR Program.

Objective: By August 30th, 2020, create a data tracking system to identify key documents needed for thorough SUID case review.

Strategy: Implement a reporting template for Fetal and Infant Mortality Review (FIMR) Coordinator.

Strategy: Continue monitoring the FIMR Coordinators through the new reporting template.

Activities: The current FIMR program operates to review fetal/infant deaths from the three coastal counties of Mississippi – Harrison, Hancock, and Jackson. The new tracking system for the FIMR program began in March 2019. To date, little to no technical assistance has been required. A new electronic and survey-based tracking system was to be implemented for the 2021-2022 reporting period, which would allow all the information to be generated into an ongoing data collection system. Due to being unable to access the data files of former MIHB staff, a report providing precise information is unavailable. However, a summary of available information follows below.

During the reporting period, eight CRT meetings were held with an undeterminable number of cases being reviewed.

FIMR Case Review Team Meetings

- 10/14/2021 – hosted by Singing River Hospital – Ocean Springs
- 3/16/2022 – hosted by Singing River Hospital– Pascagoula
- 4/26/2022 – hosted by Highland Community Hospital
- 5/9/2022 – hosted by George Regional Hospital
- 5/10/2022 – hosted by Memorial Health Gulfport
- 6/28/2022 – hosted by Singing River Hospital – Gulfport
- 7/20/2022 – hosted by Merit Health Biloxi
- 9/20/2022 – hosted by Singing River Hospital – Ocean Springs

Upon reviewing fetal and infant deaths, the panel provided recommendations which centered on precipitating or contributing factors and strategies for prevention of future deaths. From the meetings held in the reporting period, recommendations centered on COVID-19, vaccines during pregnancy, vaping, second/third hand smoke, maternal cocaine use, depression after stillbirth, drug use in pregnancy, post-partum hypertension, maternal obesity, maternal age and birth defects, infant sleep safety, syphilis, self-induced abortions, infant car safety, maternal depression screening, preconception and postpartum maternal care, blood clots, and stillbirth prevention. The recommendations were then shared in the context of the FIMR Community Action Team meetings, which allow for a much larger audience of medical professionals, social service organizations, faith-based communities, etc. for programming and implementation at the local level.

FIMR Community Action Team Meetings Dates and Topics:

- 9/17/2021 – Interpersonal Partner Violence
- 11/18/2021 – Internet Safety and Child Exposure
- 2/23/2022 – Preconception Care Services
- 5/11/2022 - Therapeutic Foster Care & Adoption Program; Parent Strong Program (Parenting Classes), Adoption Permanency Program (post adoption services)
- 7/27/2022 – Immigrant Alliance for Justice and Equity

- 8/24/2022 – Child Sexual Abuse

After requests to MIHB for support over the course of the reporting period, the FIMR Coordinator worked with the MIHB leadership and the MMRC Informant Interviewer to develop a process for adding a maternal/family interview to the case exploration process. A draft of interview assessment questions was prepared by mid-July 2022, with the first maternal/family interview occurring in August 2022. This has been well-received among the FIMR panel and has added context that has been absent with only records reviews for many years. This effort was supported by non-federal/private funds.

Strategy: Assess the quality of the completion of Sudden Unexplained Infant Death Investigation (SUIDI) forms, autopsy reports and death scene investigation of SUID Cases that are reviewed by Child Death Review Panel (CDRP).

Strategy: Assist the Mississippi Child Death Review Panel with continuing to develop recommendations for state leaders and other stakeholders

Activities: There was no specific activity directed to the strategy concerning SUIDI forms and investigation of SUID cases during the reporting period. However, to follow-up on content shared in the prior MCH Block Grant report, the CDRP produced the annual report on 2018 death case findings and released the report public-facing on May 13, 2022. The report can be reviewed at: <https://msdh.ms.gov/page/resources/18967.pdf>

The recommendations in the annual report were the following:

State Leaders:

- Legislation that requires firearms to be traced through the Bureau of Alcohol, Tobacco, and Firearms and Explosives when a child has been injured or fatally injured by a firearm.
- Representative from the Department of Mental Health assigned to the Child Death Review Panel.
- Representative from the District Attorney's Office assigned to the Child Death Review Panel.

Healthcare System and Providers:

- Mass media campaigns discouraging co-sleeping and a realistic approach to helping put babies to sleep.
- Increase awareness about the importance of prenatal visits and support groups. Highlight areas where prenatal support groups exist, their success and where these support groups are not available.

School Administrators, Teachers, and Counselors:

- Incorporating a curriculum on risky behaviors for new drivers in high school health courses.

Local Leaders, Communities, and Families:

- More calls to the Child Protection Service hotline for infant and child fatalities from accidents, homicides, suicides, or any injury related deaths.
- Public service announcements on water safety, swimming safety, and other safety precautions for residential lakes, ponds, and pools.
- Public Service announcements on fire safety and the importance of smoke alarms in homes.

During the reporting period, the Child Death Review Panel (CDRP) held 2 review meetings virtually to complete the review of 2019 infant and child deaths and prepare for the review of 2020 cases. Meetings were held on:

- April 20, 2022 – SUID – 19 cases reviewed

- August 9, 2022 – Fire, drowning, notable deaths – 19 cases reviewed

The CDRP also participated in a virtual site visit on October 26-27, 2021, with the National Center for Fatality Review and Prevention (NCFRP). This site visit was facilitated by leadership in MIHB and representatives of the Michigan Public Health Institute/NCFRP. A key takeaway from this meeting was to have the CDRP begin strategic planning for translating CDRP data to action, specifically around prevention efforts and activities. In a debriefing held on November 18, 2021, the CDRP began discussions of instituting a subcommittee focused on prevention and advocacy.

Strategy: Work with community partners to disseminate safe sleep education and provide resources to community.

Activities: The Lead Poisoning Prevention and Health Homes (LPPHH) program distributed over 11,000 pieces of safe sleep educational materials to hospitals statewide and distributed 2,300 pieces of safe sleep education at community events.

During the reporting period, the MIHB partnered with 4 additional subgrantees, in addition to Mom.ME and Six Dimensions, LLC (described in the Women’s/Maternal Health section) to implement a range of activities aimed at improving infant health outcomes.

The partnerships and activities were as follows from October 1, 2021 – March 31, 2022. Data is not immediately accessible for the remainder of the reporting period and is being further sought.:

- National Council on Alcoholism and Drug Dependence (NCADD)
 - Infant Mortality- Education/Resource Distribution*
 - Provided safe sleep education to 30 parents, grandparents, and/or extended care givers
 - Screened and distributed 30 pack n’ plays to eligible participants
 - Distributed 118 car seats
 - Distributed 161 packs of diapers
 - Maternal Mortality-Mental Health Support*
 - Assessed 78 pregnant and postpartum mothers for mental health and substance use disorder
 - Referred 6 pregnant and postpartum mothers to counselors/therapist for mental health disorders
 - Host 6 monthly workshops for pregnant and postpartum mothers on mental health and substance use topics – 163 participants
- Memorial Health Gulfport
 - Infant Mortality- Education/Resource Distribution*
 - Provided discharge education on post-childbirth, breastfeeding, and parenting to 47 families
 - Screen attendees for their needs for pack n plays, sleep sacks, and car seats – distributed 60 sleep sacks and 2 car seats
 - Provided follow-up assessment with moms post-delivery (2 weeks-12 months) about safe sleep practices - # unknown.
 - Provided referrals for postpartum moms for additional resources - # unknown.
 - Maternal Mortality- Mental Health Support*
 - Provided classes on prepared childbirth, breastfeeding, and parenting to expectant mothers
 - Educational materials provided on post-partum signs and symptoms – 550 materials distributed
 - Provided follow-up call 2 weeks post-delivery to 16 families

- North Mississippi Medical Center
Infant Mortality- Education/Resource Distribution
 - Through support groups, educate participating women about breastfeeding, infant feeding behavior, breast feeding at work, strategies to address breastfeeding challenges – 8 meetings held, 11 participants total
 - Through support groups educate participating women on baby sleep safety, proper use of care seats, postpartum depression, etc. – 8 meetings held, 11 participants total
- *Maternal Mortality-Enhanced Postpartum Care*
 - Screened 11 participating women on their needs and infant needs by using the Edinburg Postnatal Depression Scale. None required referral.

The MIHB also partnered with the Institute for the Advancement of Minority Health as a subgrantee during the reporting period. A summary of that project follows:

Goal 1: Enhance the capacity and efficacy of patients and family to advocate for themselves and their loved ones, engage in shared decision making and informed consent, and escalate concerns in emergency situations.

Objective 1: By September 29, 2022, IAMH will conduct four (4) health literacy workshops to provide health literacy information to at least 100 expectant mothers in the target areas that increases their knowledge about pregnancy risk factors and their ability to advocate for themselves.

Throughout the course of the project period, IAMH conducted four virtual health literacy workshops via Zoom which provided educational material from a curriculum that was developed entitled, “Mommy Basics.” The four sessions were conducted in partnership with Magnolia Medical Foundation. The curriculum provided educational information about proper prenatal care which included warning signs and symptoms that, if experienced, indicated that a care provider visit was needed. The workshops were attended by 127 women. Pre-test/post-test scores showed marginal gains in knowledge, highlighting the need for emphasizing the warning signs of preeclampsia and premature labor, the importance of placing an infant to sleep on his/her back, and that too many blankets in the crib is a risk factor for sudden infant death syndrome (SIDS).

Goal 2: Improve maternal and child health outcomes by training health care providers about the effects of racism on maternal and child health outcomes.

Objective 2: By September 29, 2022, IAMH will implement an evidence-based anti-racism curriculum to increase knowledge and awareness among at least 50 healthcare providers about the effects of racism on maternal and child health outcomes.

Throughout the project period, The Institute held five (5) workshops that implemented an evidence-based anti-racism curriculum. The workshops were facilitated by Dr. Tanya Funchess, Assistant Professor in the College of Nursing and Health Professions at the University of Southern Mississippi. All workshops were held virtually via the Zoom platform. Overall, 44 participants representing 19 organizations attended at least one workshop in the series. All workshops were evaluated by measuring knowledge prior to and after content delivery via online pre- and post-survey.

Goal 3: Improve infant mortality rates in the target area by providing safe sleep education to parents, grandparents, and extended caregivers such as childcare providers.

Objective 3: By September 29, 2022, IAMH will distribute at least 500 educational materials through community outreach events and in partnership with daycare centers.

Throughout the course of the project period, The Institute hosted or attended community outreach events whereby they distributed educational materials (pamphlets, fact sheets, booklets, and brochures), diapers, personal hygiene items, infant formula and other items within the prioritized counties. The Institute hosted five (5) Community Baby Showers. Educational materials were supplied to these partners so that they could be distributed to parents and caregivers. There were 2,625 educational items distributed in the prioritized counties. Partnerships were established with ten (10) daycare providers.

Goal 4: Identify the needs of pregnant and postpartum women in Bolivar, Copiah, Hinds, Simpson, Sharkey, Sunflower, Issaquena, and Washington counties.

Objective 4: By September 29, 2022, IAMH will distribute and obtain completed peripartum and postpartum assessment forms from at least 80 pregnant and postpartum women in the target counties.

During the project period, an assessment survey was developed to be distributed to pregnant and postpartum women within the prioritized counties. The goal of the assessment was to identify women who needed referrals and link them to services or resources. Though the goal was to reach at least 80 women in the prioritized counties, only 46 individuals completed the assessment. Questions were asked around secondhand smoke risk, infant feeding, postpartum depression and anxiety, and awareness of services and resources in the community. Among those who responded, 17.4% reported that someone smoked inside the home. Regarding infant feeding, many respondents reported bottle-feeding their infant (41.3%), almost one-third (30.4%) breast fed, and 26.1% do both. Approximately 15.2% of respondents had concerns or questions around breastfeeding their infant. Almost one-fourth (23.9%) had concerns that they may have postpartum depression or anxiety. About one in ten (10.9%) did not have a pediatrician for their infant, and 13.0% did not have a medical provider for their own primary care. Lastly, when asked about awareness of specific services and resources, almost all (89.1%) were aware of the Women, Infants, and Children (WIC) Program, but only 45.7% were aware of services provided by the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. Findings from the survey indicate that there is a need for resources related to breastfeeding support, and postpartum behavioral health services.

Strategy: Implement social marketing strategies to promote safe sleep.

Activities: The MIHB maintained the website domain for www.safesleepms.org; however, analytics are not available to address viewer usage and other metrics as the domain subscription has since lapsed. The SafeSleepMS social media pages (Facebook, Twitter, and Instagram) remained live, but very few posts were made in the reporting period. Due to the end of the funding agreement which supported these activities in prior reporting periods, they were largely discontinued. However, there continued to be periodic social media messages on safe sleep posted to the MSDH Facebook. New, deliberate strategies are proposed in the 2024 SAP to optimize the use of social media platforms and websites to promote health, safety, and other messages regardi perinatal/infant health.

Strategy: Facilitate the statewide Perinatal Quality Collaborative to engage obstetrics, neonatal and pediatric stakeholders in applying quality improvement methodologies related to perinatal outcomes.

Activities: During the reporting period, the MIHB scaled back its involvement in activities related to

neonatal/pediatric quality improvement initiatives to prioritize maternal health work. However, MIHB staff continued to participate in and push announcements of educational opportunities sponsored by the National Institute for Children’s Health Quality (NICHQ), the National Network for Perinatal Quality Collaboratives (NNPQC), and other stakeholders to the MSPQC listserv, notably related to maternal opioid use and neonatal effects, trauma informed care, postpartum transitions for mother and baby, and reducing inequities for Black birthing people. MSPQC did not launch a new neonatal initiative at the April 2022 MSPQC conference, however, did offer a full-day neonatal track that covered the following:

- Patient-Family Partnership Workshop
- Eat Sleep Console and Wrap Up of Neonatal Abstinence Syndrome (NAS) Project
- Express Yourself: Human Milk Initiative Training
- Necrotizing Enterocolitis- Best Practices

The MIHB/MSPQC Neonatal Team continued partnering with the “Express Yourself: Human Milk Initiative” to promote and encourage exclusive breastfeeding. “Express Yourself” is a statewide quality improvement project funded by the Kellogg Foundation and in partnership with MSPQC to educate on Quality Improvement methodology and increase the availability of breast milk to very low birthweight (VLBW) babies in NICUs across Mississippi. Express Yourself meetings with hospital staff were held as follows:

- October 12, 2021 – “COVID-19 in the NICU: Impact on Pregnancy, Breastmilk, and Breastfeeding” (virtual)
- April 21, 2022 – MSPQC Conference (virtual and in-person)

MSPQC partnered with the Mississippi Public Health Association (MPHA) and national Count the Kicks (CTK) organization to distribute communications materials free to hospitals for a stillbirth awareness and prevention campaign. MSPQC supplied CTK with a listserv of participating hospitals. An introductory letter was sent to each facility explaining the program. Also, an introductory webinar was scheduled for July 19, 2022, that explained the Count the Kicks campaign and instructed hospitals on how to order materials for distribution to patients. In just two months, CTK had received 67 orders for materials, distributed over 10,000 pieces of literature, had 53 mobile App users from Mississippi, and over 500 views to its website from Mississippi viewers. This initiative was put on hold with the exit of the MIHB staff who had launched it. However, the effort will once again be carried out and on a larger scale starting in July 2023.

Objective: By September 30th, 2021, continue to work with partners to reduce the prevalence of tobacco/alternative tobacco products among women ages 18-44.

Objective: By September 30th, 2021, continue to empower the MS Tobacco-Free Coalitions and other partners to provide education to local municipalities and counties on the importance of a smoke-free environment.

Strategy: Increase cessation among women of childbearing age to promote better birth weights and infant health.

Activities: The Office of Tobacco Control provided technical assistance and training to participating Community Health Clinics. Increased awareness of Baby & Me Tobacco-Free through health fairs, table displays on site at CHCs, posting posters in targeted businesses in the community, digital media, community events (drive through baby showers and by sharing program brochures/flyers with stakeholders, providers, and community partners. The MS Quitline provided cessation services to 17 pregnant participants while Baby and Me Tobacco Free Program provided cessation services to 47 pregnant participants. There were 1,010 referrals to the Quitline in FY 2022. This number is down significantly due to a limited number of cessation training courses provided by OTC statewide subgrantees due to competing clinic priorities.

Demographics: Tobacco Users by Pregnancy Status

- 10 = total number of current pregnant women who utilized the Quitline pregnancy program.
- 2 = total number of not pregnant women who utilized the QL pregnancy program.
- 11 = total number of women planning to become pregnant who utilized the QL pregnancy program.
- 3 = total number of women currently breastfeeding who utilized the QL pregnancy program.
- Overall total of 26 women who utilized the QL pregnancy program from October 1, 2021-September 30,2022.

PRIORITY: Breastfeeding

NPMs, NOMs, SPM, and ESMs:

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

Objective: By September 30th, 2021, increase enrollment and participation in the WIC Program by 5% via partnerships and evidence- based initiatives.

Objective: By September 30th, 2021, increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support.

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

Activities: COVID-19 has crippled in-person Baby Café’ support group meetings. Due to the cost associated with maintaining licenses for Baby Cafés, the model is being phased out in Mississippi. The Mississippi Breastfeeding Coalition has created Mississippi MILC (Making an Impact in the Lactation Community) Leagues. MILC Leagues are breastfeeding support groups. They aim to improve breastfeeding rates in Mississippi by offering access to equitable lactation support statewide. Support groups are facilitated by certified lactation professionals with most leagues meeting weekly.

Strategy: Increase breastfeeding initiation and duration rates through prenatal breastfeeding, education, and post-discharge support.

Activities: The MSDH WIC Program established a Memorandum of Understanding (MOU) to provide support for prenatal breastfeeding education and post-discharge breastfeeding support of the Baby Friendly Hospital Initiative. The MOU has been signed by 26 of the 41 delivery hospitals in the state. Several of the MOU agreements are set to expire in FFY 24; however, MSDH WIC plans to work with these hospitals to renew agreements during this time period. One of the important strategies in the agreement is the referral partnership between the hospitals and MSDH WIC. WIC staff provide support in teaching prenatal breastfeeding education classes onsite at partnering hospitals. These efforts were paused in March 2020. Beginning April 1, 2023, MSDH WIC transitioned to hybrid operations which has allowed staff to begin rebuilding these relationships and assisting partnering hospitals during FFY 24. WIC staff promote MILC Leagues to mothers for access to post-discharge breastfeeding support. The COVID -19 pandemic adversely impacted Baby Café’ operations in Mississippi with many locations choosing to close. Lactation leaders in the state to include: the WIC State Breastfeeding Coordinator, the Mississippi Breastfeeding Coalition and Baby Café’ facilitators joined together to

establish the Mississippi MILC League. The Mississippi MILC League stands for Making an Impact in the Lactation Community. The MILC League offers free peer support groups for new and expectant mothers virtually or in-person in communities throughout Mississippi. The vision of the Mississippi MILC League is to improve breastfeeding rates in Mississippi by offering access to equitable lactation support statewide. We will continue the establishment of MILC League locations and further develop promotion efforts of this new initiative during FY 24.

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

Breastfeeding peer counselors will rebuild in-person breastfeeding group classes within MSDH WIC while continuing to provide education through individual telephone counseling sessions and virtual platforms when applicable. MSDH WIC has rolled out a mandatory breastfeeding training program for staff. This curriculum is designed to build competencies among all levels of WIC staff in breastfeeding promotion and support strategies in the WIC Program. It relies on recent science, as well as best practices adopted by State and local WIC agencies across the country. WIC Breastfeeding Curriculum training will be provided to new hires through the agency learning management system in FFY 24. WIC participants will have continued access to the Pacify Mobile App for assistance and real time education when breastfeeding issues and questions arise.

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

Perinatal/Infant Health - Application Year

Perinatal/Infant Health Application Year - FY2024

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

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

NPMs, NOMs, SPM, and ESMs:

- NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

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

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

Activity: Extend existing or select by competitive RFP, subgrantees, including health systems or community-based partners, to execute specific activities for recruitment, referral, enrollment, direct services, and participant navigation to address SDOHs of MCH program participants that improve perinatal/infant health.

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

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

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

Activity: Identify 3-4 potential healthcare settings, community-based, faith-based, social, volunteer service organizations, homeless/domestic violence shelters, residential programs, treatment programs, housing complexes, etc. to outreach per quarter. Request opportunities to share information with “gatekeepers” of (i.e., community health workers, patient navigators, care coordinators, case managers, faith leaders, non-profit social service workers, helpers, etc.) or to the target population.

Activity: Optimize MSDH electronic health record (Epic) and other platforms to create referral management processes and templates for use by external and internal referral sources to home visiting/case management programs.

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

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

Activity: Submit work requests to the Office of Communications to promote CDC/HRSA/other approved messaging related to perinatal/infant health issues etc. Prepare social media post schedules and templates for observance months/days.

Activity: Maximize available funding and in-kind support to develop or enhance direct health education approaches for consumers of MCH-serving programs focused on improving perinatal/infant health issues.

PRIORITY: Increase Breastfeeding, Healthy Nutrition, and Healthy Weight

NPMs, NOMs, SPM, and ESMs:

- SPM 12: Percent of women who are enrolled in WIC and initiate breastfeeding.
- NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

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

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

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

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

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

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

Activity: Provide breastfeeding education and support to prenatal WIC participants.

Activity: Support hospitals in achieving Baby Friendly designation.

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

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

Activity: Provide WIC participants access to certified lactation consultants.

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

NPMs, NOMs, SPM, and ESMs:

- NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
- NOM 9.1 - Infant mortality rate per 1,000 live births
- NOM 9.3 - Post neonatal mortality rate per 1,000 live births
- NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Objective: *By September 30, 2024, produce the annual Child Death Review Report to include*

recommendations for preventing infant deaths.

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

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

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

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

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

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

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

Activity: Partner with other stakeholders to promote/expand offerings of safe sleep/infant safety training (i.e., car seat/travel safety) and material resources (i.e., cribs, sleep sacks, car seats) to professionals and individuals/families.

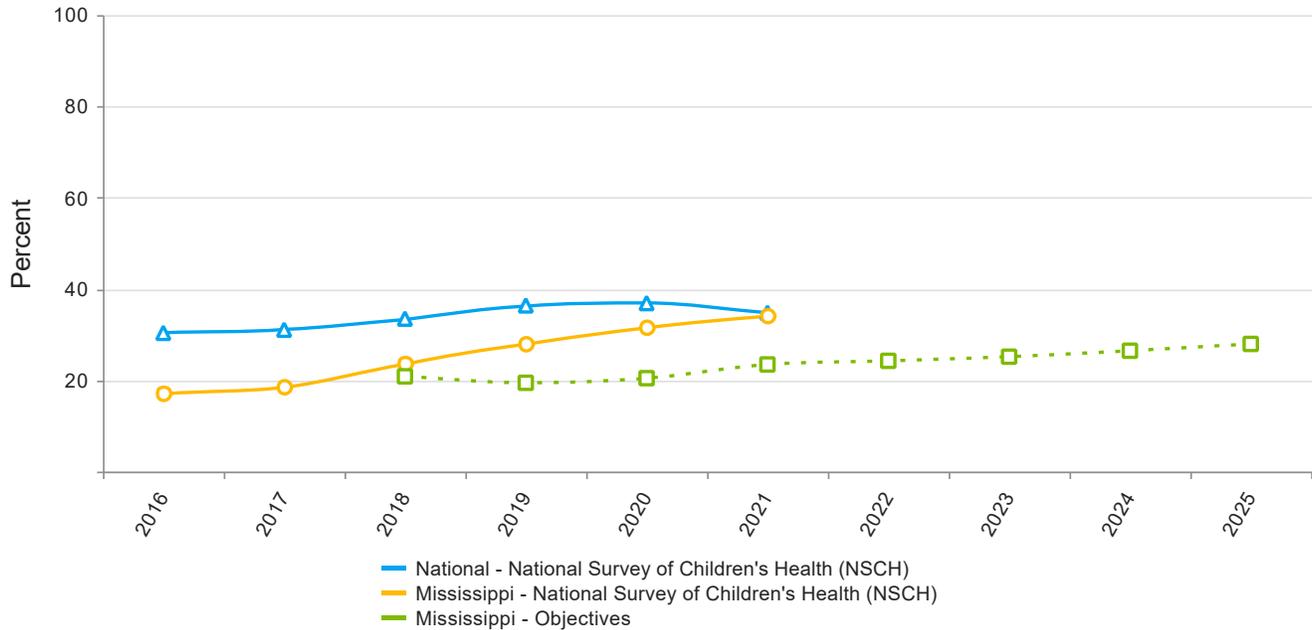
Activity: Initiate and launch a statewide stillbirth awareness campaign (i.e., Count the Kicks™).

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

Child Health

National Performance Measures

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



Federally Available Data

Data Source: National Survey of Children's Health (NSCH)

	2018	2019	2020	2021	2022
Annual Objective	20.9	19.5	20.5	23.5	24.3
Annual Indicator	18.6	23.7	28.0	31.5	34.1
Numerator	13,102	16,993	19,663	25,115	28,605
Denominator	70,253	71,794	70,109	79,686	83,842
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives

	2023	2024	2025
Annual Objective	25.2	26.5	28.0

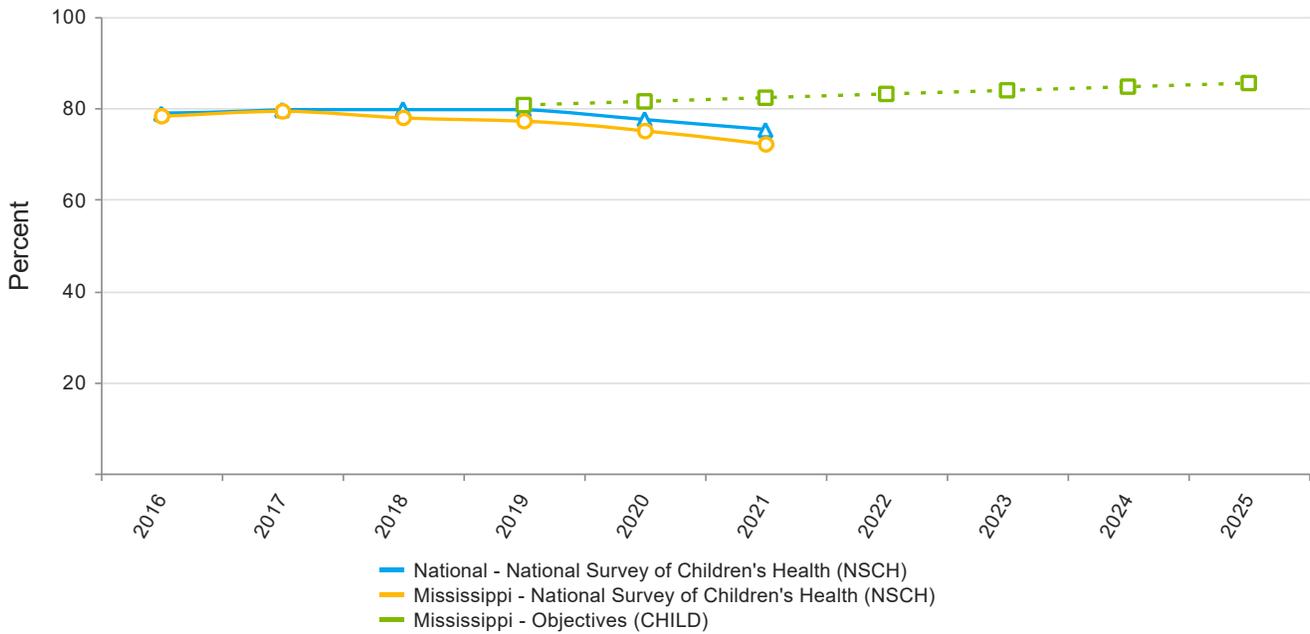
Evidence-Based or –Informed Strategy Measures

ESM 6.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

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

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	30.0	40.0

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Indicators and Annual Objectives



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	2019	2020	2021	2022
Annual Objective		80.6	81.4	82.2	83
Annual Indicator	79.1	77.8	77.1	75.0	72.0
Numerator	544,787	525,080	500,754	484,100	468,061
Denominator	689,107	675,079	649,719	645,270	650,503
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	83.8	84.6	85.4

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		1,000	2,000	3,000	4,000
Annual Indicator		0	903	0	29
Numerator					
Denominator					
Data Source		Office of Oral Health	Office of Oral Health	Office of Oral Health	EPIC
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	150.0	200.0

ESM 13.2.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		1,000	2,000	3,000	4,000
Annual Indicator		0	976	424	20
Numerator					
Denominator					
Data Source		EPIC	EPIC	EPIC	EPIC
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	450.0	500.0	550.0

ESM 13.2.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		60	65	70	75
Annual Indicator		10	2	8	14
Numerator					
Denominator					
Data Source		Office of Oral Health	Office of Oral Health	Office of Oral Health	MSDH Office of Oral Health REDCAP
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	25.0	30.0

State Performance Measures

SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age

Measure Status:		Active	
State Provided Data			
	2020	2021	2022
Annual Objective			3.9
Annual Indicator		3.8	5
Numerator		5,554	7,297
Denominator		144,844	146,681
Data Source		Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	4.0	4.1	4.2

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	11.7	7.1
Numerator	5,221	2,995
Denominator	44,528	42,144
Data Source	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	11.2	10.7	10.2

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	46.9	40.4
Numerator	30	23
Denominator	64	57
Data Source	EPIC	EPIC
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	67.0	77.0	87.0

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	310	272
Numerator		
Denominator		
Data Source	EPSDT Visits in EPIC	EPSDT Visits in EPIC
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	341.0	375.0	413.0

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	100	93.2
Numerator	60	2,722
Denominator	60	2,922
Data Source	Newborn Screening data	MS Newborn screening database and EPIC database
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

SPM 21 - Percent of children with and without special healthcare needs who have a medical home

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	46.2	43.2
Numerator	72,719	68,226
Denominator	157,506	157,885
Data Source	National Survey of Childrens Health	National Survey of Children's Health
Data Source Year	2019-2020	2020-2021
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	46.5	46.7	47.0

State Action Plan Table

State Action Plan Table (Mississippi) - Child Health - Entry 1

Priority Need

Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

Objective: By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

Objective: By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

By September 30, 2025, increase screening rates in low-resource areas of the state

By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

ESMs	Status
ESM 6.1 - The number of participants who received training about Bright Futures Guidelines for Infants, Children, and Adolescents.	Inactive
ESM 6.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring	Active

NOMs
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

Improve Oral Health

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By September 30, 2025, increase the percent of children with a preventive dental visit by 1% annually.

Strategies

Promote the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals and nondental providers

Support trainings of medical providers, including doctors, nurse practitioners, and physician assistants, on oral health assessments and use of fluoride varnish in the primary care setting

Work with internal and external partners to identify barriers and solutions to access and utilization of preventive dental services

ESMs

Status

ESM 13.2.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist Active

ESM 13.2.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses Active

ESM 13.2.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

Improve Access to Family-Centered Care

SPM

SPM 21 - Percent of children with and without special healthcare needs who have a medical home

Objectives

By September 30, 2025, increase the percentage of children enrolled into family-centered services in a medical home

By September 30, 2025, increase the percentage of the children who demonstrate improvements in their growth, health, and development through participation in MCH child health programs providing early intervening services (i.e., service/care coordination and/or home visiting programs) by 5%

By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5%

By September 30, 2025, increase the number of families of children who have access to peer-to-peer support and role models by 5%

Strategies

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners of MCH child health programs to improve timely referrals for early intervening services

Implement interventions with families to promote the adoption of home- and community-based strategies to promote the health and development of their children (e.g., safe sleep, healthy homes, nutrition, and physical activity)

Implement evidence-based approaches using family-centered practices to improve health and developmental outcomes for young children, including school readiness

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

Priority Need

Increase Breastfeeding, Healthy Nutrition and Healthy Weight

SPM

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Objectives

By September 30, 2025, decrease the percentage of children, ages 2-5 years, who receive WIC services and have a BMI at or above the 85th percentile

Strategies

Increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support to reduce childhood obesity

Implement evidence-based practices to decrease obesity in early childhood

State Action Plan Table (Mississippi) - Child Health - Entry 5

Priority Need

Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

SPM

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Objectives

By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

By September 30, 2025, increase screening rates in low-resource areas of the state

By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings.

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

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

Priority Need

Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

SPM

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Objectives

By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

By September 30, 2025, increase screening rates in low-resource areas of the state

By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

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

Priority Need

Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

SPM

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Objectives

By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

By September 30, 2025, increase screening rates in low-resource areas of the state

By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

State Action Plan Table (Mississippi) - Child Health - Entry 8

Priority Need

Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

SPM

SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age

Objectives

By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

By September 30, 2025, increase screening rates in low-resource areas of the state

By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues

Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

Child Health - Annual Report

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

- Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
- Mississippi First Steps Early Intervention Program (MSFSEIP)
- Lead Poisoning Prevention and Healthy Homes Program (LPPHHP)
- Genetics Services Bureau – Newborn Screening Program (NBS) and Mississippi Early Hearing Detection and Intervention Program (EHDI-MS)
- Office of Oral Health

The following section outlines strategies and activities implemented between 10/1/2021-9/30/2022 to meet the objectives and show improvement on the measures related to child health:

PRIORITY: Increase Access to Care (women, children, adolescents, and families).

NPMs, NOMs, SPM, and ESMs:

- 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
- SPM 3: Percent of children who receive a blood lead screening test at age 12 and 24 months of age.
- SPM 9: Percent of dried blood spot specimen results reported out by day of life 7.
- NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
- NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
- ESM 6.1: The number of participants who received training about Bright Futures Guidelines for Infants, Children, and Adolescents.
- ESM 6.2: Number of health professionals and parents/families who receive training on developmental screening and/or monitoring

Objective: *By September 30, 2022, increase the percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year*

Strategy: Partner with the Division of Medicaid to identify and address gaps in developmental screening for Medicaid-eligible children, ages 9 to 35 months

Activities: The MSDH EPSDT program ensures eligible children and youth receive comprehensive, age-appropriate screening at 3-5 days, one month, two months, four months, six months, nine months, 12 months, 15 months, 18 months, 24 months, and 30 months of age and then, once annually for ages 3-21 years old. These visits include a comprehensive unclothed physical exam, comprehensive beneficiary and family/medical history, developmental history, measurements (including, but not limited to length/height, weight, head circumference, body mass index (BMI) and blood pressure), vision and hearing screenings, developmental/behavioral assessment and/or surveillance, Autism screening, psychosocial/behavioral assessment, tobacco, alcohol and drug use assessment, depression screening, maternal depression screening, newborn metabolic/hemoglobin screening, vaccine administration, if indicated, anemia screening, lead screening and testing, Tuberculin test, if indicated, dyslipidemia screening, sexually transmitted infection, HIV testing, cervical dysplasia screening,

nutritional assessment, and/or dental assessment and counseling. Participants are provided anticipatory guidance, referrals to general and specialty care providers for follow-up diagnosis and treatment, referrals for other supports, such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP) benefits, and nutrition through WIC, and support in accessing local primary care providers (PCPs) to establish a medical home and continuity of care.

During the reporting period, the MSDH EPSDT Program continued efforts to partner with Medicaid to analyze data on EPSDT visits completed by age and County to determine which geographic areas with gaps in the completion of EPSDT visits, including the provision of developmental screening for Medicaid-eligible children, including those between the ages 9 to 35 months. The MSDH EPSDT Program request data on the number of children eligible for Medicaid by age and County as well as completed EPSDT data disaggregated by age and by County. Analyses of the data obtained resulted in determining significant limitations in the data and how it could be reported. Most importantly, although Medicaid could provide unduplicated counts of children who were eligible by County of residence, the data on completed EPSDT visits by County were reported by County of the facility that conducted the visit rather than the child's residence. Given how many of the children received services from a primary care provider (PCP) in a different County, the program was unable to determine the counties with the greatest gaps in completion rates.

Furthermore, given the complexity of the number of EPSDT visits that may occur over the first three years of life, interpretation of the results for these children is exceptionally difficult. For children under 35 months of age, there are 11 possible visits that could be conducted, with up to six visits possible during the first year of life (i.e., at three-five days, one month, two months, four months, six months, and nine months of age). According to the Bright Futures Periodicity Schedule, children should receive three developmental screenings before 35 months of age, once each at nine months, 18 months, and 30 months of age. Although the Medicaid data were useful in determining the total number of visits completed compared to the number of eligible children and possible total EPSDT visits (i.e., six for infants and five for toddlers), the program could not determine the number of unduplicated children captured in these data and whether the visit completed included a developmental screening.

Given these challenges, MCH personnel met with Medicaid representatives to review possible data variables to further refine data extracts to improve the ability to analyze and interpret the results to identify the Counties with greatest gaps in completion of developmental screening.

Objective: *By September 30, 2021, develop and distribute resources among MSFSEIP and other early childhood stakeholders regarding early identification of infants/toddlers who may be eligible for MSFSEIP services.*

Strategy: Provide training and technical assistance to referral sources for early intervention to ensure they are embedding developmental screening into their practices with families to ensure all infants and toddlers who may be in need for early intervention services are identified

Strategy: Partner with early care and education providers and family-based childcare providers to increase the number of children, ages 9 to 35 months, who receive developmental screening

Activities: During the reporting period, the MSFSEIP personnel conducted 1,162 instances of outreach to increase the number of children who received developmental screening and to ensure all infants and toddlers in need of early intervention services were identified. These efforts included personal contacts with referral sources,

distribution of literature related to developmental screening, including resources from Learn the Signs Act Early, and participation in health fairs and community events to conduct developmental screenings for infants, toddlers, and preschool children. As a result, MSFSEIP received 4,321 referrals for infants and toddlers with suspected developmental delay.

Personal contacts were made with pediatricians and pediatric therapists and individuals who work in clinics and hospitals, early care, and education centers, Child Protective Services, MSDH Programs (WIC, PHRM, and CYSHCN), Head Start, Boys and Girls Club, Salvation Army, and community initiatives (Excel by 5, South Delta). In addition, informational resources regarding the MSFSEIP and developmental screenings were mailed to traditional partners and provided non-traditional ways, such as leaving resources at supermarkets, to ensure information was provided to those with limited access.

Personnel also participated in local health fairs and Medicaid/MS-CAN events, including Community Baby Showers, and partnered with local Head Start program to conduct developmental screenings for infants, toddlers, and preschool children.

The MSFSEIP provided ongoing training for professionals who work with infants and toddlers with and without disabilities to ensure they have the knowledge and skills to identify children in need of intervention services.

The MSFSEIP continued to offer training on the Early Communication Indicator (ECI), one of the Individual Growth and Development Indicators (IGDIs) developed by Juniper Garden at the University of Kansas for monitoring progress on early language development for young children. According to the developers, "The ECI is a brief, repeatable, play-based, observational measure of a child's communicative performance during a 6-minute play period with a familiar adult. The play session is standardized around one of two toys – either the Fisher-Price House or Farm." The IGDI-ECI provides counts of the use of gestures, vocalizations, single words, and multiple words used to communicate with a play partner which can be combined to provide a total communication score. Performance on the IGDI-ECI can be plotted to show progress over time and development from prelinguistic communication (i.e., mainly gestures and vocalizations) to spoken language (i.e., single words and multiple words). In addition, the individual subskills and the overall communication score can be compared to norms to determine if children are performing similar or dissimilar to typical-developing children.

The IGDI-ECI data are used to monitor language development, evaluate the impact of language interventions, and inform goal development on an Individual Family Service Plan (IFSP) provided to infants and toddlers with disabilities enrolled in Part C early intervention services. Prior to the COVID pandemic, the IGDI-ECI was administered quarterly with all infants and toddlers enrolled in early intervention. As a result of the COVID pandemic and subsequent shift to virtual service delivery for many families, the IGDI-ECI was not able to be consistently implemented, as it required in person administration. In September 2021, the MSFSEIP worked with IGDI-ECI consultants to certify 40 EI personnel on adapted procedures to administer the IGDI-ECI virtually. In addition, 5 additional personnel were certified as IGDI-ECI Trainers to ensure the state could sustain these efforts. As a result, the MSFSEIP has resumed quarterly administration with all enrolled infants and toddlers whether they receive services in person or virtually. Continued implementation will support efforts to ensure children enrolled in the MSFSEIP are expected to exit at or near age expectations in their acquisition and use of knowledge and skills, including language/communication.

In 2022, the MSFSEIP and Mississippi State University kicked off the Early Intervention Credential – Level I for MSFSEIP and early intervention providers. The Level I Early Intervention (EI) Credential is a 240-hour online certification program consisting of 6 modules focusing on: introduction to EI; family-centered practice; IDEA law; evidence-based intervention and instruction; coordination and collaboration; and professionalism. The Level I

Credential is intended as an entry-level credential for all individuals working with young children ages birth to 36 months of age who have developmental delays and disabilities and their families in the state. Nationally, the number of young children identified and enrolled in IDEA services has steadily increased. During the pandemic these trends reversed with fewer children enrolling in services as they did not receive the ongoing health and developmental screenings needed. This under-identification will likely result in more children needing more significant services and increased enrollment necessitating more trained professionals to meet the needs of very young children with disabilities and their families.

Objective: By September 30, 2021, collaborate with Mississippi Department of Education to develop state-wide materials for a Child Find public awareness campaign.

Activities: During the reporting period, the MSFSEIP Program worked with numerous stakeholders to identify materials for a statewide Child Find public awareness campaign as well as strategies for dissemination of resources.

In 2022, the MSFSEIP Program contracted with Morris, West & Baker (MWB) to assist the program with a marketing campaign for early intervention. The campaign is to include mass media ads for television and radio, digital media ads, social media graphics, informational videos, promotional materials, and the redesign of the program symbol.

Objective: By September 30, 2020, increase the number of children less than six years of age tested for blood lead from 36,074 by 10%.

Strategy: Increase knowledge and awareness among the public, public health professionals, childhood lead prevention workforce members, and other partners and stakeholders about childhood lead poisoning and prevention interventions through tailored education and outreach.

Activities: The program met with the Lead Advisory Board four times during this reporting period to review and revise the Blood Lead Screening and Healthy Homes Summary Sheet to identify more children under the age of 72 months who should be tested for lead poisoning.

In partnership with MSDH Pharmacy, the pharmacy residents began contacting providers in March 2022 to notify them about the decrease in blood lead reference value from 5 micrograms per deciliter ($\mu\text{g}/\text{dL}$) to 3.5 $\mu\text{g}/\text{dL}$ and new recommendations for obtaining a confirmatory venous sample and venous follow-up testing. From April 1, 2022-September 29, 2022, 30 providers were contacted to discuss the following key messages: (a) housing and other products can cause low-level lead exposure; (b) the Centers for Disease Control and Prevention/American Academy of Pediatrics Bright Future guidelines require the Risk Assessment and Healthy Homes Questionnaire to be administered at well-child visits from 6 months to 6 years of age; (c) the Centers for Medicaid and Medicare Services require blood lead testing of Medicaid eligible/beneficiaries at 12- and 24-months of age, or at least once before age 6 if not previously tested; and (d) clinics in Mississippi using the ESA Leadcare machine are required to report all blood lead test and demographic data to the Mississippi State Department of Health Lead Poisoning Prevention and Healthy Homes Program.

Objective: By September 30, 2022, decrease the number of children less than six years of age identified with lead poisoning from 251 by 10%.

Strategy: Improve data usage that leads to a greater identification of geographic areas and populations at high-risk

for lead exposure.

Strategy: Increased identification of children exposed to lead and linkage to recommended services.

Strategy: Increase the ability to target interventions to high-risk geographic areas and populations.

Activities: During the reporting period, the program provided education, telephone counseling, home visits, and environmental assessments to 139 families of children with a confirmed venous blood lead level $\geq 3.5\mu\text{g/dL}$. Six (6) families of children with a venous blood lead level $\geq 15\mu\text{g/dL}$ qualified for a home visit and environmental assessment; however, only one (1) family accepted the services. One (1) family declined services, and the remaining five (5) families could not be contacted or did not respond to the letters mailed.

The program referred 54 families of children with a confirmed venous blood lead level of 10 or higher for long term follow-up and coordination of services. Of these, 28 families less than three years of age were referred to the Mississippi First Steps Early Intervention Program and 26 families of children over the age of three were referred to the Children and Youth with Special Healthcare Needs Program. Of those referred, 18 families accepted services. The remaining families declined.

Data sharing agreements have been developed and implemented with three Managed Care Organizations in MS to make referrals for families they insured who could not be reached to schedule program services (i.e., home visit and environmental assessment). This collaborative partnership has ensured that families of children who qualify for services are contacted, and services provided to improve the children's quality of life.

Objective: *By December 31, 2021, conduct six (6) virtual hospital staff quality improvement trainings/in-services.*

Strategy: Facilitate six (6) virtual trainings/in-services that will provide an overview of the screening process mandated by Mississippi Code §§ 41-21-201; 41-21-203; 41-90-1; 41-90-5. Hospital nursery and laboratory staff will be equipped with information and resources to assist in improving newborn bloodspot, CCHD, and hearing screening and reporting, including specimen collection procedures.

Activities: A total of six virtual classes comprised of newborn bloodspot collection and critical congenital heart disease training were held from October 1, 2021- May 2022 for health department staff. The training provided examples of proper specimen collection, proper CCHD and hearing screening, and timely transit to increase timely diagnosis reporting and treatment of newborn screening (NBS).

Newborn bloodspot collection virtual training was conducted Fall 2021:

- October 19, 2021
- October 20, 2021
- October 21, 2021

CCHD and hearing screening virtual trainings were conducted Spring 2022:

- May 20, 2022
- May 24, 2022
- May 26, 2022

An evaluation of the training resulted in recommendations to increase training time to allow participants more

time to ask questions and provided feedback. Virtual team members also expressed recommendations to keep meetings as interactive as possible. This feedback was used in the development of online training modules available via Health Streams to allow for immediate access and use during New Nurse Orientation and for quarterly training for healthcare providers.

Strategy: Update the current dried blood spot specimen collection card to include additional collection variables

Activities: In Spring 2022, the MSDH Genetics Advisory Committee considered the addition of X-Linked Adrenoleukodystrophy (X-ALD) to the Mississippi Newborn Screening Panel. The recommendation to add this disorder was not approved until October 2022, as such there were no updates needed for the dried bloodspot specimen collection card during this reporting period.

Strategy: Increase timely screening and referral to tertiary centers for babies diagnosed with a positive genetic condition.

Activities: During the reporting period, reports were extracted and reviewed from the EPIC database identifying hospitals that screened babies prior to the 24 hour or after 48 hour recommended timeframe. Hospitals were alerted and reminded of protocols. In addition, hospitals were advised to note transfusions cases at the top of the bloodspot card to ensure appropriate follow-up could be provided.

Reports were also reviewed to determine which hospitals did not meet the 1-day transit timeline to the assigned laboratory so this delay in procedures could be addressed immediately. Identified hospitals were alerted, and a virtual meeting ensued to discuss probable causes and solutions to prevent future delays. On one occasion, specimens were lost in transit which resulted in a delayed diagnosis report, due to rescreening.

Hospitals were contacted virtually to review protocols and expectations to ensure babies are screened timely. During the meeting, hospitals provided feedback regarding barriers that caused early or late screening reporting due to staff turnover, staff increase of duties, staff shortages due to COVID reassignments, and new staff training needs.

Strategy: Develop a Quality Improvement (QI) program utilizing the PDSA Cycle and frameworks/tools to manage and monitor all aspects of the NBS program to improve the overall system and ensure a seamless process from screening to closure of newborn screen cases.

Activities: During the reporting period, the program transitioned into the new agency electronic health record, EPIC. To support monitoring of cases and timeliness, a report was developed listing newborn screening caseloads for the Regional Nurse Case Managers by county. This allowed the Director to be able to monitor the timeliness of case closures and identify any issues preventing timely case closures. These reports for the Regional Case Managers was combined to create a comprehensive status report for follow-up actions across the state.

Throughout the year, the program personnel worked with the EPIC development team regularly to refine the EPIC database, reports, and workflows, resulting in ongoing changes to the system, dashboards, and available reports.

Strategy: Identify barriers, challenges, and areas needed for improving screening and collection among hospital nursery and lab staff.

Activities: During the reporting period, due to COVID, visits with low performing hospitals to review status and provide recommendations for improvements were contacted virtually. During these meetings, NBS personnel reviewed data from the state lab, via the online portal, identifying critical checklists and timelines.

Quarterly, letters were mailed to birthing hospitals with updates regarding RUSP conditions alerts and additions, cost differentiations, highlighting corrective issues for low performing hospitals, and announcements for important upcoming events. A copy of the hospital performance ranking was attached to inform hospitals of their status regarding performance outcomes.

PRIORITY: Oral Health

NPMs, NOMs, SPM, and ESMs:

- NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
- NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
- NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
- NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- ESM 13.2.1: Number of children 0-3 years who had a preventive dental visit with referred dentist
- ESM 13.2.2: Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses

Objective: *By 2021, increase public knowledge about the importance of oral health over the entire lifespan from baseline to 12%.*

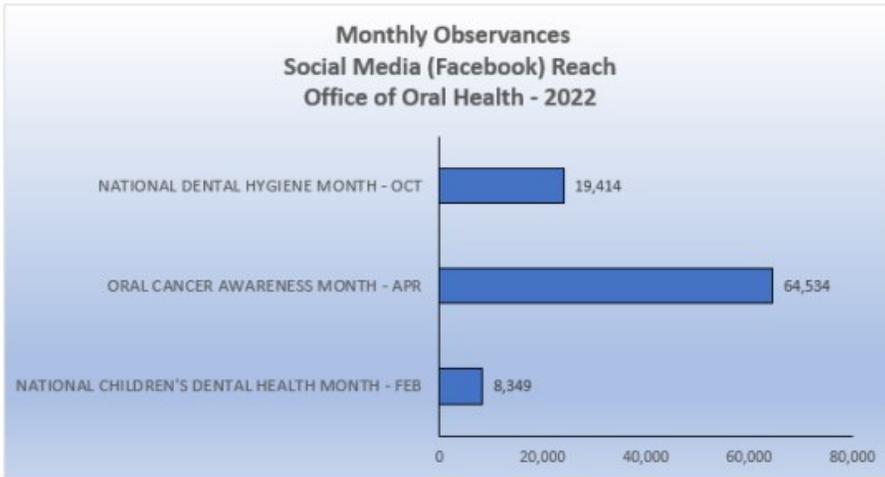
Strategy: Continue to Increase Oral Health Awareness; Increase oral health awareness with the three MCH community-based partners.

Activities: The Office of Oral Health has continued its focus on getting information to our partners electronically and through social media platforms like Facebook and twitter. While the Office of Oral Health highlights many health observances and their link to oral health, we generally focus on the months of February (National Children’s Dental Health Month); March (World Oral Health Day); April (Oral Cancer Awareness Month and October (Dental Hygiene Month). Below, see graphic depictions of activities to our webpage or social media platforms.

FACEBOOK

The total number of people who viewed oral health postings on Facebook during the period from October 1st, 2021, to September 30th, 2022, is 92,297. The content that was posted in observance of "National Children's Dental Health Month" in February was viewed by 8,349 individuals. The posts for "Oral Cancer Awareness Month" in April were viewed by 64,534 individuals, and 19,414 individuals viewed the posts for "National Dental Hygiene Month" in October. Figure 1 below is a graphic representation of the Facebook media reach.

Figure 1: Facebook Media Reach

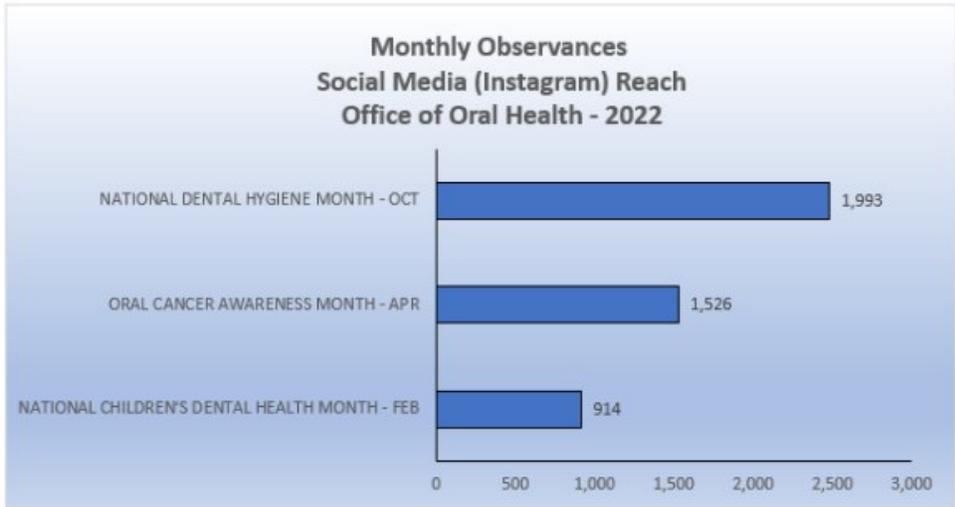


*Data were available only from the February, April, and October months. Data from the remaining Oral Health Observance months of January, March and December were not available.

INSTAGRAM

The total number of people who viewed oral health postings on Instagram during the period from October 1st, 2021, to September 30th, 2022, is 4,433. The content that was posted in observance of "National Children's Dental Health Month" in February was viewed by 914 individuals. The posts for "Oral Cancer Awareness Month" in April were viewed by 1,526 individuals, and 1,993 individuals viewed the posts for "National Dental Hygiene Month" in October. The graphic representation is shown in Figure 2 below.

Figure 2: Instagram Reach

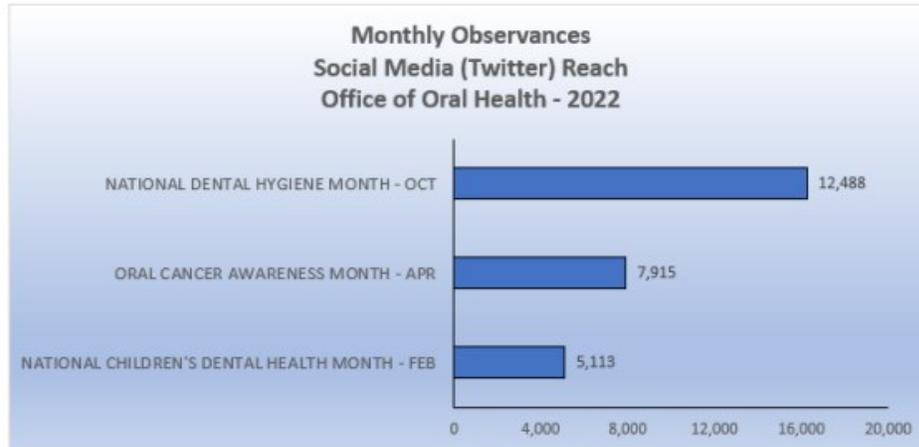


*Data were available only from the February, April, and October months. Data from the remaining Oral Health Observance months of January, March and December were not available.

TWITTER

The total number of people who viewed oral health postings on Twitter during the period from October 1st, 2021, to September 30th, 2022, is 25,516. The content that was posted in observance of "National Children's Dental Health Month" in February was viewed by 5,113 individuals. The posts for "Oral Cancer Awareness Month" in April were viewed by 7,915 individuals, and 12,488 individuals viewed the posts for "National Dental Hygiene Month" in October. Figure 3 below represents the social media, Twitter reach.

Figure 3: Twitter Reach



*Data were available only from the February, April, and October months. Data from the remaining Oral Health Observation months of January, March and December were not available.

Objective: By September 2020, fully integrate oral health literacy into all nine MCH programs within Health Services at MSDH.

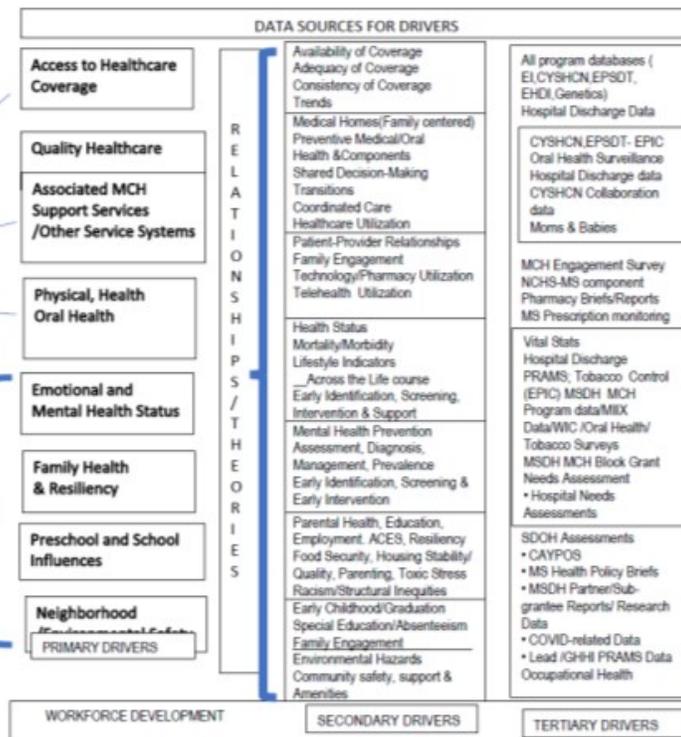
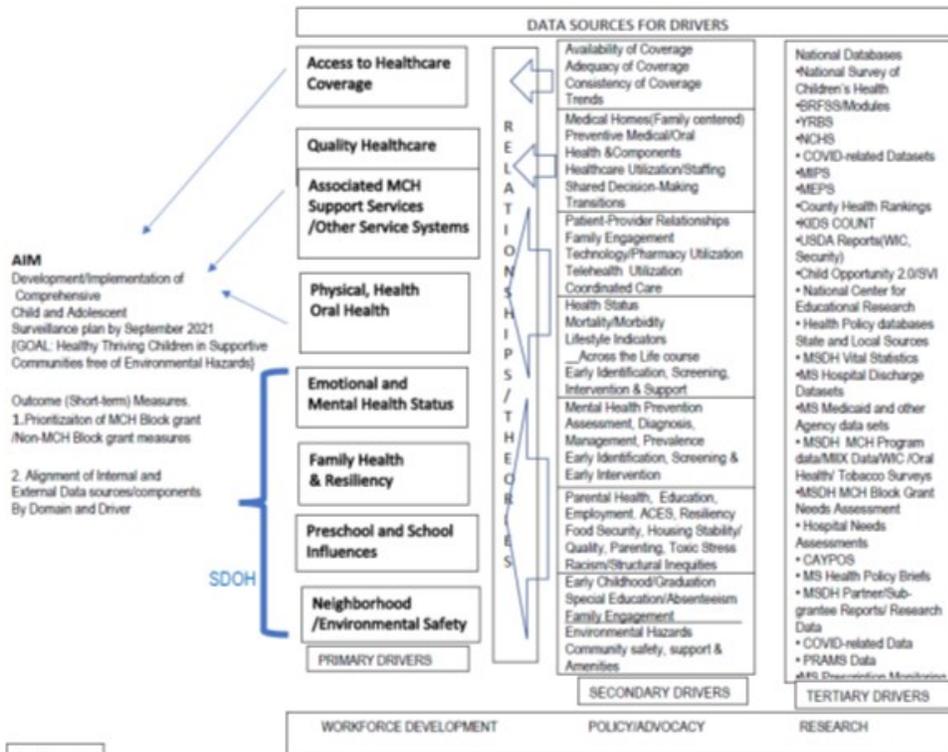
Strategy: Provide oral health literacy to all MCH programs and their participants within Health Services at MSDH.

Strategy: Provide region-specific dental directory to expectant mothers for routine exams and dental procedures during and after pregnancy.

Strategy: Monitor dental care coordination efforts.

Strategy: Provide oral health education and referral to a dental home in 25 counties to participants of the WIC program.

Activities: The Office of Oral Health continues to incorporate integrated templates into EPIC for internal agency use. We have an EPDST template in the EPIC portal. During this reporting period, the pediatrician consultant and oral health program director began to address child health surveillance tools, adolescent tools and the like.



We used the EPDST dental care assessments in EPIC to examine the ease of input and retrieval of data.

MSDH EPSDT Oral Health Screening

Assessment: Caries Risk: Low/High

Anticipatory Guidance, Fluoride Varnish, Dental Referral

Clinical Findings: White spots or visible decalcifications in the past 12 months? Y=Yes N=No

Oral Health Screening: Child's Oral Health: Families with children less than 3 years of age. Does your child sleep with a bottle? Y=Yes N=No

Child's Oral Health Screening (cont'd)

Do you have any questions or concerns about your child's teeth or mouth? Y=Yes N=No

Does your child have special health care needs? Y=Yes N=No

Does your child have a dental home (a place where he or she can go for any dental care)? Y=Yes N=No

Has your child had a dental visit in the past 6 months? Y=Yes N=No

Has your child ever had a cavity? Y=Yes N=No

Have you (mother or primary caregiver) had a cavity in the past 12 months? Y=Yes N=No

Does your child eat snacks most days of the week? Y=Yes N=No

Does your child eat foods that stick to their teeth such as sticky candy, raisins, etc., most days of the week? Y=Yes N=No

Does your child drink fluoridated water or take fluoride supplements most days of the week? Y=Yes N=No

Do you brush your child's teeth twice daily with toothpaste that has fluoride? Y=Yes N=No

Has your child had a fluoride varnish treatment in the past 6 months? Y=Yes N=No

Does your child wear a mouth guard when playing in sports or other activities? Y=Yes N=No

While these tools are embedded in our EPIC system, generating a report on all fields was not possible. We utilized this reporting period to work with our EPIC team on making sure we could generate a report on the variables indicated in the oral health screening tool and assessing workflow processes and training needs of staff performing the wellness visits. Unfortunately, we were not able to complete this process during the reporting period. Our pedestrian consultant is no longer with the team, and we have had some program revamping and staffing turnover. We look forward to sharing updates to our efforts in the next reporting.

Objective: By December 2021, provide a 1-2-hour inter-professional educational training to 107 medical providers and staff in primary care settings in 8 counties on fluoride varnish use and application in medical settings to decrease early childhood caries in children.

Strategy: Combat oral disease in MS children and adolescents by integrating oral health education training into the medical setting.

Activities: We continued to carry our Cavity Free in Mississippi program supporting fluoride varnish application

in primary care settings. During this reporting period we trained family nurse practitioners, medical assistants, medical doctors, medical provider auxiliary support staff and registered nurses on the importance of interprofessional collaborative practice and oral health assessments in primary care settings. A total of 54 medical providers and staff were trained, representing twelve counties.

Over the years, we have strengthened our work with the Mississippi State Board of Dental Examiners, Mississippi Dental Association (MDA) and Mississippi Dental Society (MDS). During this reporting period, we continued to use platforms provided by these entities to connect with dental providers throughout the state, and share program updates to encourage increased care to children and adolescents in the state. ROHCS participated in MDA District Meetings: Feb 4, 2022; February 18, 2022; February 11, 2022, January 22, 2022, January 14, 2022, and January 28, 2022. At these meetings program updates were shared around, oral health surveillance of Head Start children, new child dental forms, the Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP Affinity initiative, The Screening Brief Intervention and Referral to Treatment program with our office, and community water fluoridation.

Additionally, our program director had the opportunity to share with the MDA an article sent through egram to all MDA constituents (over 700) about reducing childhood caries in Mississippi. Similarly, the program director participated in the October 29-30, 2021, MDS Winter Conference sharing similar program updates with MDS constituents.

Objective: By October 2021, provide statewide oral disease data collected on 2000 Head Start children by way of the Basic Screening Surveillance.

Strategy: Collaborate with Early Head Start and Head Start programs, home visiting programs, and/or WIC clinics to train staff to provide preventive oral health care and referrals to oral health professionals for dental visits.

Activities: The 2015-2016 Third Grade Basic Screening Survey results provided evidence that 3rd graders in our State are getting more preventive treatments like sealants and fluoride varnish as well as receiving treatment for cavities and fillings.

However, improvements are still needed to reduce dental caries experience in the primary or permanent teeth. A partnership with the MS State Head Start Association and day care centers across the state was established to reduce the number of children developing cavities during their early childhood years. During this reporting period, the Oral Health Workgroup did not meet frequently due to staffing issues. However, the oral health program director and the executive director for the MS Head Start Association continuously communicated about how to better address the oral health surveillance needs and the practicality of reporting for the grantees.

The scheduled Basic Screening Oral Health Surveillance did not occur because we did not receive the sample demographic information from each of the centers to formulate the methodology. Therefore, there is no data to report on oral health indicators of disease for Head Start children. A child dental health form was created for dental providers to use when completing an oral health screening on children in Head Start and shared with the Mississippi Dental Society and the Mississippi Dental Association. This form was also placed on our agency's website. Additionally, during this reporting period, we lost our three program epidemiologists which made it more difficult to strategize other ways to collect data from this population of constituents.

We, however, maintained our oral health promotion and education activities with Head start agencies. Oral health supplies and educational materials were donated to be distributed to both children who were learning onsite and for those who were learning virtually.

Two new regional oral health consultants were hired in the later part of 2021 and trained on the WIC SPIRIT electronic health record system in January of 2022. The Office of Oral Health has trained the new team members on the collaborative partnership with WIC and have connected them with chief nutritionists in their perspective coverage areas.

Since this reporting period, we have updated the documentation tools in the SPIRIT portal to allow the WIC nutritionist/or clerk to identify if the participant received oral health education or if a hygiene kit was disseminated.

During the summer of 2021, the Office of Oral health hired a dental care coordinator to centralize our care coordination state-wide. By Fall 2021, dental care coordination management tools were created using an Excel Spreadsheet with a protocol that was shared with all oral health and WIC Team members. Based on the current protocol, all patients identified as not having a dental home and who are okay with us following up with them are placed onto our spreadsheet and later contacted via phone call or email to further assist them in finding a dental home or other resources. Demographic information is collected from patients who are willing and all correspondence with said patients is documented. Recently, this referral process has been expanded and the Office of Oral Health now receives referrals in REDCAP from the WIC department. Now, those patients receive phone follow up and oral health educational information and provider correspondence via the mail to better address their needs. REDCAP allows all WIC staff to refer patients to the office of oral health if they don't have a dental home or need help finding one; if they are experiencing dental pain or other signs of acute infection and if they have questions related to oral health.

While not effective during this reporting period, these meetings resulted in updates to the SPIRIT system, a more synchronized process of retrieving referrals from the WIC department and an increase in partnership opportunities.

Objective: By December 2021, establish a comprehensive health collaboration that includes oral health with 10 to 15 faith-based organizations.

Strategy: Increase the number of faith-based organizations we work with who provide resources to families.

Activities: The Office of Oral Health distributed several oral hygiene kits, toothbrushes, boxes of floss, and educational material to several faith-based organizations throughout Mississippi. Some of those entities include Butterflies by Grace Defined (BBGDF); First Baptist Church of Jackson, MS, Holly Bush Church, Old Bethel Missionary Baptist Church, and Kuntry Kidz Teen Program-Shady Oak Church affiliate. Hollybush Church (Rankin County) and El Bethel Missionary Baptist Church (Tallahatchie County) were given 50 adult and 50 child health fair and blood drive on September 17, 2022. The health fair provided blood pressure checks, Alzheimer's educational materials, oral health education, smoking cessation information, skin care, COVID vaccinations, diabetes education and autism awareness.

Butterflies by Grace Defined by Faith is a Jackson based community organization founded in 2021, whose mission is "to educate, empower and advocate awareness in order to protect victims and survivors of sexual assault, human trafficking and domestic violence." Forty-five adult hygiene kits and 30 children's kits were donated to the awareness event held at First Baptist Church of Jackson in December 2021. In July of 2022, 600 adult hygiene kits, 60 children hygiene kits and 25 oral health educational flyers (60 each) covering vaping, oral cancer, pregnancy and dental tobacco cessation, e cigarettes, oral health and again, and baby's healthy mouth were donated to First Baptist Church of Jackson's Dress A Child Event. Kuntry Kidz is a 501c3 located in Collins

MS whose mission is to provide positive exposure accessibility to uplifting programs and positive role models for youths growing up in the South were donated 204 hygiene kits for their 8th Annual Teen Empowerment summit on September 13, 2022. Four hundred teens attended the event. The regional oral health consultant working on this event also provided oral health education on vaping, e-cigarettes, diabetes, and sugar and provided an Oral B spin brush as a door prize.

Similarly, the Office of Oral Health assisted with the planning and logistics of the March 2022, Lauderdale Dental Mission. Central Baptist Church in Meridian Mississippi was the host site where the event was held. Over 21 churches donated food, snacks, chairs, and support volunteers for this two-day event providing preventive and restorative dental services. A total of 106 patients were seen; 100 teeth extracted, 126 tooth surfaces filled; 47 glucose blood sugar tests, 63 vision screenings; and 14 COVID 19 vaccinations. It was truly a collaborative partnership bringing MSDH partners and community stakeholders together. Fifty percent of the people screened had an abnormal blood pressure and seven percent had abnormal glucose tests. Those persons were referred for additional assessments and care. Because oral health is important to overall health and well-being, opportunities as such to provide interprofessional collaborative care in a trusted environment aid our efforts of building a healthier Mississippi. Now that the Office of Oral Health has a centralized team member to assist with its dental care coordination efforts, it is planning to create a few flyers about this service to share with said organizations.

Objective: *By December 2021, increase the opportunities to partner with the Oral Health State Program and Division of Medicaid.*

Strategy: Work with the Mississippi Division of Medicaid to obtain benchmark information regarding Medicaid-funded dental providers and oral health services.

Strategy: Strengthen collaborative partnership with the Division of Medicaid.

Strategy: Promote the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals

Activities: The Office of Oral Health continued work with the Division of Medicaid with monthly scheduled meetings with the Medicaid staff that work directly with the oral health benefits department. In these meetings, the program director was given insight on how to get Medicaid codes without an associated fee active. Additionally, the program director began attending quarterly meetings with the Division of Medicaid representatives that are held with other MSDH Health Services director's and their teams.

We also continued our work with the Division of Medicaid to find out why in Mississippi, non-medical providers must bill dental CDT codes for this service as opposed to medical CPT codes. We were informed that the Mississippi Division of Medicaid had some concerns about vendor information on supplies and materials and elected to keep this coding under dental. However, we did discuss the possibility of changing these codes to medical CPT codes with the new software launched by the Mississippi Division of Medicaid. Unfortunately, the go live date for the software occurred after this reporting period. We continue to work with them on this initiative.

Also, in our work with the Mississippi Division of Medicaid and partners with the Advancing Prevention and Reducing Childhood Caries initiative, we learned more about the data sharing through the Dental Quality Alliance (DQA). The DQA was established by the American Dental Association to develop performance measures for oral health.

It houses a State Oral Health Quality Dashboard that generates reports reflecting analysis of Transformed Medicaid Statistical Information System Analytic files from the Centers for Medicare and Medicaid Services. These tools have been helpful for us in addressing oral health state measures and how we compare nationally.

Objective: *By September 2021, through oral health promotion and awareness efforts, expose 200 students to careers in dentistry*

Strategy: Build connections and strengthen opportunities with university and allied health schools with dental degree and dental hygiene degree programs.

Activities: The Office of Oral Health continued its efforts with the School of Dentistry (SOD) at the University of Mississippi Medical Center (UMMC) in maintaining a public health presence. Similarly, the Office of Oral Health worked with the school to identify people from the National Health Service Corps who could provide information to students regarding working in public health and the loan payment options. With leveraged funds obtained during this reporting period, the program continued to support dental student rotations to underserved areas throughout the state. With this opportunity, third- and fourth-year dental students rotated working in private and public clinics with faculty dentists throughout the state.

This reporting period, our program director introduced Dean Koka to the American Cancer Society and HPV RoundTable efforts. With provisions for licensed dentist in Mississippi to administer HPV, COVID 19, Flu and Shingles vaccination, an opportunity for dental school faculty and students would be paramount in preventing cancers and disease. Additionally, Dean Koka was introduced to the immunization and vaccination for children team to go over the process for providing vaccinations through the dental school. Fortunately, now, the UMMC School of Dentistry is a vaccination provider and received additional training through the Mississippi State Board of Dental Examiners.

April 22, 2022, the MSDH dental director and immunization consultant co-hosted a zoom webinar entitled "Oral Health and Human Papilloma Virus (HPV): State-wide Efforts to Enhance Dental Provider roles". The goal of this webinar was to better inform dentists and dental teams in Mississippi on national and state statistics regarding oropharyngeal cancer, importance of oral cancer screenings at each dental visit and opportunities to vaccinate for HPV.

Child Health - Application Year

Child Health Application Year - FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023-9/30/2024 to meet the objectives and show improvement on the measures related to child health:

PRIORITY: Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings

Objective: By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually

Objective: By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss

Objective: By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation

Strategy: Develop a comprehensive, coordinated, and integrated system of services for children

Activity: Develop and implement policies and procedures in child health programs to support a comprehensive, coordinated, and integrated system of services for children

Activity: Develop and implement agreements with state and local agencies, community-based and family-based organizations, and public and private health providers to support a comprehensive, coordinated, and integrated system of services for children

Activity: Develop improved functionality and reports in data systems to support a comprehensive, coordinated, and integrated system of services for children

Strategy: Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification

Activity: Coordinate with the state lab, birthing hospitals, tertiary centers, and other specialists to maintain a robust newborn screening program

Activity: Expand the number of healthcare providers, interventionists, and specialists who provide screening and ongoing monitoring for timely identification of medical, environmental, or developmental concerns

Activity: Refer families to local primary healthcare providers for screening and monitoring for timely identification of medical, environmental, or developmental concerns

Activity: Provide information to families and primary health care providers supporting timely follow-up

Strategy: Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification

Activity: Collaborate with traditional and non-traditional early childhood partners in assisting families with accessing screenings, evaluations, and referrals to family-centered services for follow-up

Activity: Provide tailored education and outreach with traditional and non-traditional early childhood partners.

Objective: By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results

Strategy: Provide professional development opportunities for healthcare professionals to learn about best practices

and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening

Activity: Invite screening providers to participate in training and education sessions on screening using HealthStream, conferences, workshops, lunch-and-learns, learning communities, and other educational opportunities.

Activity: Provide tailored education and outreach to communities, partner organizations, and stakeholders to address identified issues and concerns.

Objective: By September 30, 2025, increase screening rates in low-resource areas of the state

Objective: By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs

Strategy: Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners

Activity: Assess hospital performance, including specimen collection, screening, and reporting procedures among hospital and laboratory staff to determine gaps with the newborn screening program and intervene with improvement efforts

Activity: Analyze data on screening rates and identify low-resource areas with gaps to be addressed collectively through program improvement or development

Activity: Analyze root causes of loss to follow up and loss to documentation with internal and external partners to implement quality improvement efforts

Activity: Refine agency data systems to document and track screening, diagnosis, and other follow-up activities, including referral and linkage to family-centered medical, environmental, developmental, and social services

Activity: Develop improved functionality and reports in program databases to support data-driven quality improvement efforts

Activity: With technical assistance from local, state, and national partners, engage stakeholders in quality improvement using the Model for Improvement: Plan-Do-Study-Act (PDSA) methodology

Objective: By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings.

Strategy: Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues.

Strategy: Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings

Activity: Submit work requests to the Office of Communications to promote national and state messaging related to child health issues etc. Prepare social media post schedules and templates for observance months/days.

Activity: Conduct outreach and public awareness campaigns to increase awareness of child health issues

PRIORITY: Improve Access to Family-Centered Care

Objective: By September 30, 2025, increase the percentage of children enrolled into family-centered services in a medical home

Strategy: Provide professional development opportunities for healthcare professionals to learn about family-centered care practices and medical homes

Activity: Invite screening providers to participate in training and education sessions on screening using HealthStream, conferences, workshops, lunch-and-learns, learning communities, and other educational opportunities.

Activity: Provide tailored education and outreach to healthcare providers, interventionists, and specialists to promote family-centered care practices.

Strategy: Coordinate and collaborate with birthing hospitals, healthcare providers, interventionists, and specialists to implement family-centered care practices

Activity: Expand the number of birthing hospitals, healthcare providers, interventionists, and specialists who implement family-centered care practices

Activity: Link children with potential and identified needs to local primary healthcare providers, interventionists, and specialists who implement family-centered care practices

Strategy: Increase knowledge and awareness among families on family-centered care practices

Activity: Provide tailored education and outreach to families, communities, partner organizations, and stakeholders about medical homes and family-centered care practices.

Activity: Refer families to local primary healthcare providers, interventionists, and specialists who implement family-centered care practices and can serve as a medical home

Activity: Promote self-advocacy by families on demanding family-centered care practices in their systems of care and medical homes

Objective: By September 30, 2025, increase the percentage of the children who demonstrate improvements in their growth, health, and development through participation in MCH child health programs providing early intervening services (i.e., service/care coordination and/or home visiting programs) by 5%

Objective: By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5%

Objective: By September 30, 2025, increase the number of families of children who have access to peer-to-peer support and role models by 5%

Strategy: Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners of MCH child health programs to improve timely referrals for early intervening services

Activity: Develop and distribute promotional materials about early intervening services through a variety of approaches including personal contacts with referral sources; exhibitions and/or presentations at MSDH meetings, community meetings, public events, and/or conferences; distribution of Public Service Announcement to local media venues, social media, and in print

Activity: Review data to identify areas with low or late referrals and provide tailored outreach to communities, partner organizations, and stakeholders

Strategy: Implement interventions with families to promote the adoption of home- and community-based strategies

to promote the health and development of their children (e.g., safe sleep, healthy homes, nutrition, and physical activity)

Activity: Provide tailored education to families on home- and community-based strategies to promote the health and development of their children

Activity: Provide ongoing supports for families to implement home- and community-based strategies to promote the health and development of their children.

Activity: Provide ongoing peer-to-peer supports for families to promote the health and development of their children.

Strategy: Implement evidence-based approaches using family-centered practices to improve health and developmental outcomes for young children, including school readiness

Activity: Provide professional development on evidence-based approaches using family-centered practices that improve health and developmental outcomes for young children (e.g., Routines-Based Model for Early Intervention and Parents As Teachers Model for MIECHV)

Activity: Provide ongoing support for personnel to implement adopted evidence-based models with fidelity

PRIORITY: Improve Oral Health

Objective: By September 30, 2025, increase the percent of children with a preventive dental visit by 1%

Strategy: Promote the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals and nondental providers

Strategy: Support trainings of medical providers, including doctors, nurse practitioners, and physician assistants, on oral health assessments and use of fluoride varnish in the primary care setting

Strategy: Work with internal and external partners to identify barriers and solutions to access and utilization of preventive dental services

Activity: Increase oral health awareness regarding oral disease indicators

Activity: Conduct a basic health surveillance of Mississippi's children enrolled in Head Start

Activity: Coordinate efforts with the WIC program to improve access for WIC recipients (both children and pregnant mothers) to dental care

Activity: Monitor dental care coordination efforts among children 1-17 years

Activity: Strengthen the collaborative partnership with the Division of Medicaid

Activity: Continue to build connections and strengthen opportunities with the UMMC SOD and with other schools offering dental hygiene degree programs

PRIORITY: Increase Breastfeeding, Healthy Nutrition and Healthy Weight

Objective: By September 30, 2025, decrease the percentage of children, ages 2-5 years, who receive WIC services and have a BMI at or above the 85th percentile

Strategy: Increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support to reduce childhood obesity

Strategy: Implement evidence-based practices to decrease obesity in early childhood

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

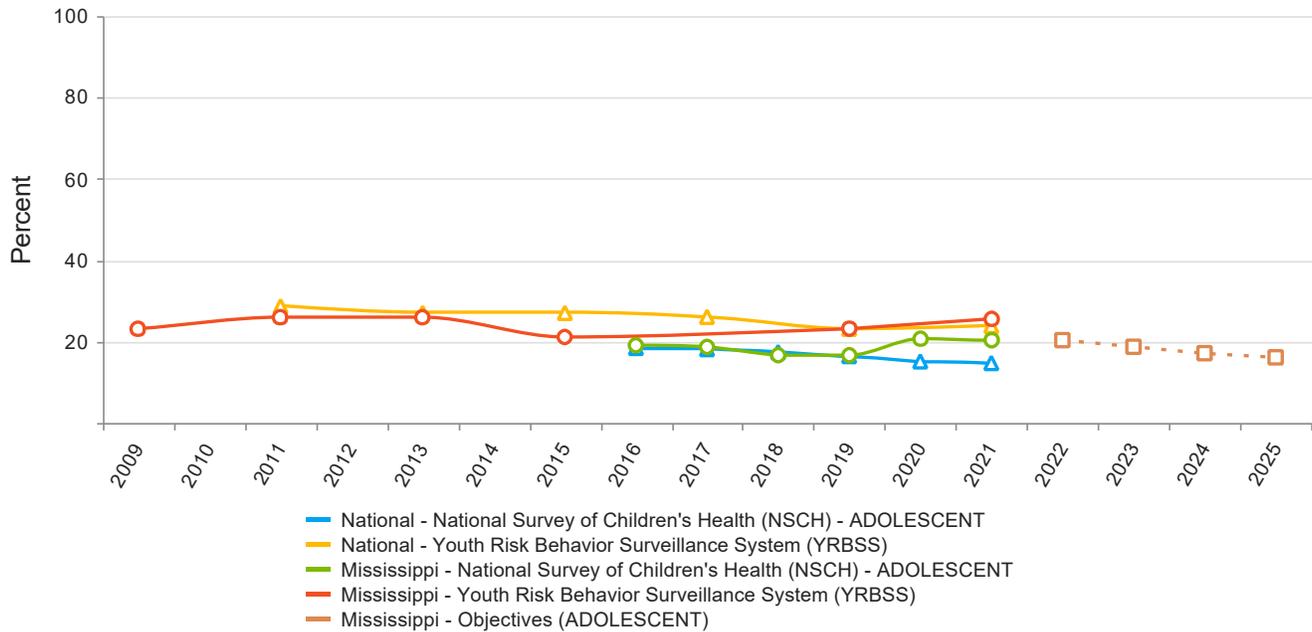
Activity: Provide breastfeeding education and support to prenatal WIC participants

Activity: Provide WIC participants access to certified lactation consultants

Adolescent Health

National Performance Measures

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day Indicators and Annual Objectives



Federally Available Data

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

	2020	2021	2022
Annual Objective			20.4
Annual Indicator	23.4	23.4	25.5
Numerator	29,043	29,043	31,054
Denominator	123,981	123,981	121,794
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2019	2019	2021

Federally Available Data

Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT

	2020	2021	2022
Annual Objective			20.4
Annual Indicator	16.7	20.6	20.5
Numerator	38,663	48,356	48,374
Denominator	231,717	234,684	235,476
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020	2020_2021

Annual Objectives

	2023	2024	2025
Annual Objective	18.8	17.2	16.2

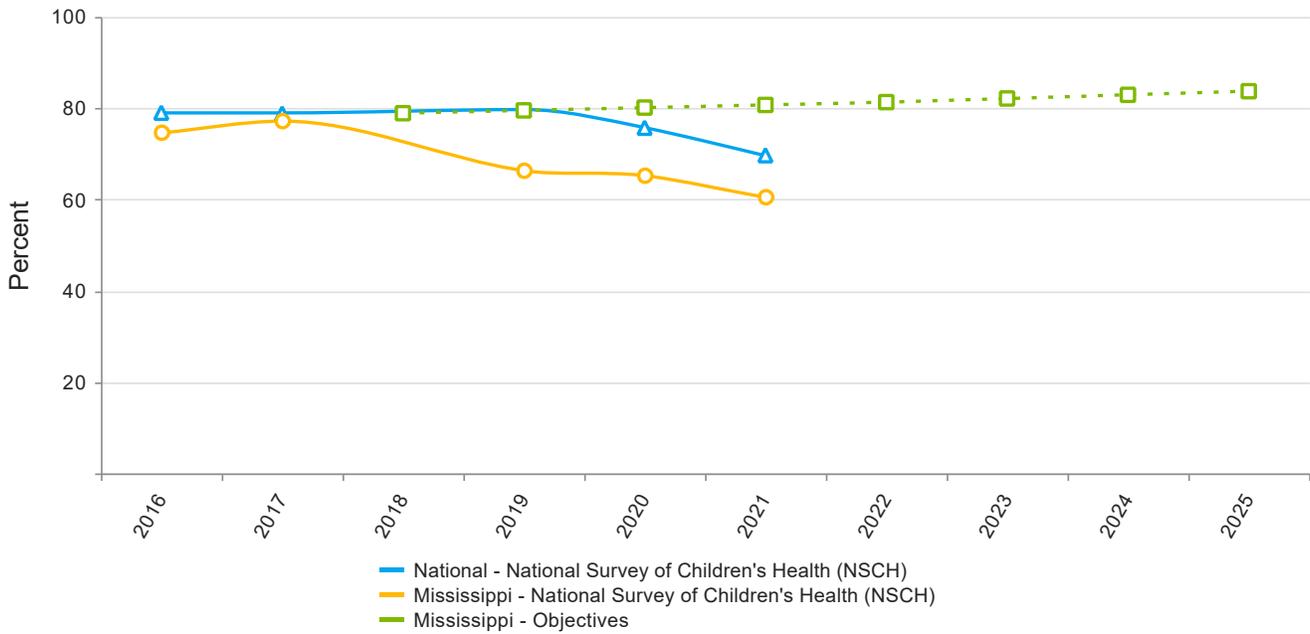
Evidence-Based or –Informed Strategy Measures

ESM 8.2.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide

Measure Status:		Active	
State Provided Data			
	2020	2021	2022
Annual Objective			22
Annual Indicator	20.6		20.5
Numerator	48,356		48,374
Denominator	234,684		235,476
Data Source	National Survey of Childrens Health		National Survey of Children's Health
Data Source Year	2019-2020		2020-2021
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	23.0	24.0	25.0

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives**



Federally Available Data

Data Source: National Survey of Children's Health (NSCH)

	2018	2019	2020	2021	2022
Annual Objective	78.8	79.4	80	80.6	81.2
Annual Indicator	77.0	77.0	66.2	65.1	60.5
Numerator	188,821	188,821	155,497	155,882	145,341
Denominator	245,226	245,226	234,939	239,310	240,226
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives

	2023	2024	2025
Annual Objective	82.0	82.8	83.6

Evidence-Based or –Informed Strategy Measures

ESM 10.2 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	100	100
Numerator		
Denominator		
Data Source	MSDH County Health Department information	MSDH County Health Department information
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (Mississippi) - Adolescent Health - Entry 1

Priority Need

Improve Access to Care

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By September 30, 2025, increase percentage of youth who complete an annual EPSDT visit

By September 30, 2025, increase HPV vaccination rate among youth 9-13 years and 14-17 years

Strategies

Provide professional development opportunities for healthcare professionals to learn about best practices in teen-friendly care

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of adolescent health issues and preventative care and the importance of medical homes

Educate transitioning youths and their families about accessing adult care, healthcare coverage options, health literacy, and self-advocacy

ESMs

Status

ESM 10.1 - Number of clinic sites engaged in youth-centered care quality improvement cycles.

Inactive

ESM 10.2 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years

Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

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

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

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

Priority Need

Increase Breastfeeding, Healthy Nutrition and Healthy Weight

NPM

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Objectives

By September 30, 2025, increase the percent of adolescents, ages 12-17 years who are physically active at least 60 minutes per day

Strategies

Develop partnerships and work with internal and external partners and schools to complete the School Health Index (SHI) Self-Assessment and Planning Guide

Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase daily physical activity among adolescents ages 12-17

Provide professional development opportunities for healthcare and education professionals to learn about best practices to promote daily physical activity among adolescents ages 12-17

ESMs

Status

ESM 8.2.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Adolescent Health - Annual Report

Adolescent Health Annual Report - FY2022

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

- Adolescent Health Program (AH)
- Children and Youth with Special Healthcare Needs Program (CYHCN)

The following section outlines strategies and activities implemented between 10/1/2021-9/30/2022 to meet the objectives and show improvement on the measures related to child health:

PRIORITY: Access to Care (women, children, adolescents, and families)

NPMs, NOMs, SPM, and ESMs:

- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
- NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
- NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
- NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
- NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
- NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
- NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
- NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
- NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
- NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
- NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
- NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- ESM 10.1 – Number of clinic sites engaged in youth-centered care quality improvement cycles.

Objective: *By 2022, Increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care from 0% to 3%.*

Strategy: Provide health care transition education and self-advocacy training to youth, families, and professionals.

Activities: CYHCN staff in collaboration with MSPTI provided training to care coordinators, health care providers, parents and youth on the importance of self-advocacy and medical literacy. These meetings were both virtual and in person and promoted on the MSPTI website and email listserv.

Due to staff attrition, a Youth Summit was not able to be organized by the AH program, although staff provided resources and participated at youth events if requested.

Strategy: Provide education to young adults on healthcare coverage options and coverage literacy.

Activities: AH staff participated in round table discussion hosted by the JSU School of Public Health regarding healthcare college readiness of incoming freshmen.

Objective: *By September 30, 2020, increase provider capacity to deliver youth-friendly, high-quality services to expectant and parenting teens through training modules and resource directory development*

Strategy: Collaborate with Teen Health Mississippi to develop minor consent and confidentiality online training for MSDH and Title X funded clinic staff.

Strategy: Collaborate with Teen Health Mississippi to provide LGBTQ friendly services training and youth-centered practices training to public health staff and school-based clinic staff and partners.

Activities: Due to staff attrition and continual interruption of schools due to COVID outbreaks, school staff were not available to participate in training.

Objective: *Increase the percentage of adolescents, ages 12 through 17 years, with a preventive medical visit in the past year by 3% each year for the next 5 years.*

Objective: *Increase the percentage of adolescents and young adults, ages 12 to 21, that receive at Least 1 Well-Care Visit with a Primary Care Practitioner by 2% each year for the next 5 years.*

Strategy: Collaborate with school-based health clinics to increase rates of youth-centered preventative wellness visits completed.

Strategy: Collaborate with MSDH Health Equity Unit, Jackson Heart Study, and the Winter Institute to engage youth councils/groups to promote health literacy and self-advocacy through peer education.

Activities: AH program personnel participated in health fairs at local schools to promote importance of preventive health visits and health care advocacy among youth and participated in a health care panel with JSU School of Public Health to promote the importance of healthcare literacy and advocacy among teens and young adults.

Objective: *By 2024, reduce the percentage of adolescents, ages 12 through 17, who are bullied by 5% from baseline.*

Strategy: Provide Mental Health First Aid training to MSDH health care professionals.

Activities: AH and CYSHCN program staff received Mental Health First Aid Training for both youth and young adults administered by Mental Health Alliance.

Due to staff attrition, this training was not provided for health care professionals by the AH Program during the reporting period.

Objective: *By September 30, 2022, increase views of the comprehensive resource guide to expectant and parenting teens and providers serving this population via social media from 0% to 5%.*

Strategy: Using MSDH and partner organizations' webpages and social media promotion of the comprehensive resource guide to expectant and parenting teens and providers serving this population will have been initiated.

Activities: Eight (8) Resource Guides for Expecting and Parenting Youth developed in collaboration with Teen Health Mississippi were posted on the MSDH webpage (<https://msdh.ms.gov/page/41,24785,106,86.html>) and other partners' websites. These resource guides were used by programs supporting teen parents, including HM/HB.

Strategy: To provide or link expectant and parenting teens to services that improve educational, health, and social outcomes

Activity: Screening for eligibility for the PHRM/ISS program is conducted on Medicaid eligible, pregnant women and infants up to age one in health department county clinics. As the PAF grant falls within the PHRM/ISS program, it allows for an expanded, broader category of eligibility, 17-19-year-old expectant and parenting teens without Medicaid and no medical risk factors. Program staff made significant efforts to promote services available under the grant. Fifty-one (51) risk screens/referrals were received from outside providers/partners. Data reflected from January 1, 2020 – June 30, 2021, 510 expectant teens (13-19 years old) were enrolled in the PHRM/ISS program and received services within MSDH clinics, home visits, and/or telehealth.

MCH personnel experienced significant challenges and barriers to implementing this activity due to the inability to reliably identify teen parents from birth records in the new the agency's new electronic health record (EHR). As many Health Services programs were undertaking new builds in the EHR, the development team was not available to assist with building new reporting features to identify records where an infant was born to a teen nor a maternal age field. While MSDH do narratively record those facts as part of assessments, progress notes, etc., the variables are not easily extracted with any accuracy. The enrollment for the PHRM/ISS program has been declining during this period due to a decrease in patients traveling to clinics causing a decline in teen referrals to MSDH. Despite COVID-19 impacts on the program, project leadership and program staff have adjusted accordingly to continue to implement technology where possible to offer remote services to participants to avoid interruptions in service, and to remain engaged to provide timely supervision and guidance.

PRIORITY: Nutrition and Physical Activity

NPMs, NOMs, SPM, and ESMs:

- NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
- NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
- NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
- ESM 8.2.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide

Objective: *By 2024, reduce the percentage of high school students that did not participate in at least 60 minutes of physical activity on at least 1 day by 3.4% (From 20.4% to 17.0%).*

Strategy: Deliver training methods to appropriate school staff during professional development sessions that supports providing education on 30+ minutes of daily physical activity to adolescents.

Activities: Due to staff attrition and continual interruption of schools due to COVID outbreaks, school staff were not available to participate in training.

Adolescent Health - Application Year

Adolescent Health Application Year - FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023-9/30/2024 to meet the objectives and show improvement on the measures related to adolescent health:

PRIORITY: Improve Access to Care

Objective: By September 30, 2025, increase percentage of youth who complete an annual EPSDT visit

Objective: By September 30, 2025, increase HPV vaccination rate among youth 9-13 years and 14-17 years.

Strategy: Provide professional development opportunities for healthcare professionals to learn about best practices in teen-friendly care

Activity: Partner with other MSDH offices as well as external partners to provide information to healthcare professionals about teen-friendly health practices.

Activity: Partner with TeenHealth MS to conduct focus groups with teens regarding their perceived barriers to healthcare.

Strategy: Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of adolescent health issues and preventative care and the importance of medical homes.

Activity: Identify 1 high school or college in each MSDH District to provide education and referral resources about the importance of HPV vaccination.

Activity: Work with Office of Communications to promote health observances and activities on the agency website and other media outlets

Strategy: Educate transitioning youths and their families about accessing adult care, healthcare coverage options, health literacy, and self-advocacy

Activity: Provide education to young adults on healthcare coverage options and coverage literacy

Activity: Encourage parents and caregivers to share decision making responsibilities with their youth and teach them advocacy skills

PRIORITY: Increase Breastfeeding, Healthy Nutrition and Healthy Weight

Objective: By September 30, 2025, increase the percent of adolescents, ages 12-17 years who are physically active at least 60 minutes per day

Strategy: Develop partnerships and work with internal and external partners and schools to complete the School Health Index (SHI) Self-Assessment and Planning Guide

Activity: Identify a School Health Champion at 1 high school or college in each MSDH District.

Activity: Partner with the School Health Champion at 1 high school or college in each MSDH District and

provide support for conducting or reviewing the School Health Index (SHI) Self-Assessment according to the Planning Guide.

Strategy: Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase daily physical activity among adolescents ages 12-17.

Activity: Work with Office of Communications to promote health observances and activities on the agency website and other media outlets

Activity: Collaborate with MDE Offices of School Nutrition and Healthy Schools to provide promotional materials directly into school districts regarding benefits of physical activity among adolescents

Strategy: Provide professional development opportunities for healthcare and education professionals to learn about best practices to promote daily physical activity among adolescents ages 12-17

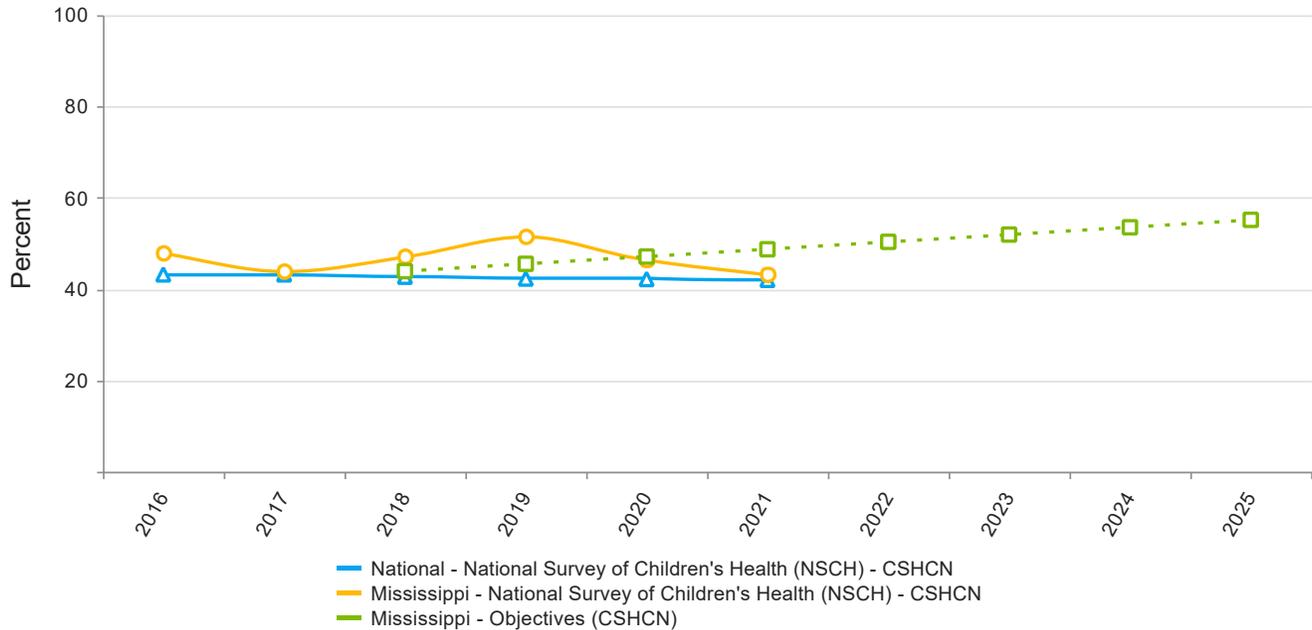
Activity: Present on best practices to promote daily activity for adolescents in at least one Grand Rounds Sessions during the year.

Children with Special Health Care Needs

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	2019	2020	2021	2022
Annual Objective	43.9	45.5	47.1	48.7	50.3
Annual Indicator	43.8	46.9	51.4	46.2	43.2
Numerator	75,832	78,448	82,086	72,719	68,226
Denominator	173,259	167,120	159,664	157,506	157,885
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	51.9	53.5	55.1

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	15	48	50	52	54
Annual Indicator	46	100	100	0	30
Numerator					
Denominator					
Data Source	MSDH CYSHCN Program				
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	56.0	58.0	60.0

State Performance Measures

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	46.9	40.4
Numerator	30	23
Denominator	64	57
Data Source	EPIC	EPIC
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	67.0	77.0	87.0

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	310	272
Numerator		
Denominator		
Data Source	EPSDT Visits in EPIC	EPSDT Visits in EPIC
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	341.0	375.0	413.0

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	100	93.2
Numerator	60	2,722
Denominator	60	2,922
Data Source	Newborn Screening data	MS Newborn screening database and EPIC database
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

SPM 18 - Percent of children with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	16.2	15.4
Numerator	8,954	9,208
Denominator	55,176	59,681
Data Source	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2019-2020	2020-2021
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	17.2	18.2	19.2

State Action Plan Table

State Action Plan Table (Mississippi) - Children with Special Health Care Needs - Entry 1

Priority Need

Assure Medical Homes for C/YSHCN

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

By September 30, 2025, increase the percentage of CYSHCN who receive care coordination services by 10%

Strategies

Ensure the delivery of high-quality care coordination services across the state through alignment of practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) in internal and partnering MCH programs, including in FQHCs and specialty clinics

Provide education to CYSHCN and families on the importance of medical homes, family-centered care, healthcare coverage options, and health literacy

Work with internal and external partners to increase referrals to home visiting/care coordination programs

ESMs

Status

ESM 11.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

Active

NOMs

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

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Mississippi) - Children with Special Health Care Needs - Entry 2

Priority Need

Assure Medical Homes for C/YSHCN

SPM

SPM 18 - Percent of children with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

By September 30, 2025, increase the percentage of CYSHCN participating in home visiting/care coordination programs who have plans for transitioning to adult care in place by age 16 years

Strategies

Ensure the delivery of high-quality care coordination services across the state through alignment of practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) in internal and partnering MCH programs, including in FQHCs and specialty clinics

Educate transitioning youths with special health care needs and their families on accessing adult care, healthcare coverage options, health literacy, and self-advocacy

Children with Special Health Care Needs - Annual Report

Children and Youth with Special Healthcare Needs (CYHCN) Annual Report - FY2022

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

- Children and Youth with Special Healthcare Needs Program (CYHCN)
- Mississippi First Steps Early Intervention Program (MSFSEIP)
- Lead Poisoning Prevention and Healthy Homes Program (LPPHHP)
- Office of Oral Health

The following section outlines strategies and activities implemented between 10/1/2021-9/30/2022 to meet the objectives and show improvement on the measures related to child health:

PRIORITY: Medical Home (lack of or inadequate access to coordinated comprehensive care)

NPMs, NOMs, SPM, and ESMs:

- NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
- NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
- NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
- NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
- NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
- ESM 11.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

Objective: *By September 30, 2022, increase the number of external partnerships by 10% from 19 to 21 to establish cross systems of care for CYHCN.*

Strategy: Maintain Cross Systems of Care Coordination with partners and CYHCN and families.

Activities: The CYHCN Program has implemented an ongoing model of public-private partnerships with healthcare facilities serving CYHCN populations to place care coordinators and parent consultants in their communities, known as CYHCNCares2 (CC2). The initiative is supported by CYHCN Leadership/Parent Consultant Advisory Council (PCAC) comprised of but not limited to parents and caregivers of CYHCN, youths with special needs service providers, healthcare providers, agency staff, and other advocates. The goal is to increase awareness of the initiative and develop the curriculum/resources for participants. There were five meetings of the (PCAC) held during this reporting period with partners (11/15/21, 12/17/21, 1/19/22, 3/8/22 and 5/26-27/22). The meetings were held using hybrid methods of both zoom and/or in-person to accommodate schedules of team members and allow for greater participation with both internal and external partners. The number of participating healthcare facilities decreased during the reporting period as two facilities dropped out due to ongoing staffing issues that prevented them from meeting requirements for the CC2 initiative.

The CYHCN program continued collaborative relationships with internal MSDH partners, EI, Lead, Preventive Health and Genetics as well as external partners, MDE, MSPTI and MS Institute for Disability Studies to support

clients/families enrolled in the CYHCN program and to inform larger populations about the CYHCN program and how it supports the larger community.

CYHCN care coordinators contacted families enrolled in the CYHCN program to encourage covid 19 vaccinations and boosters, reminding them of the impact that the contracting the Covid virus has on their chronic health condition and its long-term effects. They promoted covidhomebound.com to ensure age-appropriate CYHCN who are bedridden had an opportunity to receive the COVID-19 vaccination.

Objective: *By September 30, 2023, increase the percentage of CYHCN who receive care coordination services by 10% (i.e., from 24,936 to 27,430).*

Strategy: Implement standardized population-based strategies to improve care coordination services and quality reporting.

Strategy: Collect data from CYHCN Cares 2 healthcare systems on selected measures (MICH, HP2020, and SPM).

Strategy: Identify or customize a Care Coordination Curriculum for Care Coordinators

Strategy: Continue enrolling children and youth with special health care needs into the CYHCN Program.

Strategy: Assess youths with special health care needs, ages 12 -21 years of health for mental health concerns.

Strategy: Provide respite care services to parents and caregivers of children and youth with special health care needs.

Activities: CYHCN partnered with an independent consulting company (BC3 Technologies) to establish a platform for the external clinics to report number of CYHCN actively enrolled in the CYHCN program and those with chronic conditions that are served in the clinic not enrolled. All persons were provided information about health condition and importance routine/preventive healthcare and maintenance. Internal CC also reported in the platform to provide a comprehensive model of effectiveness of care coordination.

CYHCN partnered with an independent evaluation company (Fastring Evaluation & Consulting) to determine the level of engagement of participating facilities and their capacity to continue participation and to evaluate the effectiveness of external partnerships and how they supported the population of focus and increasing the population of spread of CYHCN community.

1. Patients with special health care needs receiving care in a medical home (MICH 30.2/HP2020)	51.8%
2. Patients receiving developmental screening (Health Maintenance /Bright Futures/EPSDT)	80%
3. Patients receiving care in a dental home	50%
4. Patients referred for annual dental visits	100%
5. Patients who receive their care in family-centered, comprehensive, and coordinated system (MICH 31.2/HP2020)	80%
6. Patients who talked to the healthcare team about their special health care need, as he or she becomes an adult (DH-5)	50%
7. Patients whose healthcare team encouraged them to become more independent in managing their special health care need (DH-5)	50%
8. Patients who have a shared care plan documented in the EHR	80%

The CYHCN Program was unable to recruit additional healthcare systems to provide coordinated comprehensive support to CYHCN to participate in the CC2 learning collaborative to ensure sustainability of current participating systems.

CYHCN partnered with an independent consulting and evaluation company (BC3 Technologies and Fastring Evaluation & Consulting) to establish a platform for the external clinics to report patient demographics to monitor health disparities and inequities among the targeted population and plan interventions for implementation. Data included number of CYHCN actively enrolled in the CYHCN program and those with chronic conditions and monitor effectiveness of process of those served in the clinics whether enrolled in CYHCN program or not enrolled. All persons were provided information about health condition and importance routine/preventive healthcare and maintenance. Partnerships with specialty clinics who support CYHCN were also monitored at assess effectiveness of partnership.

Quarterly Learning Sessions for the entire multidisciplinary teams were held on evidence-based medicine, clinical decision support, CYHCN patient and family engagement, shared plans of care, and community-based services and support.

An electronic data submission and resource platform was established for cohort clinics. It was called the CYHCN Data Dashboard (<http://23.254.244.126/CYHCNsitestats/login.aspx>). It serves as an online resource and registration portal, to share resources, including EHR utilization to monitor the targeted population demographics and reduce health disparities, quality reporting, team-based care, provider prompts/feedback, patient educational resources.

The CYHCN Program adopted the Foundational Standards for Systems of Care for CYHCN from AMCHP to provide guidance to all CYHCN care coordinators. This ensures that Care Coordinators are meeting the national expectations of care standards Care Coordinators in the CYHCN system.

This process also includes outreach, identification, and recruitment of CYHCN across the state, informing them of resources and supports in their areas. These include but are not limited to mental health resources and Respite services. CYHCN staff participated in several Mental Health First Aid trainings to provide them with skills to support CYHCN and their families by making them aware of signs/symptoms of persons experiencing a mental health challenge and what resources are available in their communities. The CYHCN program has had a

longstanding partnership with the MS chapter of American Academy of Pediatrics and MS Families for Kids organizations to provide respite services to CYHCN and their families. These partnerships also serve as recruitment tools, as they identify CYHCN in areas throughout the state.

Objective: *By September 30, 2023, increase the percentage of participating CYHCN Cares 2 healthcare systems with policies to transition YSHCN to an adult provider (from 75% to 90%)*

Strategy: Establishing and implementing protocols/policies for transitioning youths with special health care needs to adult care and adulthood.

Strategy: Provide CYHCN Cares 2 clinical teams with an assessment tool to assess and reassess youths' understanding of care, use of care, readiness to transition to an adult provider.

Strategy: Conduct an assessment to determine if CYHCN Cares 2 healthcare systems in cohort III have a transition policy by 2022.

Strategy: Promote preventive health and wellness screenings and other emerging topics of interest among adolescents.

Activities: The CYHCN Program developed and implemented detailed policies to identify when transition practices are to occur beginning with education for caregivers and CYHCN regarding the understanding of healthcare need, medical literacy, and advocacy. These policies are listed in the Child and Adolescent Health manual and posted on the MSDH website. They are also posted on the CYHCN data dashboard for access by all the cohort clinics. There were also procedures in place addressing educational transition and understanding ADA laws.

All CYHCN Care Coordinators and Parent Consultants use a standardized Shared Plan of Care document that assess the CYHCN and caregivers' readiness regarding transitioning to adult medical care. The document asks foundational questions such what the CYHCN is understanding of their specific health care condition and its impact on their live. The primary health care and specialty providers are also encouraged to discuss long-term health care options with the CYHCN.

The CYHCN Program was unable to recruit additional healthcare systems to provide coordinated comprehensive support to CYHCN to participate in the CC2 learning collaborative to ensure sustainability of current participating systems, therefore there is not a third cohort.

CYHCN team members participated in or partnered with other entities via health fairs or panel discussions to highlight the benefits of routine healthcare screenings, including oral health screenings and its benefits to overall health. CYHCN also and partnered with an independent evaluation company (Fastring Evaluation & Consulting) to determine the level of engagement of participating facilities and their capacity to continue participation and to evaluate the effectiveness of external partnerships and how they supported the population of focus and increasing the population of spread of CYHCN community.

Objective: *By September 30, 2021, increase the percentage of Parent Consultants (i.e., a parent of a CYHCN who can help parents and caregivers navigate a comprehensive system of care) hired by systems participating in the Cares 2 Initiative (from 75% to 85%).*

Strategy: Increase Community Based Services and Support for CYHCN and Families.

Strategy: Assess parents/caregivers of CYHCN on the social determinants of health.

Strategy: Collaborate with CYHCN Cares 2 healthcare systems, parent consultants and community partners to conduct regional CYHCN Families' and Caregivers' Family Engagement Summits.

Strategy: Assist CYHCN families and caregivers with establishing CYHCN support groups and offer a series of training sessions and engagement activities.

Strategy: Develop a booklet of Parent Consultant's Success Stories

Activities: The CYHCN program was able to ensure that each clinic participating in the CC2 initiative has a Parent Consultant as part of the care team and they meet monthly with the CYHCN state staff to discuss any concerns they may have to address the needs of their CYHCN and families.

Through monthly meetings with the CC2 clinics, the team discusses the impact of the social determinants of health and how it also affects the CYHCN and their long-term success. They are provided information about resources, both locally and nationally that can guide CYHCN and their families or where resources can be obtained including support groups about specific health care conditions.

Although the CYHCN program collected success stories from both CC2 clinics and state level staff, they have not formally compiled a booklet of those success stories.

Children with Special Health Care Needs - Application Year

Children and Youth with Special Healthcare Needs (CYSHCN) Application Year - FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023-9/30/2024 to meet the objectives and show improvement on the measures related to cross-cutting issues:

PRIORITY: Assure Medical Homes for C/YSHCN

Objective: By September 30, 2025, increase the percentage of CYSHCN who receive care coordination services by 10%

Strategy: Ensure the delivery of high-quality care coordination services across the state through alignment of practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) in internal and partnering MCH programs, including in FQHCs and specialty clinics

Activity: Promote use of National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) with internal and external partners and other MCH home visiting programs for effective service delivery.

Strategy: Provide education to CYSHCN and families on the importance of medical homes, family-centered care, healthcare coverage options, and health literacy

Activity: Conduct monthly meeting with CYHCHN Care Coordinators, Parent Consultants and Specialty clinic partners about healthcare transition education for both CYHCHN and their caregivers.

Strategy: Work with internal and external partners to increase referrals to home visiting/care coordination programs

Activity: Participate in health fairs and other outreach activities to inform public about home visiting and care coordination programs.

Objective S2: By September 30, 2025, increase the percentage of CYSHCN participating in home visiting/care coordination programs who have plans for transitioning to adult care in place by age 16 years

Strategy: Ensure the delivery of high-quality care coordination services across the state through alignment of practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) in internal and partnering MCH programs, including in FQHCs and specialty clinics

Activity: Share National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) with internal and external partners and other MCH home visiting programs.

Strategy: Educate transitioning youths with special health care needs and their families on accessing adult care, healthcare coverage options, health literacy, and self-advocacy

Activity: Provide education to young adults on healthcare coverage options and coverage literacy

Activity: Encourage parents and caregivers to share decision making responsibilities with C/YSHCN and teach advocacy skills

Cross-Cutting/Systems Building

State Performance Measures

SPM 19 - Adolescent suicide rate

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	11.6	10.8
Numerator		
Denominator		
Data Source	CDC WONDER Multiple Cause of Death Files	Office of Vital Records and Public Health Statisti
Data Source Year	2017-2019	2021
Provisional or Final ?	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	11.3	11.0	10.6

SPM 20 - Number of MCH programs that have developed a written plan to address health equity

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	1	3
Numerator		
Denominator		
Data Source	MCH program data	MCH program data
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	3.0	6.0	9.0

State Action Plan Table

State Action Plan Table (Mississippi) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Improve Access to Mental Health Services Across MCH Populations

SPM

SPM 19 - Adolescent suicide rate

Objectives

By September 30, 2025, reduce the percentage of suicide attempts among high school student by 1%

By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities on mental health for MCH workforce, partners, and providers serving MCH populations

Strategies

Promote, provide, sponsor, or facilitate education, training, and reflective supervision on mental health for MCH workforce, partners, and providers serving MCH populations

Engage with Regional Department of Mental Health MAP Teams to coordinate home/community-based services for children and youth with mental health or behavioral disorders at risk of institutional placement

Promote mental health awareness in children, youth, young adults, and families and linkages to resources to support positive mental/behavioral health

State Action Plan Table (Mississippi) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Ensure Health Equity by Addressing Implicit Bias, Discrimination, and Racism

SPM

SPM 20 - Number of MCH programs that have developed a written plan to address health equity

Objectives

By September 30, 2025, establish partnerships or collaborations with at least 10 new MSDH program areas, providers, or external organizations and businesses to improve equitable access to services and care

By September 30, 2025, communicate with health care professionals, service providers, and families to address diversity and inclusion across MCH programs

By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities to support providers in delivering culturally and linguistically appropriate healthcare setting.

Strategies

Translate program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information.

Partner and collaborate with internal and external partners, providers, organizations, and businesses across the state to improve equitable access to services and care

Use language, images, graphics, and messaging that is both responsive to diversity and health literacy

Conduct PDSA cycles to improve systems, programs, and outcomes to decrease health inequities

Educate MCH workforce, partners, and providers on implicit bias, discrimination, racism, and implementing culturally and linguistically appropriate practices in healthcare settings.

Cross-Cutting/Systems Building - Annual Report

Cross-Cutting Issues Annual Report - FY2022

Activities in this domain were carried out by all MSDH MCH offices, bureaus, and programs during the reporting period:

The following section outlines strategies and activities implemented between 10/1/2021-9/30/2022 to meet the objectives and show improvement on the measures related to child health:

Priority: Mental Health across MCH Populations

NPMs, NOMs, SPM, and ESMs:

- SPM 8 - Strengthen mental, social and emotional health and well-being through partnerships and programs that build capacity and reduce stigma.

Objective: *By 2022, partner with a community-based perinatal and postpartum program to provide services to at least 30 women on maternal mental health, breastfeeding, baby basics, safe sleep, infant/child safety and childbirth preparation.*

Strategy: Provide mental health services to women in the perinatal and postpartum period.

Activities: Collaboration with Mom.ME on the provision of mental health services to women in the perinatal and postpartum period was described in the Women's / Maternal Health section.

PRIORITY: Implicit Bias/Discrimination/Racism & Health Equity

NPMs, NOMs, SPM, and ESMs:

- SPM 6 - Percentage of pregnant women and new mothers who felt they were treated unfairly while receiving services.
- SPM 7 - Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff.

Objective: *By September 30, 2024, embed racial and social justice throughout the MSDH's current culture, systems, policies and practices.*

Strategy: Develop structures and processes to consistently center the experiences and ideas of historically marginalized populations

Activities: The MCH Workforce Development Office identified current policies and gaps regarding internships and professional development for the MSDH Title V and Health Service program staff and subgrantees to include implicit bias, discrimination, diversity, inclusion and racial equity. Currently, MSDH has Health in All Policies (HiAP)-CLAS Internal Assessment for FFS, Contracts, Plans, Subgrants, Policies, MOUs, and RFPs form. The form was created to provide a guide to ensure all programs, subgrantees, and contracts conform to a Health in All Policy framework and align with National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare. For example, the form requires responses to determine the impact on historically marginalized or discriminated populations (i.e., age, class, race, ethnicity, immigration status, gender, sexual

orientation, geographic location).

The Early Hearing and Detection Intervention (EHDI) program establish an Inclusion and Diversity Plan. The purpose of this plan is to promote and foster a culture that values diversity, equity, and inclusion throughout the EHDI program and the diverse communities that the program serves.

Objective: By September 30, 2024, build alliances with historically marginalized and minoritized physicians and other stakeholders.

Strategy: Provide education and training to strengthen clinicians' knowledge of public health and structural/social drivers of health and inequities

Activities: The MIHB partnered with the Institute for the Advancement of Minority Health (IAMH) as a subgrantee during the reporting period. IAMH held five (5) workshops that implemented an evidence-based anti-racism curriculum. The workshops were facilitated by Dr. Tanya Funchess, Assistant Professor in the College of Nursing and Health Professionals at the University of Southern Mississippi. All workshops were held virtually via the Zoom Platform. Overall, 44 participants representing 19 organizations attended at least one workshop in the series. All workshops were evaluated by measuring knowledge prior to and after content delivery via online pre and post survey.

To assist with increasing knowledge and awareness on the importance of culturally competent and responsive healthcare providers, in 2017, Office of Oral health team members received national train the trainer training to provide culturally competent training to healthcare systems and organizations throughout the state. Over this reporting period, Office of Oral Health team members partnered with the Office of Preventive Health and Health Equity staff to provide Cultural Competence Training to the following entities: Pearl River Valley Head Start, Mississippi Department of Transportation, East Central Health Net, Jackson State University-School of Public Health, and Mississippi Delta Community College (dental hygiene program).

Strategy: Engage in cross-sector collaboration and advocacy efforts.

Activities: In June 2022, the OCAH posted a Notice of Funding Opportunity (NOFO) for potential partners to assist the MSDH with achieving key MCH goals and objectives. Through this process two partners, Six Dimensions and Teen Health Mississippi, were selected to assist with supporting MCH Programs in health equity work. The agreement with Six Dimensions outlined plans to provide consulting services to MCH Programs to review internal policies, procedures, and practices through a health equity lens and to develop plans to implement with the MCH populations, professionals, and external stakeholders for each respective program. The agreement with Teen Health Mississippi outlined plans to conduct focus groups specifically with teens in populations experiencing health disparities in the state (e.g., individuals with disabilities, people of color, LGBTQ youth) to identify the unique experiences and to develop educational materials for internal and external professionals who serve these teen populations on being teen friendly and welcoming to underserved populations to address and eliminate health disparities. This work will be continued for the remainder of this planning cycle.

Objective: By June 30, 2022, continue collaboration with the Office of Policy Evaluation, Health Equity, and Government Relations to educate providers on promoting a culturally and linguistically appropriate healthcare setting. (BCCP Program)

Strategy: Collaborate with the Office of Health Equity and Office of Policy and Evaluation to develop material in

accordance with healthy literacy guidelines for the program's health literature disseminated at outreach events.

Activities: There were no activities for this strategy conducted in Women's Health during the reporting period, as the work had already been accomplished in the prior reporting period. By close of the reporting period, 229 requests for materials had been received since MS-BCCP implemented the online request process in mid-June 2021.

The Office of Child and Adolescent Health (OCAH) engaged in several meetings to review existing materials and to create guidelines for revisions and all subsequently developed materials to ensure an appropriate balance of graphics and text, the literacy level of the text shared, ensuring graphics were representative of the MCH populations in the state and did not contain stereotyped images (e.g., always using a white or male healthcare professional or using stereotypical images or graphics to represent populations). The OCAH developed a guidance document outline the recommendations and checklist to review all subsequent materials prior to finalization.

Strategy: Explore resources for translating program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information.

Activities: Outreach materials and two MS-BCCP forms requiring patient signature were translated to Vietnamese through intra-agency resources during the reporting period. Materials were already available in English and Spanish. During the reporting period, there were two requests for materials in Vietnamese and Spanish.

Family Planning continued to collaborate with STD/HIV services by providing Family Planning Waiver materials and condoms as requested by that program. Continuous efforts were made to ensure the integration of literacy, age appropriate and cultural/linguistic materials are included in all preconception health messages and outreach activities. Educational materials were translated into other languages and disseminated to each county health department and Title X delegate agencies to provide clinicians with tools to better educate clients served.

Objective: *By September 31, 2023, develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient partners.*

Strategy: Incorporate racial equity training into individual staff training plans and minimum strategic planning requirements into subrecipient agreements.

Activities: In June 2022, the OCAH posted a Notice of Funding Opportunity (NOFO) for potential partners to assist the MSDH with achieving key MCH goals and objectives. Through this process two partners, Six Dimensions and Teen Health Mississippi, were selected to assist with supporting MCH Programs in health equity work. The agreement with Six Dimensions outlined plans to provide consulting services to MCH Programs to review internal policies, procedures, and practices through a health equity lens and to develop plans to implement with the MCH populations, professionals, and external stakeholders for each respective program. The agreement with Teen Health Mississippi outlined plans to conduct focus groups specifically with teens in populations experiencing health disparities in the state (e.g., individuals with disabilities, people of color, LGBTQ youth) to identify the unique experiences and to develop educational materials for internal and external professionals who serve these teen populations on being teen friendly and welcoming to underserved populations to address and eliminate health disparities. This work will be continued for the remainder of this planning cycle.

Strategy: Provide support and education to MCH Title V regional and central office staff, and interagency staff on planning and implementing MCH programs with attention to racial equity and upstream factors.

Activities: With Health Services, the MCH Workforce Development Office hosted various webinars surrounding such topics. They included Declaring Racism as a Public Health Crisis, Cross-Cultural Communication-Cognition and Language, Reimagining a Public Health System to Build an Equitable Tomorrow, Advancing Equity and Justice by Connecting Evaluations to Strategy, Provider-Driven Innovation: Reducing Disparities, Messaging Health Equity to Decision-Makers, A Model for Addressing Racism and Belonging, Addressing Rural Health Disparities with Data, and Best Practices in Public Health Communication to Promote Equity and Inclusion.

The MCH Strategic Planning Team, consisting of Title V Core team members, hosted a Diversity, Equity and Inclusion strategic planning meeting in November 2022. This was the second of four MCH Steering Committee meetings. The purpose of the meeting was to review the current cross cutting/systems building State Action Plan objectives, identify how MCH Program were performing relative to the proposed strategies (i.e., ranging from completely new work to this has been core work for the program for many years), determine how to assess the needs of the community relative to the issue, identify any standards to be adopted across MCH programs and in programmatic policies regarding Diversity, Equity and Inclusion, and identify ways of incorporating professional development on Diversity, Equity and Inclusion into individual staff training plans, clinicians' knowledge about structural drivers of health and inequity, long with provide support and education to MCH Title V staff with attention to racial equity and upstream factors.

Strategy: Pilot racial equity training with internal and statewide partners.

Activities: There were no activities reported for this strategy during the reporting period.

Strategy: Review MCH Tile V current policies that address racial equity.

Activities: The MCH Workforce Development Office identified current policies and gaps regarding internships and professional development for the MSDH Title V and Health Service program staff and subgrantees to include implicit bias, discrimination, diversity, inclusion and racial equity. Currently, MSDH has Health in All Policies (HiAP)-CLAS Internal Assessment for FFS, Contracts, Plans, Subgrants, Policies, MOUs, and RFPs form. The form was created to provide a guide to ensure all programs, subgrantees, and contracts conform to a Health in All Policy framework and align with National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare. For example, the form requires responses to determine the impact on historically marginalized or discriminated populations (i.e., age, class, race, ethnicity, immigration status, gender, sexual orientation, geographic location).

Cross-Cutting/Systems Building - Application Year

Cross-Cutting Issues Application Year - FY2024

The following section outlines strategies and activities to be implemented between 10/1/2023-9/30/2024 to meet the objectives and show improvement on the measures related to cross-cutting issues:

PRIORITY: Improve Access to Mental Health Services Across MCH Populations

Objective: By September 30, 2025, reduce the percentage of suicide attempts among high school student by 1%

Strategy: Promote, provide, sponsor, or facilitate education, training, and reflective supervision on mental health for MCH workforce, partners, and providers serving MCH populations

Activity: Identify and share professional development opportunities for supporting the mental health of children, youth, and young adults on the MCH Workforce Development Training Calendar

Strategy: Engage with Regional Department of Mental Health MAP Teams to coordinate home/community-based services for children and youth with mental health or behavioral disorders at risk of institutional placement

Activity: Identify home/community-based resources for children and youth with mental health or behavioral disorders to support their health and wellbeing as part of a comprehensive plan to prevent institutional placement.

Objective: By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities on mental health for MCH workforce, partners, and providers serving MCH populations

Strategy: Promote mental health awareness in children, youth, young adults, and families and linkages to resources to support positive mental/behavioral health

Activity: Identify and compile mental health resources for pregnant/parenting women and families for the Mississippi Access to Maternal Assistance (MAMA) for a one-stop website and mobile app

Strategy: Promote, provide, sponsor, or facilitate education, training, and reflective supervision on mental health for MCH workforce, partners, and providers serving MCH populations

Activity: Provide access to training and reflective supervision for MSDH Care/Service Coordinators and Public Health Social Workers who work with programs serving infants and toddlers and their families to earn the Infant Family Specialist Credential from the Alliance for Infant Mental Health.

PRIORITY: Ensure Health Equity by Addressing Implicit Bias, Discrimination, and Racism

Objective: By September 30, 2025, establish partnerships or collaborations with at least 10 new MSDH program areas, providers, or external organizations and businesses to improve equitable access to services and care

Strategy: Partner and collaborate with internal and external partners, providers, organizations, and businesses across the state to improve equitable access to services and care

Activity: Establish a new partnership agreement focused on improving equitable services and care for populations experiencing health disparities

Activity: Identify 3-4 potential healthcare settings, community-based, faith-based, social, volunteer service organizations, homeless/domestic violence shelters, residential programs, treatment programs, housing complexes, etc. to outreach per quarter.

Objective: By September 30, 2025, communicate with health care professionals, service providers, and families to address diversity and inclusion across MCH programs

Strategy: Translate program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information

Activity: Submit work requests to the Office of Communications to ensure all educational materials, guidance, and resources for families are translated.

Strategy: Use language, images, graphics, and messaging that is both responsive to diversity and health literacy

Activity: Use the guidance document developed by the Office of Child and Adolescent Health to ensure all new materials have had their language, image, graphics, and messaging reviewed to ensure they will be accessible and appropriate for use with diverse populations.

Objective: By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities to support providers in implementing culturally and linguistically appropriate practices in their healthcare settings.

Strategy: Educate MCH workforce, partners, and providers on implicit bias, discrimination, racism, and promoting culturally and linguistically appropriate practices in healthcare settings.

Activity: In partnership with Teen Health Mississippi, distribute training for the MCH workforce on teen-friendly care for populations experiencing health disparities in the state (e.g., individuals with disabilities, people of color, LGBTQ youth)

Strategy: Conduct PDSA cycles to improve systems, programs, and outcomes to decrease health inequities

Activity: Analyze program data on enrollments and/or service utilization to identify areas or populations of need to be addressed collectively through program improvement or development

III.F. Public Input

The Mississippi MCH Title V Program has implemented various mechanisms to solicit public input, not only during the statewide needs assessment process, but also during ongoing MCH-related activities, including sharing during public meetings with advisory boards and committees and posting reports and applications on the agency website and opportunities to submit feedback via an online form and by phone.

The MCH Advisory Board serves as a critical venue for providing feedback to the Title V Program on planned activities and implementation. The Maternal and Child Health Advisory Board assists all MCH programs by: reviewing the development, implementation, and adoption of programs, policies, and strategies to ensure integration across agencies and systems; advising on methods of integration at the local and state level; advising use of block grant funds to address needs in local communities based on state measures and supported by data; and assisting in the development of information on MCH services and activities to ensure information is created in a culturally, literacy-level, and linguistic manner. In addition, some MCH programs also have program-specific advisory boards or committees based on federal or state requirements. (See *Family Partnership* for more information)

One main way opportunity for the public to learn about the MCH Block Grant and provide input is on the dedicated MCH Block Grant webpage on the agency website (<https://msdh.ms.gov/page/44,0,407,1017.html>). Embedded within the page is a book for feedback, including the statement, “*Your input is important. We want to hear from you about maternal and child health needs, the MCH Block Grant, and programs in Mississippi. Take a moment to share your comments, ideas, and concerns with us.*” Submission of an email address with comments is optional for individuals who wish to receive a reply. All comments are immediately sent to the MCH Block Grant/Health Service Director. During the 2022 reporting year, there were 466 hits to the State Title V website. In addition, 21 Health Service programs provide the following language on their webpage: For more information about Maternal and Child Health Programs and the MCH Block Grant, call 1-800-721-7222.” In reporting year of 2022, the 1-800 number received 520 calls.

Through these approaches, the MCH Title V program provides two-communication between programs and the populations that they serve as well as establish an environment within the agency and outside the agency to support family and consumer engagement that will allow our programs to provide resources and services to MCH populations that are both beneficial and relevant to their needs.

III.G. Technical Assistance

SECTION INCOMPLETE – TO BE ADDED

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Title V-Medicaid IAA-MOU FY24 comp.pdf](#)

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [Attachment 1 - MS County Maps 2024.pdf](#)

Supporting Document #02 - [Attachment 2 Additional MCH Success Stories FY24.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [MCH Org Chart.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Mississippi

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 9,305,490	
A. Preventive and Primary Care for Children	\$ 2,791,647	(30%)
B. Children with Special Health Care Needs	\$ 2,791,647	(30%)
C. Title V Administrative Costs	\$ 930,549	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 6,513,843	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 1,053,440	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 5,525,678	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 400,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 6,979,118	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 6,576,655		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 16,284,608	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 106,139,568	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 122,424,176	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	\$ 300,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	\$ 435,947
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 2,200,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 235,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 92,418,687
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 4,417,559
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$ 300,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 3,038,018
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 711,463
US Department of Education > Office of Special Education Programs > Individual with Disabilities Education Act/American Rescue Plan Act of 2021	\$ 2,082,894

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 9,278,900 (FY 22 Federal Award: \$ 9,305,490)		\$ 9,305,490	
A. Preventive and Primary Care for Children	\$ 2,783,672	(30%)	\$ 2,824,110	(30.3%)
B. Children with Special Health Care Needs	\$ 2,783,672	(30%)	\$ 2,820,943	(30.3%)
C. Title V Administrative Costs	\$ 927,889	(10%)	\$ 845,954	(9.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 6,495,233		\$ 6,491,007	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 6,959,175		\$ 366,106	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 660,083	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 5,520,459	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 216,034		\$ 432,470	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 7,175,209		\$ 6,979,118	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 6,576,655				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 16,454,109		\$ 16,284,608	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 4,625,000		\$ 48,599,460	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 21,079,109		\$ 64,884,068	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 4,625,000	\$ 6,111,071
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)		\$ 1,935,260
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)		\$ 321,622
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees		\$ 221,326
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)		\$ 234,364
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Grants to States to Support Oral Health Workforce		\$ 422,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention		\$ 93,788
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)		\$ 33,852,512
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)		\$ 3,500,237
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)		\$ 744,056
US Department of Education > Office of Special Education Programs > Individual with Disabilities Education Act/ARP)		\$ 1,162,624

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	No funds were budgeted for our GFO1 enough funds budgeted for local and other to cover match amount
2.	Field Name:	4. LOCAL MCH FUNDS
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	003S Grant # 5321
3.	Field Name:	5. OTHER FUNDS
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	008S and 007S other state funds grants # 5326 & 5418
4.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	059S ESPT grant # 5442 program income
5.	Field Name:	1.FEDERAL ALLOCATION
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	Total Awarded
6.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children:
	Fiscal Year:	2022
	Column Name:	Annual Report Expended

Field Note:

B51M 3000030575 grant# 8979

7. **Field Name:** **Federal Allocation, B. Children with Special Health Care Needs:**

Fiscal Year: **2022**

Column Name: **Annual Report Expended**

Field Note:

C51M 3000030576 grant # 8980

8. **Field Name:** **Federal Allocation, C. Title V Administrative Costs:**

Fiscal Year: **2022**

Column Name: **Annual Report Expended**

Field Note:

Total Admin fee charged

9. **Field Name:** **3. STATE MCH FUNDS**

Fiscal Year: **2022**

Column Name: **Annual Report Expended**

Field Note:

Based on GF01 State Funds

Fund was budgeted to GF01 State Funds but should have been budgeted accordingly between local and other funds

10. **Field Name:** **4. LOCAL MCH FUNDS**

Fiscal Year: **2022**

Column Name: **Annual Report Expended**

Field Note:

25% of actual expenditures of 003S Grant # 5399.

11. **Field Name:** **5. OTHER FUNDS**

Fiscal Year: **2022**

Column Name: **Annual Report Expended**

Field Note:

Only used 90% of 08PS (5418) and 007S (5326) expenditures of these funds for matching.

12. **Field Name:** **6. PROGRAM INCOME**

Fiscal Year: **2022**

	Column Name:	Annual Report Expended
	Field Note:	Program income reported on 059S (5442)
13.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	212K 3000030625 grant # 8989
14.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	B68M 3000030605 grant # 8987
15.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	068M 3000030585 Grant # 8984
16.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	055M 3000030579 grant # 8982
17.	Field Name:	Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)
	Fiscal Year:	2024

	Column Name:	Application Budgeted
	Field Note:	All other WIC grant
18.	Field Name:	Other Federal Funds, US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	004N 3000030492 grant # 8976
19.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	077I 3000030790 grant # 9042
20.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	First year of this grant
21.	Field Name:	Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	C58N 3000033430 grant # 9866
22.	Field Name:	Other Federal Funds, US Department of Education > Office of Special Education Programs > Individual with Disabilities Education Act/American Rescue Plan Act of 2021

	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	CVIT 3000032035 grant # 9444
23.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	054L Grant # 8023 IO # 3000027932 Last year for this grant Total awarded expanded authority for budgeted period was \$6,639,832.00 Grant ended 3/31/2023
24.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	068M Grant # 8984 IO # 3000030585
25.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	B68M 3000030585 Grant # 8987
26.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	212K Grant # 8989 IO # 3000060625

27.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	077L Grant # 9042 IO # 3000030790
28.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Grants to States to Support Oral Health Workforce
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	161L Grant # 8985 IO # 3000030598 last year of this grant ended 5/31/2023
29.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	055M grant # 8982 IO # 3000030579
30.	Field Name:	Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	All WIC Grant
31.	Field Name:	Other Federal Funds, US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	Grant # 8976 IO # 3000030492 004N

32.	Field Name:	Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	062M 3000030582 grant # 9019
33.	Field Name:	Other Federal Funds, US Department of Education > Office of Special Education Programs > Individual with Disabilities Education Act/ARP)
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	Grant # 9444 IO # 3000032035 CVIT Grant in first year

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Mississippi

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	\$ 2,791,647	\$ 2,814,483
2. Infants < 1 year	\$ 0	\$ 0
3. Children 1 through 21 Years	\$ 2,791,647	\$ 2,824,110
4. CSHCN	\$ 2,791,647	\$ 2,820,943
5. All Others	\$ 0	\$ 0
Federal Total of Individuals Served	\$ 8,374,941	\$ 8,459,536

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	\$ 1,406,246	\$ 1,406,246
2. Infants < 1 year	\$ 4,125,673	\$ 4,125,673
3. Children 1 through 21 Years	\$ 664,860	\$ 664,860
4. CSHCN	\$ 782,339	\$ 782,339
5. All Others	\$ 0	\$ 0
Non-Federal Total of Individuals Served	\$ 6,979,118	\$ 6,979,118
Federal State MCH Block Grant Partnership Total	\$ 15,354,059	\$ 15,438,654

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Mississippi

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	\$ 2,791,647	\$ 2,388,692
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 638,084	\$ 545,981
B. Preventive and Primary Care Services for Children	\$ 1,100,128	\$ 941,332
C. Services for CSHCN	\$ 1,053,435	\$ 901,379
2. Enabling Services	\$ 2,791,647	\$ 3,195,080
3. Public Health Services and Systems	\$ 3,722,196	\$ 3,721,718
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
Nursing Services		\$ 2,388,692
Direct Services Line 4 Expended Total		\$ 2,388,692
Federal Total	\$ 9,305,490	\$ 9,305,490

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	\$ 0	\$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 0	\$ 0
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 0	\$ 0
2. Enabling Services	\$ 1,256,241	\$ 2,964,066
3. Public Health Services and Systems	\$ 5,722,877	\$ 4,015,052
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Direct Services Line 4 Expended Total		\$ 0
Non-Federal Total	\$ 6,979,118	\$ 6,979,118

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	Field Name:	IIA. Federal MCH Block Grant, 4. Physician/Office Services
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	No direct services provided by PHysician
2.	Field Name:	IIA. Federal MCH Block Grant, 4. Dental Care (Does Not Include Orthodontic Services).
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	No direct service provided through Dental care
3.	Field Name:	IIA. Federal MCH Block Grant, 4. Laboratory Services
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	No direct service provided by laboratory service

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Mississippi

Total Births by Occurrence: 33,768

Data Source Year: 2022

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	33,683 (99.7%)	4,351	109	109 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism	Propionic Acidemia
S, βeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
β-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Isobutyrylglycinuria	33,683 (99.7%)	0	0	0 (0%)
Methylmalonic acidemia with homocystinuria	33,683 (99.7%)	0	0	0 (0%)
Malonic acidemia	33,683 (99.7%)	0	0	0 (0%)
2,4 Dienoyl-CoA reductase deficiency	33,683 (99.7%)	0	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	33,683 (99.7%)	0	0	0 (0%)
2-Methylbutyrylglycinuria	33,683 (99.7%)	0	0	0 (0%)
Argininemia	33,683 (99.7%)	0	0	0 (0%)
Benign hyperphenylalaninemia	33,683 (99.7%)	0	0	0 (0%)
Biopterin defect in cofactor biosynthesis	33,683 (99.7%)	0	0	0 (0%)
Biopterin defect in cofactor regeneration	33,683 (99.7%)	0	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	33,683 (99.7%)	0	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	33,683 (99.7%)	0	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	33,683 (99.7%)	0	0	0 (0%)
Citrullinemia, type II	33,683 (99.7%)	0	0	0 (0%)
Galactosepimerase deficiency	33,683 (99.7%)	0	0	0 (0%)
Galactokinase deficiency	33,683 (99.7%)	0	0	0 (0%)

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Glutaric acidemia type II	33,683 (99.7%)	0	0	0 (0%)
Hypermethioninemia	33,683 (99.7%)	0	0	0 (0%)
Medium/short-chain L-3-hydroxy ACYL-CoA dehydrogenase deficiency	33,683 (99.7%)	0	0	0 (0%)
Medium-chain ketoacyl-CoA thiolase deficiency	33,683 (99.7%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	33,683 (99.7%)	0	0	0 (0%)
T-cell related lymphocyte deficiencies	33,683 (99.7%)	0	0	0 (0%)
Tyrosinemia, type II	33,683 (99.7%)	0	0	0 (0%)
Tyrosinemia, type III	33,683 (99.7%)	0	0	0 (0%)
Various other hemoglobinopathies	33,683 (99.7%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Regional Genetic Nurses coordinate with local primary care providers and medical subspecialty providers to identify infants with confirmed diagnoses. These children are referred for long-term care coordination (LTCC) through the Healthy Moms/Healthy Babies, Early Intervention, and/or CYSHCN programs depending upon the specific diagnoses and needs. These programs provide LTCC for 1 to 21 years of age, when they are transitioned to adult health care. LTCC helps minimize barriers to health care and consists of assessing health care needs (i.e., medical, dental, and specialty medical providers) ; ensuring access to medical coverage or payor source (i.e., insurance, CHIP, or Medicaid) ; ensuring appropriate well care (e.g., screenings, immunizations) in a medical home; assessing a shared plan of care (e.g., services, medications, or special diets/foods) ; reviewing plans (e.g., transition or emergency/disaster plans) ; and other needs.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	Field Name:	Total Births by Occurrence
	Fiscal Year:	2022
	Column Name:	Total Births by Occurrence Notes
	Field Note:	Counts are provisional and may change.
2.	Field Name:	Data Source Year
	Fiscal Year:	2022
	Column Name:	Data Source Year Notes
	Field Note:	The data period is from October 2021-September 2022

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Mississippi

Annual Report Year 2022

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,028	67.1	0.4	3.5	29.0	0.0
2. Infants < 1 Year of Age	2,478	41.6	0.1	15.2	42.4	0.7
3. Children 1 through 21 Years of Age	30,974	39.1	2.2	18.7	38.7	1.3
3a. Children with Special Health Care Needs 0 through 21 years of age^	23,874	0.0	0.0	0.0	100.0	0.0
4. Others	40,167	15.9	0.0	11.5	72.6	0.0
Total	74,647					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	35,156	Yes	35,156	73.6	25,875	1,028
2. Infants < 1 Year of Age	34,060	Yes	34,060	71.6	24,387	2,478
3. Children 1 through 21 Years of Age	818,435	Yes	818,435	49.2	402,670	30,974
3a. Children with Special Health Care Needs 0 through 21 years of age^	194,473	Yes	194,473	12.3	23,920	23,874
4. Others	2,097,012	Yes	2,097,012	2.3	48,231	40,167

^Represents a subset of all infants and children.

Form Notes for Form 5:

Notes:

1. Title XVIII is included under Private/Other Category.

2. If the field "Coverage" was blank, patient was considered to not have insurance and therefore counted in the "None" category.

3* - CYSHCN number was provided by the program. Since unable to compare categories of children < 1 and children 1-21, CYSHCN is counted in a totally separate category and not a subset.

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2022
	Field Note:	The number of deduplicated pregnant women enrolled in Healthy Moms/Healthy Babies reported in EPIC
2.	Field Name:	Infants Less Than One Year Total Served
	Fiscal Year:	2022
	Field Note:	The number of infants comes from infants who received a genetic consult due to newborn screening and infants enrolled in Healthy Moms/Healthy Babies as recorded in EPIC. It also includes infants enrolled in intervention with an IFSP as recorded in MITI.
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2022
	Field Note:	The number of children one through twenty-one comes from the number of children with an immunization consult documented in the EPIC database and referrals for early intervention services over the age of 1 documented in MITI.
4.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age
	Fiscal Year:	2022
	Field Note:	The number comes from the number of CYSHCN served by specialty clinics, MSDH Care Coordinators, and CYSHCN Cares II Cohorts.
5.	Field Name:	Others
	Fiscal Year:	2022
	Field Note:	This number comes from the deduplicated number of males and females 21 years of age and older who had at least one county health department clinic visits from the EPIC database and sub-grantee data for Title X.

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women Total % Served
	Fiscal Year:	2022
	Field Note:	The population of pregnant women served by Title V comes from the deduplicated number of women who gave birth in baby-friendly hospital plus the women who participated in Healthy Moms/Healthy Babies as documented in EPIC.
2.	Field Name:	Infants Less Than One Year Total % Served
	Fiscal Year:	2022
	Field Note:	The number of infants served by Title V comes from the number of infants in the 2021 birth cohort who received newborn screening surveillance as documented in EPIC.
3.	Field Name:	Children 1 through 21 Years of Age Total % Served
	Fiscal Year:	2022
	Field Note:	The number of children one through twenty-one comes from the number of children and adolescents who participated in family planning, received vaccination as documented in the MIIX database, received blood lead screening, and enrolled and/or participated in WIC services.
4.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age Total % Served
	Fiscal Year:	2022
	Field Note:	The MCH CYSHCN program was able to document enabling services that occurred with specialty clinics, MSDH Care Coordinators, and CYSHCN Cares II Cohorts; however, the program was unable to document their reach for children not participating in these systems.
5.	Field Name:	Others Total % Served
	Fiscal Year:	2022
	Field Note:	This number comes from the number of males and females 21 years of age and older who had at least one county health department clinic visit for STI/HIV testing, who had a clinical breast exam or cervical cancer screening, families reached with safe sleep information, webinar participants (topics including parenting, intimate partner violence, and human trafficking), and participants in Title X family planning services.

Data Alerts:

1.	Children with Special Health Care Needs 0 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
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Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Mississippi

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	35,119	17,842	14,371	1,902	222	403	13	353	13
Title V Served	1,028	395	471	33	2	1	0	8	118
Eligible for Title XIX	20,721	7,738	11,797	660	198	105	9	214	0
2. Total Infants in State	34,793	17,722	14,183	1,891	220	401	13	351	12
Title V Served	2,478	973	1,178	130	5	19	0	27	146
Eligible for Title XIX	23,660	12,051	9,644	1,286	150	273	9	239	8

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2022
	Column Name:	Total
	Field Note:	Data from vital statistics
2.	Field Name:	1. Title V Served
	Fiscal Year:	2022
	Column Name:	Total
	Field Note:	Data from vital statistics; includes deliveries of live born infants.
3.	Field Name:	1. Eligible for Title XIX
	Fiscal Year:	2022
	Column Name:	Total
	Field Note:	Data from the Mississippi Division of Medicaid
4.	Field Name:	2. Total Infants in State
	Fiscal Year:	2022
	Column Name:	Total
	Field Note:	Data from vital statistics
5.	Field Name:	2. Title V Served
	Fiscal Year:	2022
	Column Name:	Total
	Field Note:	Data from vital statistics; includes deliveries of live born infants who should have received at least one newborn screening service (note: not all infants survived, and newborn screening may not have been completed)
6.	Field Name:	2. Eligible for Title XIX
	Fiscal Year:	2022
	Column Name:	Total
	Field Note:	Data from the Mississippi Division of Medicaid

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Mississippi

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 721-7222	(800) 721-7222
2. State MCH Toll-Free "Hotline" Name	Title V MCH Block Grant	Title V MCH Block Grant
3. Name of Contact Person for State MCH "Hotline"	Beryl Polk, Ph.D., CPM, CHP, CCM	Beryl Polk, Ph.D., CPM, CHP, CCM
4. Contact Person's Telephone Number	(601) 576-7472	(601) 576-7472
5. Number of Calls Received on the State MCH "Hotline"		520

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	Centralized Scheduling ,Breastfeeding Information Line, Children and Youth with Special Health Care Needs Administration Office, Early Intervention Systems, Immunizations for Children, Public Health Pharmacy, Radon Information, STD/HIV Disease Report	Centralized Scheduling ,Breastfeeding Information Line, Children and Youth with Special Health Care Needs Administration Office, Early Intervention Systems, Immunizations for Children, Public Health Pharmacy, Radon Information, STD/HIV Disease Report
2. Number of Calls on Other Toll-Free "Hotlines"		130,000
3. State Title V Program Website Address	https://msdh.ms.gov/msdhsite/index.cfm/44,0,407,1017,html	https://msdh.ms.gov/msdhsite/index.cfm/44,0,407,1017,html
4. Number of Hits to the State Title V Program Website		466
5. State Title V Social Media Websites	None	
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

MCH Hotline (i.e., Women's Health Hotline) calls were estimated at approximately 2 calls per workday. Other hotlines calls were combined and estimated at 500 per workday.

Form 8
State MCH and CSHCN Directors Contact Information

State: Mississippi

1. Title V Maternal and Child Health (MCH) Director

Name	Beryl Polk
Title	Director of Health Services
Address 1	570 E. Woodrow Wilson
Address 2	
City/State/Zip	Jackson / MS / 39216
Telephone	(601) 576-7465
Extension	
Email	Beryl.Polk@msdh.ms.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Valecia Davis
Title	CYSHCN Director
Address 1	570 E. Woodrow Wilson
Address 2	
City/State/Zip	Jackson / MS / 39216
Telephone	(601) 576-7485
Extension	
Email	Valecia.Davis@msdh.ms.gov

3. State Family Leader (Optional)

Name	Natasha James
Title	CYSHCN Family Leader
Address 1	570 E. Woodrow Wilson
Address 2	
City/State/Zip	Jackson / MS / 39216
Telephone	(601) 576-7289
Extension	
Email	Natasha.James@msdh.ms.gov

4. State Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Mississippi

Application Year 2024

No.	Priority Need
1.	Reduce Infant Mortality
2.	Assure Medical Homes for C/YSHCN
3.	Improve Access to Care
4.	Reduce Maternal Morbidity and Mortality
5.	Increase Breastfeeding, Healthy Nutrition and Healthy Weight
6.	Improve Access to Mental Health Services Across MCH Populations
7.	Ensure Health Equity by Addressing Implicit Bias, Discrimination, and Racism
8.	Improve Oral Health
9.	Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings
10.	Improve Access to Family-Centered Care

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Decrease infant mortality.	New
2.	Increase access to health care/medical homes for children and youth with special health care needs (CYSHCN).	New
3.	Increase access to comprehensive health care for children.	New
4.	Reduce teen pregnancy and teen birth rate.	Continued
5.	Increase health insurance coverage.	New
6.	Reduce low birth weight and premature birth.	Continued
7.	Increase access to prenatal care.	New
8.	Increase child nutrition and early childhood obesity prevention	Continued

**Form 10
National Outcome Measures (NOMs)**

State: Mississippi

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	77.6 %	0.2 %	26,988	34,788
2020	77.3 %	0.2 %	27,079	35,050
2019	78.0 %	0.2 %	28,161	36,109
2018	78.3 %	0.2 %	28,308	36,171
2017	78.5 %	0.2 %	29,110	37,075
2016	78.3 %	0.2 %	29,182	37,265
2015	78.6 %	0.2 %	29,666	37,761
2014	77.5 %	0.2 %	29,681	38,311
2013	75.5 %	0.2 %	28,214	37,361

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	69.9	4.5	240	34,322
2019	72.4	4.6	252	34,786
2018	74.7	4.6	265	35,458
2017	80.6	4.8	291	36,092
2016	63.1	4.3	222	35,155
2015	78.8	5.5	210	26,636
2014	80.8	4.8	286	35,409
2013	72.7	4.8	229	31,503
2011	55.1	3.9	197	35,755
2010	53.2	4.0	182	34,233

Legends:

- Indicator has a numerator ≤ 10 and is not reportable
- Indicator has a numerator < 20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	38.0	4.6	69	181,622
2016_2020	26.0	3.8	48	184,394
2015_2019	21.4	3.4	40	187,315
2014_2018	15.3	2.8	29	189,415

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	12.3 %	0.2 %	4,339	35,138
2020	11.8 %	0.2 %	4,192	35,445
2019	12.3 %	0.2 %	4,510	36,598
2018	12.1 %	0.2 %	4,484	36,973
2017	11.6 %	0.2 %	4,333	37,340
2016	11.5 %	0.2 %	4,345	37,909
2015	11.4 %	0.2 %	4,387	38,374
2014	11.3 %	0.2 %	4,374	38,727
2013	11.5 %	0.2 %	4,458	38,618
2012	11.6 %	0.2 %	4,502	38,654
2011	11.8 %	0.2 %	4,710	39,849
2010	12.1 %	0.2 %	4,852	40,021
2009	12.2 %	0.2 %	5,249	42,877

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	15.0 %	0.2 %	5,257	35,140
2020	14.2 %	0.2 %	5,032	35,463
2019	14.6 %	0.2 %	5,340	36,621
2018	14.2 %	0.2 %	5,269	36,983
2017	13.6 %	0.2 %	5,061	37,347
2016	13.6 %	0.2 %	5,174	37,911
2015	13.0 %	0.2 %	5,008	38,385
2014	12.9 %	0.2 %	5,000	38,728
2013	13.1 %	0.2 %	5,070	38,590
2012	13.8 %	0.2 %	5,331	38,616
2011	13.5 %	0.2 %	5,387	39,771
2010	13.8 %	0.2 %	5,524	39,941
2009	13.9 %	0.2 %	5,945	42,749

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	33.1 %	0.3 %	11,627	35,140
2020	32.7 %	0.3 %	11,614	35,463
2019	32.7 %	0.3 %	11,963	36,621
2018	31.6 %	0.2 %	11,685	36,983
2017	30.5 %	0.2 %	11,395	37,347
2016	30.6 %	0.2 %	11,590	37,911
2015	30.2 %	0.2 %	11,576	38,385
2014	30.3 %	0.2 %	11,724	38,728
2013	32.9 %	0.2 %	12,686	38,590
2012	35.7 %	0.2 %	13,798	38,616
2011	35.9 %	0.2 %	14,274	39,771
2010	35.6 %	0.2 %	14,233	39,941
2009	36.1 %	0.2 %	15,424	42,749

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	4.0 %			
2015/Q3-2016/Q2	4.0 %			
2015/Q2-2016/Q1	4.0 %			
2015/Q1-2015/Q4	4.0 %			
2014/Q4-2015/Q3	4.0 %			
2014/Q3-2015/Q2	5.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	5.0 %			
2014/Q1-2014/Q4	8.0 %			
2013/Q4-2014/Q3	10.0 %			
2013/Q3-2014/Q2	13.0 %			
2013/Q2-2014/Q1	21.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	8.6	0.5	307	35,645
2019	8.6	0.5	315	36,802
2018	9.4	0.5	351	37,187
2017	9.9	0.5	372	37,542
2016	8.3	0.5	317	38,091
2015	8.1	0.5	313	38,550
2014	8.4	0.5	326	38,902
2013	7.9	0.5	307	38,781
2012	8.7	0.5	338	38,837
2011	8.6	0.5	345	40,038
2010	9.2	0.5	370	40,240
2009	8.6	0.5	370	43,073

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	8.1	0.5	288	35,473
2019	8.7	0.5	319	36,636
2018	8.4	0.5	311	37,000
2017	8.7	0.5	326	37,357
2016	8.7	0.5	329	37,928
2015	9.5	0.5	363	38,394
2014	8.2	0.5	317	38,736
2013	9.6	0.5	371	38,634
2012	8.9	0.5	344	38,669
2011	9.2	0.5	368	39,860
2010	9.6	0.5	385	40,036
2009	10.1	0.5	433	42,901

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	4.8	0.4	172	35,473
2019	5.2	0.4	189	36,636
2018	5.3	0.4	195	37,000
2017	5.8	0.4	215	37,357
2016	5.4	0.4	204	37,928
2015	5.4	0.4	208	38,394
2014	5.1	0.4	199	38,736
2013	5.8	0.4	225	38,634
2012	5.5	0.4	214	38,669
2011	5.7	0.4	226	39,860
2010	5.5	0.4	220	40,036
2009	6.1	0.4	262	42,901

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.3	0.3	116	35,473
2019	3.5	0.3	130	36,636
2018	3.1	0.3	116	37,000
2017	3.0	0.3	111	37,357
2016	3.3	0.3	125	37,928
2015	4.0	0.3	155	38,394
2014	3.0	0.3	118	38,736
2013	3.8	0.3	146	38,634
2012	3.4	0.3	130	38,669
2011	3.6	0.3	142	39,860
2010	4.1	0.3	165	40,036
2009	4.0	0.3	171	42,901

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	242.4	26.2	86	35,473
2019	267.5	27.1	98	36,636
2018	281.1	27.6	104	37,000
2017	299.8	28.4	112	37,357
2016	263.7	26.4	100	37,928
2015	320.4	28.9	123	38,394
2014	250.4	25.5	97	38,736
2013	323.5	29.0	125	38,634
2012	289.6	27.4	112	38,669
2011	286.0	26.8	114	39,860
2010	279.7	26.5	112	40,036
2009	317.0	27.2	136	42,901

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	214.2	24.6	76	35,473
2019	188.3	22.7	69	36,636
2018	205.4	23.6	76	37,000
2017	179.4	21.9	67	37,357
2016	152.9	20.1	58	37,928
2015	211.0	23.5	81	38,394
2014	131.7	18.5	51	38,736
2013	196.7	22.6	76	38,634
2012	142.2	19.2	55	38,669
2011	200.7	22.5	80	39,860
2010	222.3	23.6	89	40,036
2009	200.5	21.6	86	42,901

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.4 %	0.8 %	1,375	31,576
2020	4.5 %	0.9 %	1,475	32,522
2019	4.8 %	0.7 %	1,610	33,715
2018	5.6 %	0.8 %	1,887	33,550
2009	3.9 %	0.7 %	1,538	39,658
2008	4.8 %	0.7 %	1,978	41,339

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.2	0.3	112	34,559
2019	3.2	0.3	112	35,147
2018	2.9	0.3	104	35,571
2017	2.7	0.3	99	36,297
2016	3.0	0.3	104	35,106
2015	2.5	0.3	67	26,297
2014	1.9	0.2	67	35,365
2013	2.2	0.3	66	29,953
2011	1.4	0.2	37	27,180
2010	1.2	0.2	30	25,288

Legends:

- Indicator has a numerator ≤ 10 and is not reportable
- Indicator has a numerator < 20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	14.4 %	1.2 %	93,943	653,117
2019_2020	13.9 %	1.3 %	90,376	650,350
2018_2019	12.7 %	1.4 %	83,853	658,599
2017_2018	13.7 %	1.5 %	93,343	680,657
2016_2017	12.7 %	1.4 %	87,238	689,387
2016	11.1 %	1.7 %	76,437	686,168

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	33.9	3.2	111	327,820
2020	30.8	3.0	103	333,889
2019	31.4	3.1	106	337,337
2018	31.5	3.0	108	342,566
2017	29.9	2.9	104	348,132
2016	27.0	2.8	96	355,227
2015	28.5	2.8	103	361,291
2014	23.5	2.5	86	365,777
2013	31.7	2.9	117	369,629
2012	29.5	2.8	110	372,775
2011	31.8	2.9	119	374,324
2010	29.0	2.8	109	376,368
2009	36.2	3.1	136	375,948

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	71.8	4.2	294	409,594
2020	58.9	3.8	237	402,683
2019	52.7	3.6	215	407,632
2018	51.3	3.5	212	412,860
2017	48.4	3.4	199	411,568
2016	50.3	3.5	207	411,536
2015	50.0	3.5	205	410,093
2014	51.9	3.6	214	412,063
2013	39.6	3.1	164	414,511
2012	41.1	3.1	173	420,571
2011	48.0	3.4	205	426,951
2010	45.5	3.2	197	432,867
2009	56.0	3.6	244	435,502

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	26.0	2.1	157	603,991
2018_2020	24.7	2.0	150	606,323
2017_2019	24.0	2.0	147	613,583
2016_2018	25.5	2.0	158	620,567
2015_2017	28.0	2.1	174	621,859
2014_2016	31.3	2.2	195	622,515
2013_2015	29.9	2.2	186	622,258
2012_2014	26.2	2.0	164	626,826
2011_2013	23.7	1.9	151	637,592
2010_2012	23.8	1.9	156	654,134
2009_2011	29.4	2.1	197	669,431
2008_2010	30.6	2.1	208	680,521
2007_2009	37.3	2.3	255	682,791

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	10.4	1.3	63	603,991
2018_2020	10.6	1.3	64	606,323
2017_2019	11.6	1.4	71	613,583
2016_2018	10.3	1.3	64	620,567
2015_2017	9.6	1.3	60	621,859
2014_2016	8.0	1.1	50	622,515
2013_2015	7.4	1.1	46	622,258
2012_2014	5.9	1.0	37	626,826
2011_2013	5.8	1.0	37	637,592
2010_2012	6.1	1.0	40	654,134
2009_2011	7.2	1.0	48	669,431
2008_2010	9.0	1.2	61	680,521
2007_2009	9.7	1.2	66	682,791

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	22.8 %	1.4 %	158,021	692,879
2019_2020	22.5 %	1.4 %	157,641	699,275
2018_2019	22.6 %	1.5 %	159,664	707,453
2017_2018	23.3 %	1.7 %	167,120	716,820
2016_2017	24.0 %	1.8 %	173,259	723,179
2016	24.4 %	2.4 %	176,703	725,084

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	17.3 %	2.8 %	27,237	157,885
2019_2020	19.7 %	3.0 %	31,060	157,506
2018_2019	18.5 %	2.9 %	29,463	159,664
2017_2018	16.7 %	3.0 %	27,888	167,120
2016_2017	15.6 %	2.7 %	26,953	173,259
2016	15.7 %	3.2 %	27,792	176,703

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.5 %	0.5 %	14,433	574,336
2019_2020	2.3 %	0.6 %	13,482	574,032
2018_2019	2.9 %	0.7 %	17,429	591,840
2017_2018	2.9 %	0.8 %	17,594	616,059
2016_2017	2.2 % ⚡	0.8 % ⚡	13,379 ⚡	620,411 ⚡
2016	2.0 % ⚡	1.1 % ⚡	12,124 ⚡	615,463 ⚡

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	14.1 %	1.2 %	81,259	576,045
2019_2020	15.4 %	1.3 %	87,490	568,094
2018_2019	13.2 %	1.3 %	76,840	584,103
2017_2018	14.3 %	1.7 %	87,260	611,859
2016_2017	15.7 %	1.7 %	96,634	616,816
2016	13.6 %	1.9 %	83,472	612,081

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	47.2 %	4.7 %	44,044	93,308
2019_2020	49.3 %	4.8 %	45,329	91,964
2018_2019	42.0 % ⚡	5.2 % ⚡	36,133 ⚡	85,960 ⚡
2017_2018	44.9 % ⚡	6.0 % ⚡	42,099 ⚡	93,866 ⚡
2016_2017	47.9 % ⚡	6.1 % ⚡	47,043 ⚡	98,262 ⚡
2016	47.4 % ⚡	8.5 % ⚡	44,730 ⚡	94,314 ⚡

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	85.4 %	1.3 %	589,798	690,594
2019_2020	87.1 %	1.2 %	607,625	697,699
2018_2019	85.9 %	1.4 %	607,155	706,818
2017_2018	87.8 %	1.4 %	628,714	716,186
2016_2017	88.1 %	1.3 %	637,154	722,830
2016	86.3 %	1.8 %	625,177	724,386

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	14.4 %	0.3 %	2,839	19,685
2018	14.8 %	0.2 %	4,394	29,651
2016	14.4 %	0.2 %	4,110	28,493
2014	14.5 %	0.2 %	3,771	26,007
2012	14.8 %	0.2 %	5,082	34,417
2010	14.9 %	0.2 %	5,447	36,519
2008	15.8 %	0.2 %	4,793	30,421

Legends:

🚫 Indicator has a denominator <20 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	23.2 %	1.4 %	27,282	117,485
2019	23.4 %	1.3 %	27,848	118,939
2015	18.9 %	1.0 %	24,264	128,216
2013	15.4 %	1.2 %	18,749	122,083
2011	15.8 %	1.1 %	21,018	133,254
2009	18.1 %	1.2 %	23,349	129,304
2007	17.7 %	1.1 %	21,871	123,634

Legends:

🚫 Indicator has an unweighted denominator <100 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	23.1 %	2.1 %	68,692	296,898
2019_2020	22.3 %	2.1 %	66,425	297,213
2018_2019	22.3 %	2.2 %	63,819	286,134
2017_2018	25.4 %	2.7 %	77,947	307,073
2016_2017	26.1 %	2.8 %	80,058	306,814
2016	26.2 %	3.6 %	73,400	279,638

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	6.2 %	0.5 %	42,837	691,432
2019	5.5 %	0.4 %	38,258	698,345
2018	4.3 %	0.3 %	30,615	705,075
2017	4.8 %	0.5 %	34,507	715,140
2016	4.3 %	0.4 %	31,090	722,717
2015	4.1 %	0.4 %	29,501	729,123
2014	5.4 %	0.4 %	39,536	732,061
2013	7.4 %	0.6 %	54,774	736,122
2012	7.3 %	0.5 %	54,168	747,427
2011	7.5 %	0.5 %	56,059	751,780
2010	8.2 %	0.6 %	61,994	753,069
2009	10.1 %	0.5 %	77,482	764,467

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	67.4 %	4.0 %	24,000	36,000
2017	72.3 %	3.7 %	27,000	37,000
2016	71.1 %	3.7 %	27,000	38,000
2015	60.8 %	3.7 %	23,000	38,000
2014	69.9 %	3.9 %	27,000	38,000
2013	65.6 %	4.6 %	25,000	38,000
2012	72.0 %	4.2 %	28,000	39,000
2011	68.1 %	4.8 %	27,000	40,000

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2
- ⚡ Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	39.4 %	1.6 %	258,785	656,518
2020_2021	42.9 %	2.1 %	280,665	654,231
2019_2020	51.9 %	1.7 %	343,196	661,264
2018_2019	48.8 %	1.6 %	326,955	670,127
2017_2018	51.2 %	1.7 %	345,491	674,344
2016_2017	50.5 %	1.7 %	342,387	677,725
2015_2016	52.3 %	2.1 %	357,011	682,490
2014_2015	50.4 %	2.0 %	348,619	691,156
2013_2014	44.5 %	2.1 %	312,599	702,674
2012_2013	45.9 %	2.4 %	325,392	709,465
2011_2012	42.6 %	2.6 %	303,945	713,942
2010_2011	44.3 % ⚡	6.0 % ⚡	319,563 ⚡	721,361 ⚡
2009_2010	37.7 %	3.0 %	266,593	707,144

Legends:

📌 Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	56.2 %	3.6 %	114,744	204,032
2020	55.2 %	3.5 %	112,440	203,865
2019	49.5 %	3.9 %	99,554	201,034
2018	51.7 %	3.5 %	104,130	201,248
2017	49.6 %	3.2 %	101,455	204,421
2016	45.6 %	3.3 %	93,479	204,829
2015	45.5 %	3.1 %	94,090	206,954

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	89.1 %	2.4 %	181,754	204,032
2020	93.0 %	1.7 %	189,532	203,865
2019	90.4 %	2.5 %	181,652	201,034
2018	90.0 %	2.2 %	181,186	201,248
2017	92.4 %	1.6 %	188,870	204,421
2016	82.0 %	2.5 %	168,001	204,829
2015	74.7 %	2.7 %	154,578	206,954
2014	70.8 %	3.2 %	147,224	207,833
2013	60.2 %	3.4 %	125,534	208,669
2012	53.5 %	3.7 %	111,071	207,626
2011	36.9 %	3.5 %	77,727	210,830
2010	29.0 %	2.8 %	60,494	208,302
2009	22.6 %	2.3 %	48,507	214,998

Legends:

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

 Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	60.2 %	3.5 %	122,883	204,032
2020	63.5 %	3.5 %	129,378	203,865
2019	60.3 %	3.8 %	121,169	201,034
2018	64.0 %	3.4 %	128,821	201,248
2017	63.0 %	3.0 %	128,848	204,421
2016	57.4 %	3.2 %	117,572	204,829
2015	55.3 %	3.1 %	114,460	206,954
2014	46.0 %	3.3 %	95,645	207,833
2013	50.1 %	3.5 %	104,491	208,669
2012	40.7 %	3.6 %	84,462	207,626
2011	34.2 %	3.5 %	72,072	210,830
2010	26.0 %	2.7 %	54,238	208,302
2009	19.3 %	2.1 %	41,410	214,998

Legends:

■ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	25.6	0.5	2,545	99,415
2020	27.9	0.5	2,711	97,321
2019	29.1	0.5	2,869	98,568
2018	27.8	0.5	2,808	100,890
2017	31.0	0.6	3,137	101,191
2016	32.6	0.6	3,326	102,043
2015	34.7	0.6	3,536	101,862
2014	37.8	0.6	3,853	101,916
2013	42.2	0.6	4,347	102,917
2012	46.1	0.7	4,781	103,755
2011	50.5	0.7	5,363	106,197
2010	55.4	0.7	6,077	109,667
2009	62.2	0.8	6,945	111,688

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	20.8 %	1.7 %	6,425	30,899
2020	21.7 %	1.7 %	7,024	32,338
2019	22.1 %	1.4 %	7,341	33,197
2018	23.5 %	1.5 %	7,860	33,398

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	3.3 %	0.6 %	22,965	688,406
2019_2020	2.9 %	0.6 %	20,400	692,013
2018_2019	2.8 %	0.6 %	19,650	699,538
2017_2018	3.0 %	0.7 %	21,133	712,576
2016_2017	2.9 %	0.6 %	20,668	715,850
2016	2.9 %	0.8 %	20,740	714,338

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)
State: Mississippi

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

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

i Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	2024	2025
Annual Objective	82.1	82.9	84.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	2019	2020	2021	2022
Annual Objective	69.8	71.9	74	76.2	78.5
Annual Indicator	63.2	63.4	70.0	68.0	69.4
Numerator	22,091	22,722	22,777	21,999	23,474
Denominator	34,981	35,813	32,539	32,351	33,806
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	80.9	83.3	83.5

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	2019	2020	2021	2022
Annual Objective	12.8	13.4	14.1	14.8	15.4
Annual Indicator	13.0	16.0	18.1	16.4	15.6
Numerator	4,455	5,507	5,651	5,200	5,053
Denominator	34,243	34,464	31,217	31,729	32,343
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	16.1	16.9	17.1

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	2019	2020	2021	2022
Annual Objective	66.8	67.5	68.2	68.9	69.6
Annual Indicator	56.1	72.2	69.4	64.3	70.7
Numerator	21,733	23,861	22,384	20,451	21,727
Denominator	38,760	33,042	32,256	31,790	30,728
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2009	2018	2019	2020	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	66.8	67.5	68.2	68.9	69.6
Annual Indicator	63.6	72.2			
Numerator	21,016	23,861			
Denominator	33,023	33,042			
Data Source	MS PRAMS	MS PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	2024	2025
Annual Objective	70.3	71.0	71.7

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

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

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		64.9	66.2	67.5	68.9
Annual Indicator	63.6	28.8			
Numerator	21,016	9,167			
Denominator	33,023	31,841			
Data Source	MS PRAMS	MS PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	2024	2025
Annual Objective	70.3	71.7	73.1

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

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

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		45.6	47.9	50.3	52.8
Annual Indicator	43.4	42.3			
Numerator	15,145	13,523			
Denominator	34,882	31,973			
Data Source	MS PRAMS	MS PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	2024	2025
Annual Objective	55.4	58.2	61.2

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
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	Column Name:	State Provided Data
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Field Note:

47.5% of mothers reporting that their baby does not usually sleep with blankets.

88.7% of mothers reporting that their baby does not usually sleep with toys, cushions, and pillows.

82.1% of mothers reporting that their baby does not usually sleep with crib bumper pads.

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	2019	2020	2021	2022
Annual Objective	20.9	19.5	20.5	23.5	24.3
Annual Indicator	18.6	23.7	28.0	31.5	34.1
Numerator	13,102	16,993	19,663	25,115	28,605
Denominator	70,253	71,794	70,109	79,686	83,842
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	25.2	26.5	28.0

Field Level Notes for Form 10 NPMs:

None

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data			
Data Source: Youth Risk Behavior Surveillance System (YRBSS)			
	2020	2021	2022
Annual Objective			20.4
Annual Indicator	23.4	23.4	25.5
Numerator	29,043	29,043	31,054
Denominator	123,981	123,981	121,794
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2019	2019	2021

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT			
	2020	2021	2022
Annual Objective			20.4
Annual Indicator	16.7	20.6	20.5
Numerator	38,663	48,356	48,374
Denominator	231,717	234,684	235,476
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	18.8	17.2	16.2

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	2019	2020	2021	2022
Annual Objective	78.8	79.4	80	80.6	81.2
Annual Indicator	77.0	77.0	66.2	65.1	60.5
Numerator	188,821	188,821	155,497	155,882	145,341
Denominator	245,226	245,226	234,939	239,310	240,226
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	82.0	82.8	83.6

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	2019	2020	2021	2022
Annual Objective	43.9	45.5	47.1	48.7	50.3
Annual Indicator	43.8	46.9	51.4	46.2	43.2
Numerator	75,832	78,448	82,086	72,719	68,226
Denominator	173,259	167,120	159,664	157,506	157,885
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	51.9	53.5	55.1

Field Level Notes for Form 10 NPMs:

None

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	2019	2020	2021	2022
Annual Objective		35.9	37.7	39.6	41.6
Annual Indicator	21.2	35.4	31.6	32.1	35.3
Numerator	7,953	12,028	10,696	10,493	11,307
Denominator	37,556	33,953	33,881	32,729	31,993
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2008	2018	2019	2020	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		35.9	37.7	39.6	41.6
Annual Indicator	34.2	35.4	31.6	32.1	35.3
Numerator	11,784	12,028	10,696	10,493	11,307
Denominator	34,483	33,953	33,881	32,729	31,993
Data Source	MS PRAMS				
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	43.7	45.9	47.9

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
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	Column Name:	State Provided Data
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Field Note:

The question below from PRAMS survey has been used to measure preventive dental care visit during pregnancy:

"During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?"

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	2019	2020	2021	2022
Annual Objective		80.6	81.4	82.2	83
Annual Indicator	79.1	77.8	77.1	75.0	72.0
Numerator	544,787	525,080	500,754	484,100	468,061
Denominator	689,107	675,079	649,719	645,270	650,503
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	83.8	84.6	85.4

Field Level Notes for Form 10 NPMs:

None

**Form 10
State Performance Measures (SPMs)**

State: Mississippi

SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age

Measure Status:		Active	
State Provided Data			
	2020	2021	2022
Annual Objective			3.9
Annual Indicator		3.8	5
Numerator		5,554	7,297
Denominator		144,844	146,681
Data Source		Medicaid and Lead Poisoning Prevention Program	Medicaid and Lead Poisoning Prevention Program
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	4.0	4.1	4.2

Field Level Notes for Form 10 SPMs:

None

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

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

Annual Objectives			
	2023	2024	2025
Annual Objective	2.2	2.1	2.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2021
	Column Name:	State Provided Data

Field Note:

This initiative ended in 2022. Data for 2020 were captured and reported in 2021; however, the 2021 data are not yet available.

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	11.7	7.1
Numerator	5,221	2,995
Denominator	44,528	42,144
Data Source	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	11.2	10.7	10.2

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	49.3	54
Numerator		11,007
Denominator		20,401
Data Source	WIC Spirit database	WIC Spirit database
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	51.0	51.5	52.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2021
	Column Name:	State Provided Data

Field Note:

These data come from the WIC Spirit database. 50.71% of infants were ever breastfed in CY2020 and 6% of infants were breastfed through 6 months of age in CY2020. Projections for 2021 are 49.31% and 5.8%, respectively.

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	46.9	40.4
Numerator	30	23
Denominator	64	57
Data Source	EPIC	EPIC
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	67.0	77.0	87.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2021
	Column Name:	State Provided Data

Field Note:

During 2021, MSDH ended its use with a legacy system database for EHDl and began using MSDH's EPIC system to capture EHDl information. The EPIC system for EHDl went live in July 2021. Data for the first half of 2021 are in the process of entry. These data are preliminary.

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	310	272
Numerator		
Denominator		
Data Source	EPSDT Visits in EPIC	EPSDT Visits in EPIC
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	341.0	375.0	413.0

Field Level Notes for Form 10 SPMs:

- Field Name:** 2021

Column Name: State Provided Data

Field Note:
MSDH EPSDT encounter summary for children ages 9-30 months between 7/1/2020 and 6/30/2021
- Field Name:** 2022

Column Name: State Provided Data

Field Note:
Children between 9-35 months who received an EPDST visit between October 1, 2021 and September 30, 2022

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	100	93.2
Numerator	60	2,722
Denominator	60	2,922
Data Source	Newborn Screening data	MS Newborn screening database and EPIC database
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2021
	Column Name:	State Provided Data

Field Note:

Data for this measure regarding timeliness are not yet available. However, we do have data on the number diagnosed, screened and referred.

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

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

Annual Objectives			
	2023	2024	2025
Annual Objective	28.5	25.7	23.1

Field Level Notes for Form 10 SPMs:

None

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

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

Annual Objectives			
	2023	2024	2025
Annual Objective	78.5	79.0	79.5

Field Level Notes for Form 10 SPMs:

1. **Field Name:** 2021

Column Name: State Provided Data

Field Note:

At the time of the previous report, 2021 MS BRFSS data were not yet available, so the indicator was estimated using 2018-2019 data. The 2021 MS BRFSS data are now available for 2021, so the value has been updated.

The 2021 BRFSS variable for type of insurance was PRIMINSR, and the response options of interest were 5 (Medicaid) and 9 (State-sponsored health plan). The 2021 BRFSS variable for routine checkup was CHECKUP1, and the response option of interest was 1 (within past year, anytime less than 12 months ago).

2. **Field Name:** 2022

Column Name: State Provided Data

Field Note:

Mississippi BRFSS data are not yet available for 2022. The data reported are a 2-year prevalence estimate (2019 & 2021). Data on payer are not captured every year in BRFSS and are not available for the 2020 survey year.

The 2019 BRFSS variable for type of insurance was HLTHCVR1, and the response option of interest was 4 (Medicaid or other state program). The 2021 BRFSS variable for type of insurance was PRIMINSR, and the response options of interest were 5 (Medicaid) and 9 (State-sponsored health plan). CHECKUP1 was the variable used for routine checkup in both the 2019 and 2021 BRFSS. The response option of interest was 1 (within past year, anytime less than 12 months ago).

SPM 18 - Percent of children with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	16.2	15.4
Numerator	8,954	9,208
Denominator	55,176	59,681
Data Source	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2019-2020	2020-2021
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	17.2	18.2	19.2

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2022
	Column Name:	State Provided Data

Field Note:

The main goal of this measure is to increase the percent of children with special health care needs who have received services necessary for transition to adult health care. Therefore, the numerator used is the percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.

SPM 19 - Adolescent suicide rate

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	11.6	10.8
Numerator		
Denominator		
Data Source	CDC WONDER Multiple Cause of Death Files	Office of Vital Records and Public Health Statisti
Data Source Year	2017-2019	2021
Provisional or Final ?	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	11.3	11.0	10.6

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note:	CDC WONDER, Multiple Cause of Death Files, 2017-2019
2.	Field Name:	2022
	Column Name:	State Provided Data
	Field Note:	10.8 per 100,000 ages 15-19 years

SPM 20 - Number of MCH programs that have developed a written plan to address health equity

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	1	3
Numerator		
Denominator		
Data Source	MCH program data	MCH program data
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	3.0	6.0	9.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2022
	Column Name:	State Provided Data

Field Note:

Other programs are working with partners to help develop their written plan to address health equity, however, they have not yet been formalized.

SPM 21 - Percent of children with and without special healthcare needs who have a medical home

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	46.2	43.2
Numerator	72,719	68,226
Denominator	157,506	157,885
Data Source	National Survey of Childrens Health	National Survey of Children's Health
Data Source Year	2019-2020	2020-2021
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	46.5	46.7	47.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note:	Data come from the 2019-2020 National Survey of Children's Health.
2.	Field Name:	2022
	Column Name:	State Provided Data
	Field Note:	The main goal of this measure is to assure that all children with special healthcare needs have a medical home. Therefore, the numerator used is the percent of children, 0-17 years with special health care needs who have a medical home.

**Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: Mississippi

ESM 1.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy

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

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	125.0	150.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** 2021

Column Name: State Provided Data

Field Note:

Need to work with Quitline provider to ensure that data on sex / gender and pregnancy status are collected consistently on all callers as well as individuals who complete the intake process for treatment.

These are FY2021 data (7/1/2020 through 6/30/2021).

2. **Field Name:** 2022

Column Name: State Provided Data

Field Note:

The data represent the number of women assisted during pregnancy by the MS Quitline and Baby and Me Tobacco Free programs.

The program would need to work with Quitline provider to ensure that the data on the number of women of childbearing age (18-45) that were provided services by MS Quitline are collected.

ESM 4.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals

Measure Status:				Active	
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	3	4	5	6	24
Annual Indicator	11	18	21	22	25
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	Baby Friendly USA			
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	26.0	28.0	30.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	There is an increase in baby-friendly hospitals because of the work CHAMPS and Blue Cross & Blue Shield of Mississippi are doing to help them achieve baby-friendly designation. Over 90 percent of all hospitals in Mississippi that deliver babies are actively working toward achieving or maintaining this quality designation.
2.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	The most current information is obtained from the Baby Friendly USA website.
3.	Field Name:	2022
	Column Name:	State Provided Data
	Field Note:	25 hospitals were considered Baby Friendly The number of Baby Friendly Hospitals in Mississippi have increased and are on trend to continue to increase slightly in the following year.

ESM 5.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	25,000	20,200	20,450	20,700	21,000
Annual Indicator	20,000	10,000	14,880	9,560	11,863
Numerator					
Denominator					
Data Source	MSDH Infant Health Program				
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	21,250.0	21,500.0	21,500.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	The decrease from last year is because the hospitals do not have much storage so the shipping depends on their space and what they can handle.
2.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	This is the count for the number of books distributed in one year to all birthing hospitals in MS. The books are given to families upon discharge from the hospital.
3.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note:	This is the count for the number of books distributed in one year to all birthing hospitals in MS. The books are given to families upon discharge from the hospital. The COVID-19 pandemic continued to have an impact on the program's ability to produce and share resources in birthing hospitals.
4.	Field Name:	2022
	Column Name:	State Provided Data
	Field Note:	This is the count for the number of books distributed in one year to all birthing hospitals in MS. The books are given to families upon discharge from the hospital.

ESM 6.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

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

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	30.0	40.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2021
	Column Name:	State Provided Data

Field Note:

Activities not completed during the time period due to lack of in person training

ESM 8.2.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide

Measure Status:		Active	
State Provided Data			
	2020	2021	2022
Annual Objective			22
Annual Indicator	20.6		20.5
Numerator	48,356		48,374
Denominator	234,684		235,476
Data Source	National Survey of Children's Health		National Survey of Children's Health
Data Source Year	2019-2020		2020-2021
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	23.0	24.0	25.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	These data are from the 2019-2020 NSCH for Mississippi.
2.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note:	No data available yet for the 2020-2021 period.
3.	Field Name:	2022
	Column Name:	State Provided Data
	Field Note:	<p>The data are from the 2020-2021 NSCH for Mississippi.</p> <p>Data for the numerator for this measure: ESM 8.2.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide were not available.</p> <p>Therefore,</p> <p>Numerator used for the current report was from NPM 8.2 - Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day, everyday.</p>

ESM 10.2 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	100	100
Numerator		
Denominator		
Data Source	MSDH County Health Department information	MSDH County Health Department information
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note:	This measure may need to be refined to understand service differences in different locations and availability of the complete array of services for adolescents.
2.	Field Name:	2022
	Column Name:	State Provided Data
	Field Note:	This measure may need to be refined to understand service differences in different locations and availability of the complete array of services for adolescents.

ESM 11.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

Measure Status:		Active				
State Provided Data						
	2018	2019	2020	2021	2022	
Annual Objective	15	48	50	52	54	
Annual Indicator	46	100	100	0	30	
Numerator						
Denominator						
Data Source	MSDH CYSHCN Program					
Data Source Year	2018	2019	2020	2021	2022	
Provisional or Final ?	Final	Provisional	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	56.0	58.0	60.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

In 2016, a transition occurred in the CYSHCN program’s staff, lending to some gaps in data collection. The CYSHCN Program has addressed the issue by ensuring that providers are being trained and CYSHCN staffs are assigned to monitoring and collecting sign in sheets, reports, and evaluations summaries. Therefore, the data provided is for 2017 – 2018. The CYSHCN Program collaborated with the UMMC Pediatric Hematology/Oncology to conduct regional outreach sessions to educate providers (February and March 2018). UMMC Pediatric Hematology/Oncology staff visited pediatricians, emergency medicine physicians, family medicine physicians, nurse practitioners, nurses, and other office and hospital personnel at two clinics and two hospitals in MS. Forty six (46) providers received the training.

ESM 13.1.1 - Number of pregnant and postpartum women who received oral health education

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		600	650	700	750
Annual Indicator		409	347	0	1,000
Numerator					
Denominator					
Data Source		MSDH Office of Oral Health - REDCAP			
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	800.0	850.0	1,000.0

Field Level Notes for Form 10 ESMs:

- Field Name:** 2020

Column Name: State Provided Data

Field Note:
Data captured from WIC program and Baby Cafes
- Field Name:** 2022

Column Name: State Provided Data

Field Note:
We are currently using REDCAP as a tool to capture data from the activities of our Regional Oral Health Consultants. The number reflected includes women from WIC, community baby showers and similar events. The actual number is 1,186 but due to data ranges for this indicator, 1,000 was indicated for 2022.

ESM 13.2.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist

Measure Status:					Active
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		1,000	2,000	3,000	4,000
Annual Indicator		0	903	0	29
Numerator					
Denominator					
Data Source		Office of Oral Health	Office of Oral Health	Office of Oral Health	EPIC
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	150.0	200.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	The MSDH Oral Health Program is working to obtain data from all clinics carried out the Cavity Free in MS program.
2.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note:	The MSDH Oral Health Program is working to obtain data from all clinics carried out the Cavity Free in MS program.
3.	Field Name:	2022
	Column Name:	State Provided Data
	Field Note:	Of the 437 children seen by MSDH nurses so far, we have been able to speak with 90 parents/guardians. Twenty-nine children have been confirmed as having seen a dentist. We are working to assist those who have not seen the dentist with establishing a dental home. Some barriers encountered with these follow up calls include language, with need for an interpreter; inability to reach guardians; and the interface of Oral Health into EPIC has not been synchronized.

ESM 13.2.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		1,000	2,000	3,000	4,000
Annual Indicator		0	976	424	20
Numerator					
Denominator					
Data Source		EPIC	EPIC	EPIC	EPIC
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	450.0	500.0	550.0

Field Level Notes for Form 10 ESMs:

- Field Name:** 2020

Column Name: State Provided Data

Field Note:
Information was captured in EPIC EHR system based on EPDST wellness visits. There is an oral health evaluation component. We are working to customize reports to find out more regarding specifics of referrals.
- Field Name:** 2022

Column Name: State Provided Data

Field Note:
The program is now aware of the check box for wellness visits active in the EPIC system and the ability to generate reports on dental referrals documented. Unfortunately, with the shortage and turnover of nurses with the agency, not all team members were using this tool and additional training is needed. The program is also unsure if this information is also documented in the patient's chart and they will need to manually review each entry to decide. The program is planning to work with the Chief Nurses to update training and protocols on this tool.

ESM 13.2.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting

Measure Status:		Active			
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		60	65	70	75
Annual Indicator		10	2	8	14
Numerator					
Denominator					
Data Source		Office of Oral Health	Office of Oral Health	Office of Oral Health	MSDH Office of Oral Health REDCAP
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	25.0	30.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	The log is being updated to capture data; however, the program is awaiting an official data collection tool to be implemented that will be used for all programs under MSDH Health Services. There was a decline in the number of trainings conducted during the reporting period due to the impact of COVID-19.
2.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note:	The log is being updated to capture data; however, the program is awaiting an official data collection tool to be implemented that will be used for all programs under MSDH Health Services. There was a decline in the number of trainings conducted during the reporting period due to the impact of COVID-19.
3.	Field Name:	2022
	Column Name:	State Provided Data
	Field Note:	During this reporting period, fourteen (14) Cavity Free in Mississippi trainings were conducted where 54 non dental providers (medical doctors, nurse practitioners and physician assistants) were trained on the use of fluoride varnish in a primary care setting.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Mississippi

SPM 3 - Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age
Population Domain(s) – Child Health

Measure Status:	Active								
Goal:	Increase the proportion of children on Medicaid aged 12 and 24 months that have a reported blood lead screening								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of Mississippi children on Medicaid aged 12 and 24 months that have a reported blood lead screening is</td> </tr> <tr> <td>Denominator:</td> <td>Number of Mississippi children on Medicaid aged 12 and 24 months is</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of Mississippi children on Medicaid aged 12 and 24 months that have a reported blood lead screening is	Denominator:	Number of Mississippi children on Medicaid aged 12 and 24 months is
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of Mississippi children on Medicaid aged 12 and 24 months that have a reported blood lead screening is								
Denominator:	Number of Mississippi children on Medicaid aged 12 and 24 months is								
Healthy People 2030 Objective:	Reduce blood lead levels in children aged 1 to 5 years — EH-04								
Data Sources and Data Issues:	MSDH Lead Program data and Division of Medicaid data								
Significance:	<p>Lead is a potent and pervasive neurotoxicant. Elevated blood lead levels (EBLs) can result in decreased IQ, academic failure, and behavioral problems in children. There are approximately half a million U.S. children ages 1-5 with blood lead levels above five micrograms per deciliter, the reference level at which CDC recommends public health actions be initiated. No safe blood lead level in children has been identified. Because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized. By school age, children with a history of lead exposure can exhibit poor attention and impulse control, with lower intelligence and academic performance. A blood lead test is the only reliable way to identify a lead-poisoned child. Medicaid has required testing of enrolled children since 1989. Many states do not enforce the Medicaid requirement for children to be tested for lead poisoning. Medicaid-enrolled children are three times more likely to have elevated blood lead levels (EBLLs) than those non-enrolled children, according to national studies.</p>								

SPM 10 - Percent of severe maternal morbidity events related to hypertension
Population Domain(s) – Women/Maternal Health

Measure Status:	Active								
Goal:	By September 30, 2022, decrease the percentage of severe maternal morbidity events related to hypertension by 0.1% annually								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of severe hypertension events</td> </tr> <tr> <td>Denominator:</td> <td>Number of live births</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of severe hypertension events	Denominator:	Number of live births
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of severe hypertension events								
Denominator:	Number of live births								
Data Sources and Data Issues:	<p>Mississippi Hospital Discharge Data</p> <p>Data issues are: Hospital Discharge data are typically delayed by 18-24 months.</p>								
Significance:	Mississippi has a high severe maternal morbidity rates and significant racial disparities.								

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile
Population Domain(s) – Child Health

Measure Status:	Active								
Goal:	By September 30, 2025, decrease the percentage of children, ages 2-5 years, who receive WIC services and have a BMI at or above the 85th percentile								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of children, ages 2-5 yrs, receiving WIC services with a BMI at or above the 85th percentile</td> </tr> <tr> <td>Denominator:</td> <td>Number of children, ages 2-5 yrs who received WIC services during the reporting period</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of children, ages 2-5 yrs, receiving WIC services with a BMI at or above the 85th percentile	Denominator:	Number of children, ages 2-5 yrs who received WIC services during the reporting period
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of children, ages 2-5 yrs, receiving WIC services with a BMI at or above the 85th percentile								
Denominator:	Number of children, ages 2-5 yrs who received WIC services during the reporting period								
Data Sources and Data Issues:	WIC Spirit Database								
Significance:	Participation in WIC is low in Mississippi and participating in WIC could improve child's nutrition and health.								

SPM 12 - Percent of women who are enrolled in WIC and initiate breastfeeding
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	To increase the number of WIC mothers who initiate breastfeeding								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of WIC mothers who initiated breastfeeding</td> </tr> <tr> <td>Denominator:</td> <td>Number of mothers enrolled in WIC</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of WIC mothers who initiated breastfeeding	Denominator:	Number of mothers enrolled in WIC
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of WIC mothers who initiated breastfeeding								
Denominator:	Number of mothers enrolled in WIC								
Data Sources and Data Issues:	WIC Spirit Database								
Significance:	Breastfeeding is low within the WIC population and breastfeeding can improve newborn health and reduce childhood obesity								

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age
Population Domain(s) – Child Health, Children with Special Health Care Needs

Measure Status:	Active								
Goal:	Increase the number of infants with confirmed hearing loss who received confirmation of hearing status by 3 months to 67%								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Infants with confirmed hearing loss who received confirmation of hearing status by 3 months</td> </tr> <tr> <td>Denominator:</td> <td>Infants with confirmed hearing loss</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Infants with confirmed hearing loss who received confirmation of hearing status by 3 months	Denominator:	Infants with confirmed hearing loss
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Infants with confirmed hearing loss who received confirmation of hearing status by 3 months								
Denominator:	Infants with confirmed hearing loss								
Healthy People 2030 Objective:	Increase the proportion of infants who didn't pass their hearing screening who get evaluated for hearing loss by age 3 months — HOSCD-02 (https://health.gov/healthypeople/objectives-and-data/browse-objectives/sensory-or-communication-disorders/increase-proportion-infants-who-didnt-pass-their-hearing-screening-who-get-evaluated-hearing-loss-age-3-months-hoscd-02)								
Data Sources and Data Issues:	Program database and EPIC.								
Significance:	According to NCHAM, approximately 95% of babies receive a hearing screen shortly after birth as part of universal newborn hearing screening; however, many infants who do not pass the hearing screening become lost to follow-up or documentation before an audiological evaluation can be completed or critical educational and medical intervention can be provided. Children with hearing loss who receive timely early intervention services are often able to develop language skills on par with their hearing peers. Timely access to early intervention is dependent upon timely confirmation of hearing status.								

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Population Domain(s) – Child Health, Children with Special Health Care Needs

Measure Status:	Active								
Goal:	Increase the number of children who receive developmental screening using a parent completed tool by 10% annually								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> <tr> <td>Numerator:</td> <td>All children at 9 months, 18 months and 30 months or when indicated</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	10,000	Numerator:	All children at 9 months, 18 months and 30 months or when indicated	Denominator:	
Unit Type:	Count								
Unit Number:	10,000								
Numerator:	All children at 9 months, 18 months and 30 months or when indicated								
Denominator:									
Healthy People 2030 Objective:	Increase the proportion of children who receive a developmental screening — MICH-17 (https://health.gov/healthypeople/objectives-and-data/browse-objectives/children/increase-proportion-children-who-receive-developmental-screening-mich-17)								
Data Sources and Data Issues:	Medicaid data; EPIC EPSDT visit data								
Significance:	Developmental screening is early identification of children at risk for cognitive, motor, communication, or social-emotional delays. These are delays that may interfere with expected growth, learning, and development and may warrant further diagnosis, assessment, and evaluation.								

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely

Population Domain(s) – Child Health, Children with Special Health Care Needs

Measure Status:	Active								
Goal:	to increase timely screening and referral of newborns and infants diagnosed with a genetic or metabolic condition								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Infants born in the state diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel and who received screening within 24-48 hours of life and referral to a tertiary center for diagnosis within 24-48 hours of notification.</td> </tr> <tr> <td>Denominator:</td> <td>Infants born in Mississippi who are diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Infants born in the state diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel and who received screening within 24-48 hours of life and referral to a tertiary center for diagnosis within 24-48 hours of notification.	Denominator:	Infants born in Mississippi who are diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Infants born in the state diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel and who received screening within 24-48 hours of life and referral to a tertiary center for diagnosis within 24-48 hours of notification.								
Denominator:	Infants born in Mississippi who are diagnosed with a condition included on the Mississippi Newborn Genetic Screening Panel								
Data Sources and Data Issues:	Genetic Screening data from Perkin-Elmer and EPIC								
Significance:	Genetic testing is an important medical tool for assessing various inheritable diseases, conditions, and cancers. The ability to diagnose patients before symptoms surface can help lessen the severity of symptoms and promote quality of life.								

SPM 16 - Nulliparous, term singleton, vertex (NTSV) cesarean rate
Population Domain(s) – Women/Maternal Health

Measure Status:	Active								
Goal:	To reduce the percent of cesarean deliveries among low-risk first births								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of cesarean deliveries among term (37+ weeks), singleton, vertex births to nulliparous women</td> </tr> <tr> <td>Denominator:</td> <td>Number of term (37+ weeks), singleton, vertex births to nulliparous women</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of cesarean deliveries among term (37+ weeks), singleton, vertex births to nulliparous women	Denominator:	Number of term (37+ weeks), singleton, vertex births to nulliparous women
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of cesarean deliveries among term (37+ weeks), singleton, vertex births to nulliparous women								
Denominator:	Number of term (37+ weeks), singleton, vertex births to nulliparous women								
Healthy People 2030 Objective:	Identical to Maternal, Infant, and Child Health (MICH) Objective 06: Reduce cesarean births among low-risk women with no prior births (Baseline: 25.9% of low-risk females with no prior births had a cesarean birth in 2018, Target: 23.6%)								
Data Sources and Data Issues:	National Vital Statistics System (NVSS)								
Significance:	<p>Cesarean delivery can be a life-saving procedure for certain medical indications. However, for most low-risk pregnancies, cesarean delivery poses avoidable maternal risks of morbidity and mortality, including hemorrhage, infection, and blood clots—risks that compound with subsequent cesarean deliveries.¹ Much of the temporal increase in cesarean delivery (over 50% in the past decade), and wide variation across states, hospitals, and practitioners, can be attributed to first-birth cesareans. Moreover, cesarean delivery in low-risk first births may be most amenable to intervention through quality improvement efforts. This low-risk cesarean measure, also known as nulliparous term singleton vertex (NTSV) cesarean, is endorsed by the National Quality Forum (#0471) and included within The Joint Commission’s National Quality Measures for hospitals (PC-02), and the Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP. An Alliance for Innovation on Maternal Health (AIM) patient safety bundle for Safe Reduction of Primary Cesarean Births was released in 2018.</p>								

SPM 17 - Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	To increase the percent of women who have an annual preventive medical visit								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of women on Medicaid ages 18 through 44, who report visiting a doctor for a routine checkup in the past year</td> </tr> <tr> <td>Denominator:</td> <td>Number of women on Medicaid, ages 18 through 44</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of women on Medicaid ages 18 through 44, who report visiting a doctor for a routine checkup in the past year	Denominator:	Number of women on Medicaid, ages 18 through 44
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of women on Medicaid ages 18 through 44, who report visiting a doctor for a routine checkup in the past year								
Denominator:	Number of women on Medicaid, ages 18 through 44								
Healthy People 2030 Objective:	Related to Access to Health Services (AHS) Objective 08: Increase the proportion of adults who receive appropriate evidence-based clinical preventive services. (Baseline: 8.0% in 2015, Target: 10.9%)								
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System (BRFSS)								
Significance:	An annual well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women’s health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The Women’s Preventive Services Initiative (WPSI) is a coalition of national health professional organizations and patient advocates led by the American College of Obstetricians and Gynecologists (ACOG) and works to develop, review, and update recommendations for women’s healthcare preventive services. WPSI recommends an annual well-woman visit beginning in adolescence and continuing across the lifespan with any health care provider offering preventive well-woman care.								

SPM 18 - Percent of children with and without special health care needs who received services necessary to make transitions to adult health care

Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active								
Goal:	Increase the percent of children with special health care needs who have received services necessary for transition to adult health care								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of children with special health care needs who have received services necessary for transition to adult health care (12-17 years)</td> </tr> <tr> <td>Denominator:</td> <td>Total number of children with special health care needs (12-17 years)</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of children with special health care needs who have received services necessary for transition to adult health care (12-17 years)	Denominator:	Total number of children with special health care needs (12-17 years)
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of children with special health care needs who have received services necessary for transition to adult health care (12-17 years)								
Denominator:	Total number of children with special health care needs (12-17 years)								
Data Sources and Data Issues:	<p>NSCH 2020-2021</p> <p>The main goal of this measure is to increase the percent of children with special health care needs who have received services necessary for transition to adult health care. Therefore, the numerator used is the percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.</p>								
Significance:	<p>CYSHCN are children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. They also require health and related services of a type or amount beyond that required by children generally. According to our National Survey of Children’s Health (NSCH) (PDF), in our country:</p> <ul style="list-style-type: none"> (1) About 14 million children under 18 years old (19%) have a special healthcare need, (2) 25% of homes had one or more children with a special healthcare need, (3) CYSHCN are more likely to live in poverty, be non-Hispanic Black, and have public insurance than non-CYSHCN. <p>Mississippi needs to work on a coordinated system of care to support transition.</p>								

SPM 19 - Adolescent suicide rate
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active								
Goal:	to reduce the adolescent suicide rate among youth ages 15-19 years								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>100,000</td> </tr> <tr> <td>Numerator:</td> <td>number of adolescents aged 15-19 years who died by suicide</td> </tr> <tr> <td>Denominator:</td> <td>number of adolescents aged 15-19 years (per 100,000)</td> </tr> </table>	Unit Type:	Rate	Unit Number:	100,000	Numerator:	number of adolescents aged 15-19 years who died by suicide	Denominator:	number of adolescents aged 15-19 years (per 100,000)
Unit Type:	Rate								
Unit Number:	100,000								
Numerator:	number of adolescents aged 15-19 years who died by suicide								
Denominator:	number of adolescents aged 15-19 years (per 100,000)								
Data Sources and Data Issues:	2021 Office of Vital Records and Public Health Statistics								
Significance:	<p>Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. There are many factors that contribute to suicide. The goal of suicide prevention is to reduce factors that increase risk and increase factors that promote resilience. In 2020, an estimated 12.2 million adults seriously thought about suicide, 3.2 million made a plan, and 1.2 million attempted suicide. Suicide rates in 2020 were 30% higher than in 2000. Data for Mississippi indicate that the rate has increased from 5.9 deaths per 100,000 adolescents aged 15-19 years in 2012-2014 to 11.6 deaths per 100,000 adolescents aged 15-19 years in 2017-2019.</p>								

SPM 20 - Number of MCH programs that have developed a written plan to address health equity
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active								
Goal:	to ensure all MCH programs implement plans to achieve health equity by addressing implicit bias, diversity, discrimination, and racism								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>number of written plans that address health equity</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100	Numerator:	number of written plans that address health equity	Denominator:	
Unit Type:	Count								
Unit Number:	100								
Numerator:	number of written plans that address health equity								
Denominator:									
Data Sources and Data Issues:	MCH program data								
Significance:	<p>Mississippi ranks last, or close to last, in almost every leading health outcome. In Mississippi and nationwide, these health disparities are significantly worse for those who have systematically faced obstacles to health due to their socio-economic status, race, ethnicity, religion, sexual orientation, geographic location, and other characteristics historically linked to discrimination or exclusion.</p> <p>The result is a disproportionate burden of disease and illness that is borne by racial and ethnic minority populations and the rural and urban poor. Health disparities not only affect the groups facing health inequities, but limit overall improvements in quality of care, the health status for the broader population, and results in unnecessary costs.</p> <p>The MSDH MCH programs believe that developing written plans on how each program will implement plans to achieve health equity by addressing implicit bias, diversity, discrimination, and racism</p>								

SPM 21 - Percent of children with and without special healthcare needs who have a medical home
Population Domain(s) – Child Health

Measure Status:	Active								
Goal:	to assure that all children with special healthcare have a medical home								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>children, 0-17 years, with and without special healthcare needs who have a medical home</td> </tr> <tr> <td>Denominator:</td> <td>all children, 0-17 years, in Mississippi with special healthcare needs</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	children, 0-17 years, with and without special healthcare needs who have a medical home	Denominator:	all children, 0-17 years, in Mississippi with special healthcare needs
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	children, 0-17 years, with and without special healthcare needs who have a medical home								
Denominator:	all children, 0-17 years, in Mississippi with special healthcare needs								
Data Sources and Data Issues:	NSCH 2019-2020								
Significance:	A medical home is essential to overall mental, emotional and physical health of children. The American Academy of Pediatrics specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective care. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child’s family and a competent health professional who is familiar with the child and family and the child’s health history. In Mississippi, the C/YSHCN program is working towards developing a comprehensive, coordinated and integrated system of services for children.								

Form 10
State Outcome Measure (SOM) Detail Sheets
State: Mississippi

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Mississippi

ESM 1.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy

NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active								
Goal:	to assist women in quitting smoking during pregnancy								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of unduplicated individuals who have completed the intake process for Office of Tobacco Control-funded tobacco cessation treatment programs</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	10,000	Numerator:	Number of unduplicated individuals who have completed the intake process for Office of Tobacco Control-funded tobacco cessation treatment programs	Denominator:	
Unit Type:	Count								
Unit Number:	10,000								
Numerator:	Number of unduplicated individuals who have completed the intake process for Office of Tobacco Control-funded tobacco cessation treatment programs								
Denominator:									
Data Sources and Data Issues:	<p>Mississippi Quitline and Baby and Me Tobacco Free data</p> <p>Data issues: new Quitline provider needs to make a concerted effort to document sex / gender and pregnancy status of both callers AND persons up complete the intake process</p>								
Evidence-based/informed strategy:	<p>This ESM measures the number of unduplicated individuals who have completed the intake process for OTC-funded tobacco cessation treatment programs and is associated with NPM 1. All providers should be asking their patients about the use of tobacco and nicotine-containing products and, if using tobacco or nicotine, having a discussion around use and making recommendations around quitting and staying quit.</p> <p>Data from the Mississippi Quitline provider and the Baby and Me Tobacco Free Program</p>								
Significance:	<p>Data from the Mississippi Quitline provider and the Baby and Me Tobacco Free Program helps us understand how many individuals are accessing and initiating steps in quitting smoking. Along with other PRAMS data, it will allow MSDH to look at provider interactions with pregnant women and discussions / recommendations for quitting.</p> <p>United States. Tobacco use is the leading cause of preventable illness, disability, and death in the United States. About 34 million adults smoke cigarettes. More than 480,000 deaths each year are due to cigarette smoking, including 41,000 deaths from secondhand smoke. Cigarette smoking can negatively affect fertility, making it harder for women to become pregnant. Cigarette smoking during pregnancy has been linked to an increased risk of low birthweight, premature birth, birth defects, and sudden infant death syndrome (SIDS).</p> <p>Mississippi. There are a number of documented disparities related to smoking in Mississippi.</p> <p>Mississippi BRFSS Analytic Findings. Approximately 18% of women aged 18-44 years were current smokers. The percentage of current smokers was significantly lower among Black</p>								

women (11.3%) compared to white women (24.9%), and was significantly higher among women who have not completed a high school education (41.6%) compared to those with more than a high school education (13.2%).

Mississippi PRAMS Analytic Findings. Almost 22% of women aged 18-44 years reported smoking in the 3 months before pregnancy. In the last 3 months of pregnancy, about 1 in 10 women aged 18-44 years (10.6%) smoked. In the last 3 months of pregnancy and the postpartum period, smoking prevalence was significantly higher among non-Hispanic White women (15.4% [pregnancy] and 20.1% [postpartum]) compared to non-Hispanic Black women (5.9% [pregnancy] and 10.1% [postpartum]).

Continued monitoring and working with both providers and programs that aid smokers in quitting and staying quit can improve health outcomes for women, infants and children.

ESM 4.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals

NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active								
Goal:	Increase the percent of births occurring in birthing hospitals designated as Baby Friendly								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of birthing hospitals in the state designated as Baby Friendly</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100	Numerator:	Number of birthing hospitals in the state designated as Baby Friendly	Denominator:	
Unit Type:	Count								
Unit Number:	100								
Numerator:	Number of birthing hospitals in the state designated as Baby Friendly								
Denominator:									
Data Sources and Data Issues:	MSDH Infant Health Program and Baby Friendly USA (https://www.babyfriendlyusa.org/for-parents/baby-friendly-facilities-by-state/)								
Significance:	Research has shown that breastfeeding is recognized as the best source of nutrition for most infants. To help support breastfeeding mothers and increase breastfeeding rates in the United States, the U.S. Surgeon General released The Surgeon General’s Call to Action to Support Breastfeeding in 2011. The Call to Action sets out clear action steps that communities, health care systems, health care providers, employers, public health professionals, and other organizations and individuals can take to support mothers and make breastfeeding easier. The Baby-Friendly Hospital Initiative (BFHI) supports and recognizes hospitals and birthing centers that offer an optimal level of care for infant feeding by following the BFHI’s Ten Steps to Successful Breastfeeding. These steps are practices that hospitals can implement that have been shown to improve breastfeeding outcomes.								

ESM 5.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active								
Goal:	Increase safe sleep educational awareness to providers, MSDH staff and community partners by 1% in the next year.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of safe sleep educational books and resources distributed to families in all birthing hospitals.</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100,000	Numerator:	Number of safe sleep educational books and resources distributed to families in all birthing hospitals.	Denominator:	
Unit Type:	Count								
Unit Number:	100,000								
Numerator:	Number of safe sleep educational books and resources distributed to families in all birthing hospitals.								
Denominator:									
Data Sources and Data Issues:	MSDH Infant Health Program								
Significance:	The number of U.S. sleep-related Sudden Unexpected Infant Death (SUID) cases, including Sudden Infant Death Syndrome (SIDS), is approximately 3,500 deaths per year. Since the Back to Sleep campaign launched in 1994, the overall U.S. SIDS rate declined by more than 60%; the proportion of infants placed on their backs to sleep increased from 27% in 1993 to 74% in 2011. Strategies to increase the percentage of infants usually placed to sleep on their backs include supporting the implementation of safe sleep practices through policies, accreditation, and legislation.								

ESM 6.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

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

Measure Status:	Active								
Goal:	To increase the awareness of health professionals and parents / families on the importance of developmental screening and monitoring using a parent-completed tool								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of health professionals and parents / families who receive training on developmental screening and/or monitoring</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	10,000	Numerator:	Number of health professionals and parents / families who receive training on developmental screening and/or monitoring	Denominator:	
Unit Type:	Count								
Unit Number:	10,000								
Numerator:	Number of health professionals and parents / families who receive training on developmental screening and/or monitoring								
Denominator:									
Data Sources and Data Issues:	Early Intervention Child Find Log								
Evidence-based/informed strategy:	Professionals and families who understand the importance of developmental screening and monitoring and have the knowledge and skills to use quality measures are more likely to ensure timely developmental screenings and ongoing monitoring occurs.								
Significance:	Professionals and families need awareness of developmental milestones and the importance of regular screenings and ongoing monitoring to ensure development is on track or to identify concerns early. Professionals and families also need skills in using parent-completed developmental monitoring and screening tools to use them successfully.								

ESM 8.2.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide

NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active								
Goal:	Increase physical activity among adolescents, ages 12 through 17 years								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide</td> </tr> <tr> <td>Denominator:</td> <td>Number of junior high schools and high schools in Mississippi</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide	Denominator:	Number of junior high schools and high schools in Mississippi
	Unit Type:	Percentage							
	Unit Number:	100							
	Numerator:	Number of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide							
Denominator:	Number of junior high schools and high schools in Mississippi								
Data Sources and Data Issues:	Completed School Health Index (SHI) Self-Assessment and Planning Guides								
Evidence-based/informed strategy:	This ESM aims to identify the systems and structures that are barriers to adolescent physical activity. The School Health Index (SHI) Self-Assessment and Planning Guide is an online self-evaluation and planning tool for schools. The SHI is built on CDC’s research-based guidelines for school health programs that identify the policies and practices most likely to be effective in reducing youth health risk behaviors. By working with schools that conduct the assessment, MSDH could collaborate with schools, particularly those with school-based health centers, on assisting in the development of policies and practices (such as 'exercise prescriptions') to increase time in schools for physical activity and laying a foundation for healthy behaviors.								
Significance:	This ESM aims to identify the systems and structures that are barriers to adolescent physical activity. The School Health Index (SHI) Self-Assessment and Planning Guide is an online self-evaluation and planning tool for schools. The SHI is built on CDC’s research-based guidelines for school health programs that identify the policies and practices most likely to be effective in reducing youth health risk behaviors. Given that approximately 1 in 5 youth are physically active at least 60 minutes per day, Mississippi needs to look towards systems, structures and policies that can be leveraged to facilitate physical activity among youth.								

ESM 10.2 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active								
Goal:	to improve preventive medical visit coverage for Mississippi adolescents aged 12-17 years								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100	Numerator:	Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years	Denominator:	
Unit Type:	Count								
Unit Number:	100								
Numerator:	Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years								
Denominator:									
Data Sources and Data Issues:	number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years								
Evidence-based/informed strategy:	This ESM is a first attempt to better understand the array of services available to youth 12-17 years in each of the county health departments. This measure is designed to help show the gap filling nature for Mississippians who are uninsured, underinsured or without a medical home. While MSDH is not a medical home or the primary care provider for Mississippians, MSDH fills essential gaps in care and is the last payer of resort for many Mississippians.								
Significance:	This measure is designed to help show the gap filling nature for Mississippians who are uninsured, underinsured or without a medical home. While MSDH is not a medical home or the primary care provider for Mississippians, MSDH fills essential gaps in care and is the last payer of resort for many Mississippians. MSDH also does its best to connect all patients to a primary care provider / medical home. MSDH county health departments provide an array of integrated health services, including family planning, HIV/STI services, cancer screening, sexual health counseling, immunizations, TB screening and treatment, and EPSDT (well child checks) to Mississippians across the life span, including adolescents, ages 12-17 years. However, not all services are provided at every location. MSDH served, in some capacity, about 30,000 children (not including WIC). As a gap filler, MSDH could assess locations and types of services offered to help improve family planning, HIV and STI prevention, and immunization coverage among Mississippi youth.								

ESM 11.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care

NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active								
Goal:	Increase the number of providers receiving education or technical assistance about the need and importance of medical home/family-centered care by 5% in the next year.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100	Numerator:	Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care	Denominator:	
Unit Type:	Count								
Unit Number:	100								
Numerator:	Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care								
Denominator:									
Data Sources and Data Issues:	MSDH Children's Medical Program								
Significance:	<p>The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. We are planning to work with two (2) community based clinics utilizing the medical home model as pilot sites for referring and providing care coordination to children and adolescents enrolled in CMP.</p>								

ESM 13.1.1 - Number of pregnant and postpartum women who received oral health education
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active								
ESM Subgroup(s):	Pregnant Women, Adolescents 12 through 17								
Goal:	Increase the number of pregnant and postpartum women who received oral health education by 10% in the next year in order to increase the awareness of women regarding the importance of oral health.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of expectant and postpartum women who received oral health education</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	1,000	Numerator:	Number of expectant and postpartum women who received oral health education	Denominator:	
Unit Type:	Count								
Unit Number:	1,000								
Numerator:	Number of expectant and postpartum women who received oral health education								
Denominator:									
Data Sources and Data Issues:	<p>Office of Oral Health/PHRM/FQHC partners</p> <p>We are currently using REDCAP as a tool to capture data from the activities of our Regional Oral Health Consultants. The number reflected includes women from WIC, community baby showers and similar events. The actual number is 1,186 but due to data ranges for this indicator, 1,000 was indicated for 2022.</p>								
Significance:	Oral Health promotion and oral disease prevention in parents and children; referral to dental home								

ESM 13.2.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active								
Goal:	Increase the collaborative partnership between MSDH nurses and Office of Oral Health in preventing oral disease and supporting children having a dental home by 1st year of life								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of children 0-3 years old who actually went to referred dentist</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	10,000	Numerator:	Number of children 0-3 years old who actually went to referred dentist	Denominator:	
Unit Type:	Count								
Unit Number:	10,000								
Numerator:	Number of children 0-3 years old who actually went to referred dentist								
Denominator:									
Data Sources and Data Issues:	<p>Office of Oral Health/MSDH Nurses-Epic system -</p> <p>While we are using our EPIC system to capture data on the number of EPSDT wellness visits where agency nurses provide oral health assessments and referrals to dentist, the process for this information to be given to our dental care coordinator was not synchronized during the time of this reporting. Four hundred thirty-seven (437) children, ages 0-3, were seen for EPSDT visits by MSDH nurses. Due to the lack of centralized reporting, we are uncertain of the actual number that saw a dentist, but we are working to follow up with these participants to share these data.</p>								
Significance:	Prevention of oral disease in children under 6 years old								

ESM 13.2.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active								
Goal:	Increase the collaborative partnership between MSDH nurses and Office of Oral Health in preventing oral disease and supporting children having a dental home by 1st year of life								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> <tr> <td>Numerator:</td> <td># of referrals to dentists of children 0-3 by MSDH nurses</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	10,000	Numerator:	# of referrals to dentists of children 0-3 by MSDH nurses	Denominator:	
Unit Type:	Count								
Unit Number:	10,000								
Numerator:	# of referrals to dentists of children 0-3 by MSDH nurses								
Denominator:									
Data Sources and Data Issues:	<p>Office of Oral Health/MSDH Nurses-Epic system</p> <p>The program is now aware of the check box for wellness visits active in the EPIC system and the ability to generate reports on dental referrals documented. Unfortunately, with the shortage and turnover of nurses with the agency, not all team members were using this tool and additional training is needed. The program is also unsure if this information is also documented in the patient's chart and they will need to manually review each entry to decide. The program is planning to work with the Chief Nurses to update training and protocols on this tool.</p>								
Significance:	Prevention of oral disease in children under 6 years old								

ESM 13.2.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting

NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active								
Goal:	Increase the number of training completed by medical providers on use of fluoride varnish in primary care setting by 5% in the next year to eradicate oral disease in children through collaborative partnership between dentists and medical providers								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of training completed by medical providers on use of fluoride varnish in primary care setting</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100	Numerator:	Number of training completed by medical providers on use of fluoride varnish in primary care setting	Denominator:	
Unit Type:	Count								
Unit Number:	100								
Numerator:	Number of training completed by medical providers on use of fluoride varnish in primary care setting								
Denominator:									
Data Sources and Data Issues:	<p>Office of Oral Health</p> <p>During this reporting period, fourteen (14) Cavity Free in Mississippi trainings were conducted where 54 non dental providers (medical doctors, nurse practitioners and physician assistants) were trained on the use of fluoride varnish in a primary care setting.</p>								
Significance:	Interdisciplinary care; oral disease prevention in children								

**Form 11
Other State Data
State: Mississippi**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

**Form 12
MCH Data Access and Linkages**

**State: Mississippi
Annual Report Year 2022**

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	1		
2) Vital Records Death	Yes	Yes	Quarterly	1	No	
3) Medicaid	Yes	No	Quarterly	3	Yes	
4) WIC	Yes	Yes	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Less Often than Annually	18	No	
8) PRAMS or PRAMS-like	Yes	Yes	Less Often than Annually	18	Yes	

Other Data Source(s) (Optional)

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) BRFSS	Yes	Yes	Less Often than Annually	12	No	
10) YRBSS	Yes	Yes	Less Often than Annually	24	No	
11) NSCH	Yes	Yes	Daily	21	No	
12) EPIC	Yes	Yes	Daily	0	No	
13) HHL PSS	Yes	Yes	Daily	0	Yes	
14) Catalyst	Yes	Yes	Daily	0	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Other Data Source(s) (Optional) Field Notes:

Data Source Name:	9) BRFSS
	Field Note: Provide data about women and men of reproductive age

Data Source Name:	10) YRBSS
	Field Note: Provide data about adolescent risk and protective factors

Data Source Name:	11) NSCH
	Field Note: Provides child's data using a Mississippi sub sample

Data Source Name:	12) EPIC
	Field Note: Provides health encounter data for many programs

Data Source Name:	13) HHL PSS
	Field Note: This is the state's Lead Poisoning Prevention database

Data Source Name:	14) Catalyst
	Field Note: This is the database for the breast and cervical cancer prevention program