Maternal and Child Health Services Title V Block Grant

Mississippi

FY 2023 Application/ FY 2021 Annual Report

Created on 8/11/2022 at 11:55 AM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

August 5, 2022

Christopher Dykton, MA
Acting 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 2023 Application and 2021 Annual Report for the Title V Maternal Child Health Block Grant. We are excited to report on the work done over the past year and acknowledge the flexibility MCHB granted during the height of the COVID pandemic. The lessons learned during the pandemic created opportunities for extending more partnerships into communities; identifying trusted leaders to support the message and implementation of strategies of improving overall health; and the on-going assessment of the MCH population needs.

We look forward to sharing the successes, challenges, and opportunities we anticipate in the future for improving the health of the State's MCH population. Should you have any questions or comments, please contact me at phone number 601-576-7472 or email: beryl.polk@msdh.ms.gov.

Sincerely,

Beryl Polk, PhD, CPM, CHP, CCM
Director, Health Services/Title V Director
MS State Department of Health
Jackson, MS 39215
601-576-7472

570 East Woodrow Wilson • Post Office Box 1700 • Jackson, MS 39215-1700
601-576-8090 • 1-866-HLTHY4U • www.HealthyMS.com

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: January31, 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 of our state. MSDH's mission is to protect and advance the health, well-being, and safety of everyone in Mississippi. 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; Health Services; Field Services; Preventive Health and Health Equity; Health Data, Operations and Research; the Public Health Laboratory; and Health Protection (which includes communicable diseases, immunization, STIs/ HIV, tuberculosis). The major operations of MSDH address a wide range of functions, such as disease surveillance, disease and injury prevention, immunizations, nutrition support and supplemental food services, comprehensive reproductive health, emergency preparedness, community and emergency health communications, environmental protection, standards of care and licensure, licenses and records, and social services.

The Division of Health Services is responsible for the administration of programs under Title V MCH Block Grant, a vital resource tailored toward 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 prevention (BCCP), Healthy Moms/Healthy Babies home visiting, and perinatal health); (b) Child and Adolescent Health (including newborn screening, Early Periodic Screening, Detection, and Treatment (EPSDT), Early Hearing Detection and Intervention (EHDI), early intervention, lead poisoning prevention, and Children and Youth with Special Health Care Needs (CYSHCN)); (c) the Women, Infants and Children's Nutrition Program (WIC); (d) Oral Health; and (e) the Public Health Pharmacy. The Health Services Division partners with the Office of Health Data and Research (OHDR) which provides scientific integrity and quality assurance in data management, surveillance, data analysis, reporting, and program evaluation related to maternal and child health (MCH).

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 achieved 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 populations.

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 are open to MSDH staff, partner organizations and more broadly to the public. During these meetings, recommendations are 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

As a results 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. The priority needs identified by MCH population are listed below. 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

MCH Program Planning

The MCH Block grant works 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. Using information gathered through the comprehensive needs assessment, the MCH programs identify priority areas, strategies and activities that address the needs of one or more population domains. Ideally, programs work together across domains and the strategies and activities work towards common objectives aimed to improve population health outcomes and to decrease risk factors and barriers to optimal health outcomes. The program teams should collaboratively develop action plans, measure success, implement the plans, and report on progress in conjunction with the advisory board members throughout the year. However, in previous years, the objectives, strategies, and activities were developed by each of the programs independently without a common approach for the State Action Plan (SAP).

After the 2019-2020 Five-Year Needs Assessment, the MCH Block Grant Team determined a new process for the development of the SAP was needed to be more collaborative to break down siloed practices and to develop shared activities to address shared priorities. However, due to the COVID pandemic, staff had more responsibilities as MSDH mounted a public health response. Collaborative planning was exceptionally challenging. As the state began returning to normal operations, the MCH Block Grant Team again discussed transitioning from program-focused planning to cross-program and cross-domain planning teams to develop priority-focused plans. However, the Block Grant Team had limited opportunities to facilitate this unified approach to collective planning, resulting in a continuation of a siloed efforts. Throughout Spring 2022, key Block Grant writing team members left the agency, resulting in the formation of a new MCH leadership team to guide the planning, development, and implementation of the Block Grant. In creating the SAP for 2023, this new Team noted previous SAPs did not always capture the work of MCH programs and often proposed objectives, strategies, and activities were too fragmented and program-specific.

This 2023 application and 2021 annual report represent a transition year for Mississippi. The annual report provides an update on the status of activities in 2021 in a program-specific manner; however, the application proposes measures and activities for 2023 that look across programs and find common elements for the MCH programs to address the priority needs of MCH populations in Mississippi holistically. This SAP will be a living document to be further refined by program personnel and advisory group members. The MCH Team intends in this Block Grant cycle to implement a process for creating a more durable SAP with shared objectives, strategies, and activities providing Mississippi with 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, epidemiology and program staff ensure processes 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 all county health departments. Title V funded MCH staff work at multiple levels: Central Office, three public health regions, and local health departments. This organizational structure ensures MCH/Title V and other state and federal funds are comprehensively administered to all 82 counties and program fidelity is maintained via direct management or contract. To ensure multi-directional transmission of key information and provide opportunities for sharing 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.

In 2022, the state reorganized its three public health regions and reestablished nine public health districts, three per region, for improved coordination across programs in local areas. See the updated MSDH Region and District Map in the Attachments.

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 2019, a newly appointed MCH Engagement Coordinator and an agency pediatric consultant led an effort to work across MCH/Title V programs to improve and strengthen opportunities for family/youth/consumer engagement within all programs. As a result of this effort, an MCH Advisory Board was developed to provide vital feedback to improve MSDH programs and services and to expand opportunities for family/youth/consumer leadership. The MCH Advisory Board, consisting of 13 members, including youth, family members, and MCH professionals and stakeholders, was launched in January 2021. The Board meets quarterly, providing general guidance and conducting the following activities:

- Review the development, implementation, and adoption of programs, policies, and strategies to ensure integration across agencies and systems.
- Advise on methods of integration at the local and state level.
- Assist in the dissemination of information on MCH services and activities.
- Identify consumers' and service providers' concerns and gaps in services.
- Advise use of block grant funds to address needs in local communities based on state measures and supported by data.

State Agencies:
Continued collaboration with key stakeholders is essential to Mississippi achieving its priorities for the MCH populations. The Mississippi Title V Program also works closely with the Mississippi Department of Human Services (DHS), the Division of Medicaid, and the Mississippi Department of Education (DOE). Mississippi's Title V Program further diversifies its partnerships through grant-funded activities that align with the chosen priorities. Funded entities include, but are not limited to:

- School-based health centers

- Mississippi Perinatal Quality Collaborative
- State universities
- Community organizations
- Federally Qualified Health Centers
- Community Health Centers
- Parent Advocacy Centers

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, implementing the Pregnancy Risk Assessment Monitoring System (PRAMS), 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 implementing care coordination and medical home approaches for CYSHCN and focusing a portion of funds on other MCH priorities.

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 (state and federal Title V funds, Title X funds, and reimbursement), and investment in the built environment.

III.A.3. MCH Success Story

The past two years have had an impact on every individual worldwide, and perhaps none more than individuals living with disabilities. MSDH's CYSHCN Program experienced many unforeseen changes and challenges in the face of COVID, including staffing challenges. With a small but mighty group of devoted social workers providing care coordination services to an entire state, the inability to be everywhere at once often threatens the effectiveness of those services.

Due to staffing shortages a case in the extreme northern region of the state was being served by a Care Coordinator located in the central region of the state. The mother needed hands-on services in which a Care Coordinator could assist her by scanning documents for the Social Security Administration, Mississippi Medicaid, and Head Start as well as completing required forms online to assure her children did not lose their insurance. The SSA information, Medicaid, and Head Start all had imminent deadlines.

Due to lack of a computer, the mother of the patient was unable to scan documents as needed to complete the task from home. Despite having access to a smartphone, the mother was unable to complete the paperwork using a web-based form. The mother stated using the local library was not a viable option as she would have to take the client with her, and due to the client's age and needs it was not feasible. The mother further expressed concerns about the potential exposure to COVID at the library, especially for her child.

This Care Coordinator discussed her concerns for assisting the family and a workable option when there is no local Care Coordinator to provide direct hands-on assistance during the daily morning CYSHCN Collaboration Meeting. The CYSHCN Supervisor assisted the Care Coordinator in locating an Early Intervention Service Coordinator (EI SC) who could step in to provide the hands-on care the patient and family desperately needed.

This process was not without barriers and challenges requiring ongoing facilitation. The Care Coordinator arranged a meeting between the mother and the EI SC, followed up with the family to offer encouragement and provide coordination of the meeting with the EISC, and further followed up after the meeting to assure all needs had been met. The Care Coordinator also followed up with the EI SC to receive feedback and to express gratitude.

The African proverb "It takes a village to raise a child" has never been truer than now. COVID has been devastating to all, but as a community we can preserve and work together to achieve the smallest or the greatest needs of our neighbors.

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 2021, Jackson, the state’s capital and largest city, had a population of 153,701, and the next largest city is Gulfport, with a population estimate of 72,926. 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 2,949,965. 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, 2021 Census Bureau population estimates, for several of these factors.

Race	Mississippi (%)	United States (%)
White	58.8	75.8
Black	38.0	13.6
Two or more races	1.4	2.9
Asian	1.1	6.1
American Indian and Alaska Native	0.6	1.3
Native Hawaiian and Other Pacific Islander	0.1	0.3

Ethnicity	Mississippi (%)	United States (%)
Hispanic	3.5	18.9
Non-Hispanic	96.4	81.1

Socioeconomic Factors	Mississippi (%)	United States (%)
High school graduate or higher	85.3	88.5
Unemployment rate (July 2021)	5.6	5.4
Homeownership rate	68.8	64.4
Children in poverty (<18 yrs)	28.1	16.8
Persons in poverty (all ages)	18.7	11.4
Persons without health insurance (<65 yrs)	15.4	10.2

Health Status of Mississippi's MCH Population

According to America's Health Rankings, Mississippi ranked 46th in overall health in 2021. Historically, Mississippi has consistently ranked at the bottom for overall health. Similarly, there are several MCH population indicators that continue to have severe challenges, including infant mortality and food insecurity. However, Mississippi shows strength on a few MCH indicators that include a high enrollment level in early childhood education and a low percentage of housing with lead risk. Based on America's Women and Children report, a sub-report of America's Health Rankings, Mississippi ranked 48th overall in Women's Health and 40th 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 32 critical access hospitals, 19 rural hospitals with 49 beds or less, 21 Federally Qualified Community Health Centers, and 160 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.

According to 2020 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. Further Mississippi was the only state with significant gains in three of four tested subjects. National Assessment of Educational Progress (NAEP) Gains from 2017-2019 were:

- No. 1 in 4th grade mathematics
- No. 1 in 4th grade reading
- No. 3 in 8th grade mathematics
- No. 4 in 8th grade reading

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 45th for access and affordability, 46th for prevention and treatment, 50th for avoidable hospital use and costs, 34th for 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 2018, as part of the Behavioral Risk Factor Surveillance System (BRFSS), 20.3% 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.

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, 2021, reported Mississippi's population as 2,949,965, with 51.5% female, 48.5% male. Compared to the nation, a substantially larger percent of the Mississippi population is Black (37.8% vs. 13.4%) and substantially small percentages of the state population are Latinx (3.4% vs. 18.5%) and white (59.1% vs. 76.3%).

As of June 2021, the state of Mississippi opted out of participating in the following federal unemployment programs: Federal Pandemic Unemployment Compensation, Pandemic Unemployment Assistance, Pandemic Emergency Unemployment Compensation, and Mixed Earner Unemployment Compensation.

State Health Agency Roles, Responsibilities, and Priorities

Within MSDH, MCH/Title V is administered by the Division of Health Services. Health Services oversees provision of the WIC program; Child and Adolescent Health, including the genetic disease screening program; Women's Health; Oral Health; and the MSDH Pharmacy. Health Service partners with OHDR, which provides scientific integrity and quality assurance in management, surveillance, data analysis, reporting, and program evaluation related to MCH, chronic disease, and tobacco control. 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.

Public health efforts in Mississippi are ongoing. The 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 32 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'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 124 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 2021, Mississippi had a total of 742,741 Medicaid enrollees providing coverage to 27.7% of the state's population. The state's average length of hospital stay is 5 days compared to national average hospital stay of 4.55 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	35% 974 physicians serve 62 rural counties *3 rural counties have no primary care physicians*	65% 1,398 physicians serve 17 urban counties *all urban counties have primary care physicians*
Dentists	47% 660 dentists serve 64 rural counties *1 rural county has no dentist*	53% 720 dentists serve 17 urban counties *all urban counties have dentists*
Mental Health (Psychiatric Only)	35% 56 psychiatrists serve 63 rural counties *2 rural counties have no psychiatric mental health providers*	65% 98 psychiatrists serve 17 urban counties *all urban counties have psychiatric mental health providers*

While the percentage of Mississippi adults who report being uninsured has dropped since 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 states' 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.

State Statutes and Other Regulations Impacting MCH/Title V

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.

III.C. Needs Assessment
FY 2023 Application/FY 2021 Annual Report Update

Needs Assessment Process

Mississippi's MCH population needs are continuously assessed by MSDH MCH programs through ongoing monitoring and surveillance. These efforts include evaluating progress and trends, implementing, and executing work plans, and addressing emerging issues. This process ensures an annual follow-up to the required comprehensive needs assessment.

The ongoing mechanisms that provide data and information that inform MCH Title V efforts are:

- Collaboration across all MSDH programs
- Staff participation on regional, state, and national boards
- Development of data briefs and data fact sheets
- Data sharing
- Surveys

In addition to these ongoing mechanisms, one of the main mechanisms that inform MCH Title V efforts is conducted through monthly Title V MCH meetings with staff. These meetings provide an opportunity to discuss existing and emerging issues associated with Title V MCH programmatic efforts, accomplishments, and next steps of existing and upcoming projects. As a result, programs can align their efforts to support Mississippi's MCH population needs.

Needs Assessment Findings

Needs assessment findings revealed several re-occurring themes across domains that will be addressed through some of the ongoing needs assessment efforts. These re-occurring themes reveal the need for MSDH to align strategies and use resources for the following:

- Improving access to Mental Health Services
- Providing education on mental health issues
- Improving health equity
- Decreasing discrimination based on race, class, or gender
- Improving provider shortages
- Improving access to care

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 address the mental health needs in our state across the lifespan, many of our MCH programs have participated in mental health first aid training. The Adolescent Health Program became certified in mental health first aid. This certification will allow statewide staff trainings to combat the need for mental health efforts. The CYSHCN staff also

attended Mental Health First Aid training in March 2022 to gain skills and knowledge in recognizing and addressing mental health concerns in CYSHCN youth.

In addition to trainings, 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.

In 2020, the CYSHCN Program collaborated with Adolescent Health and the University of Southern Mississippi to conduct a Family Engagement Summit series where they focused on adolescent health and wellness, which included both adolescents with and without special health care needs. The series consisted of “Teen Talk” sessions that allowed adolescents to participate in a more engaging dialogue without the presence of parents to allow adolescents to have a space to express their needs and concerns. The “Teen Talk” sessions were led by the CYSHCN youth advisor, Kaitlyn Hawkins. The program also connected with USM-IDS, who had a young CYSHCN adult who connected with youth on YouTube through a series called “Chit Chat Thursday with Taylor,” where he provides resources and advice to YSHCN.

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, including 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.

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.

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 as 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.

Access to Care

Mississippians are affected by inequitable access to care. Barriers such as transportation impede the quality and effectiveness of care received. Although these barriers are acknowledged, strategies should be put in place to ensure all Mississippians have access to quality and equitable healthcare access. The MCH/Title V block grant supports the CYSHCN program's ability to partner with clinics within communities to provide easier access to care and aid in establishing a mental and/or dental home for some of the most under-served citizens. The ability to provide access support via tele-medicine has also improved conditions for those in under-resourced areas.

Changes in MCH/Title V Program Capacity

Over the past 2-1/2 years, MSDH has experienced numerous events that have had a serious impact on staff and services, many of which remain unresolved: 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. This year's Title V Block Grant team is composed solely of staff who are new to 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.

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 collaborates with the Title X Family Planning Program Through this collaboration, the Family Planning Program partnered with MSDH Maternal and Infant Health Bureau and 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. To build on this collaboration, the Family Planning Program partners with Teen Health Mississippi to provide training and technical assistance for youth and youth-serving organizations in Mississippi. Trainings provide recommendations on how to best support expectant and parenting youth, adolescents on sexual and mental health practices, and best practices for implementing youth friendly healthcare.

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 the most challenging epidemics of our lifetime—COVID-19—and will be remembered for his work. Daniel Edney, MD, FACP, FASAM is the incoming State Health Officer; he serves as a medical provider and previously served as Deputy State Health Officer and Chief Medical Officer since 2020.

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.

- The Office of Women's Health includes the Breast and Cervical Cancer Prevention Program, Maternal and Infant Health Bureau, Healthy Moms/Healthy Babies, a home visiting program, and the Family Planning/Title X Program. The Women's Health Director position is currently vacant.
- Ms. Stacy Callender is the Director of Child & Adolescent Health, which includes Newborn Screening, the Birth

Defects Registry, Early Hearing Detection and Intervention, Early Intervention Program (Part C), and Lead Prevention and Healthy Homes Program, Adolescent Health, and Children and Youth with Special Healthcare Needs (CYSHCN).

- MS. Valecia Davis is the Director of the Children with Special Healthcare Needs Program and has been serving in this role since summer 2022.
- Dr. Jameshyia Ballard was appointed Director of WIC on July 15, 2022, when the previous WIC Director retired after more than 30 years of service. Dr. Ballard has been with the WIC program for the last eight years.
- Angela Filzen, DDS, is the Oral Health Director and works with community-based organization on dental and medical homes for women and children across the state.
- The MCH Workforce Development Director is Ms. Danielle Seale; she has served in public health for more than a decade.

As always, the Health Services Offices collaborates with both internal and external stakeholders to carry out the mission of the agency.

Emerging Issues and MCH Program Response

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.

Racism

Racism is a serious threat to the public's health and overall quality of life. 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."

This indicates the severity of racism in our everyday lives and for all to have a greater quality of life and improved health outcomes, we must address the generational injustices that contribute to these health and racial 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 because 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.

MCH Program Response

COVID-19 realigned the MCH team's scope of work and action plans. It was evident that there was a need for coordinated care, an understanding of available services, and access to care. In response, the Title V MCH Director and MCH staff joined efforts of the COVID-19 Response team that was led by the MSDH Health Equity Program. Through these efforts, masks and PPE were distributed statewide, health information distributed to religious entities, and staff participation at vaccination sites. Below is some of the program's response to the COVID-19 pandemic.

Women's/Maternal Health

In response to the COVID-19 pandemic, essential BCCP staff were directed to an alternating onsite/telework schedule. Most BCCP staff returned to primarily onsite work effective June 15, 2020. Due to rapid increases in COVID cases in late November 2020, BCCP implemented the alternating onsite/telework schedule again. While MSDH was the lead agency for vaccination distribution, the BCCP program supported the vaccination process through the reassignment of the nursing staff.

The family planning program also assisted in the response to the COVID-19 pandemic by providing thermometers to local community-based and faith-based organizations. Several members of the Family Planning and MCH team worked directly with COVID-19 response by working in the call center, assisting with PPE and supply distribution, facilitating community events for testing, and organizing community and faith-based listservs.

Perinatal/Infant Health

In response to the COVID-19 pandemic, the Mississippi Perinatal Quality Collaborative (MSPQC) hosted weekly COVID-19 Maternal and Neonatal Updates to provide guidance to all birthing hospitals on best emerging practices and strategies to mitigate exposures to pregnant women and infants. MSPQC contacted states such as New York, Louisiana, and local Mississippi clinicians to share strategies and to present data and findings on COVID-19 response and care of women and infants.

Adolescent Health.

In response to the COVID-19 pandemic, the MSDH Adolescent Health Program staff was reassigned to assist with COVID-19 efforts. The staff, Christopher Russell and Mariesha Eason, joined the Health Equity and Disparities COVID-19 Response Team to assist with resource (adult masks, children's masks, and hand sanitizer) distribution. The team set up systems for inventory management and was responsible for coordinating pick-ups and deliveries of all resources. Since starting in late April of 2020, approximately 2 million face masks and more than 100,000 bottles of hand sanitizer have been distributed to more than 400 organizations.

The Adolescent Health (AH) team also partnered with the University of Mississippi Medical Center School of Nursing and the Woman's Foundation and Teen Health Mississippi to organize a drive-thru resource giveaway for the Georgetown Community in Jackson, distributing more than 8,000 masks at the event.

Additionally, the COVID-19 Youth Engagement Team was created. The COVID-19 Youth Engagement Team is a collaboration between the AH program, the Jackson Heart Study, and the Health Equity and Disparities COVID-19

Response Team. Initially, this project was to reduce the spread of COVID-19 by engaging youth groups (specifically mayoral youth councils) to receive feedback from youth for the development of a strategic plan that would promote youth-led COVID-19 prevention efforts around the state. Youth were engaged through virtual townhalls. From their feedback, an action plan was developed. This action plan has been shared with the youth and youth group advisors. To date, six youth councils have participated in youth-led COVID-19 prevention activities. These groups have participated in creating PSAs, community resource (face mask and hand sanitizer) distribution, creating senior care packages, food drives, and information dissemination.

Although COVID-19 was a critical public health issue this year, the Title V MCH program will continue to develop plans, monitor the effectiveness and ineffectiveness of activities, and examine key processes to address emerging public health issues.

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

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$9,170,542	$9,618,031	$9,235,413	$10,918,076
State Funds	$6,877,906	$6,877,906	$6,926,560	$6,926,560
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$1,465,388	$1,465,388	$774,608	$774,608
SubTotal	$17,513,836	$17,961,325	$16,936,581	$18,619,244
Other Federal Funds	$104,101,300	$3,811,000	$3,811,000	$4,300,000
Total	$121,615,136	$21,772,325	$20,747,581	$22,919,244

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$9,228,087	$9,153,279	$9,278,900	
State Funds	$6,921,066	$119,623	$6,959,175	
Local Funds	$0	$549,527	$0	
Other Funds	$0	$3,171,965	$0	
Program Funds	$273,030	$3,079,950	$216,034	
SubTotal	$16,422,183	$16,074,344	$16,454,109	
Other Federal Funds	$4,300,000	$583,281	$4,625,000	
Total	$20,722,183	$16,657,625	$21,079,109	

	2023	
	Budgeted	Expended
Federal Allocation	$9,272,183	
State Funds	$731,224	
Local Funds	$1,095,262	
Other Funds	$3,871,552	
Program Funds	$1,256,100	
SubTotal	$16,226,321	
Other Federal Funds	$113,758,690	
Total	$129,985,011	

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 for FY 2021 was $16,657,625 of which $9,153,279 (56 %) is Title V and $6,921,065 (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 and infants were expended as follows for FY 2021: $2,786,825 for federal funds (30% of the total federal award); $4,952,695 for non-federal funds (71% 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 program were expended as follows for FY 2021: $2,779,687 for federal funds (30% of the total federal award), $521,259 for non-federal funds (8% 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 Blake Clinic will discontinue direct care services and place emphasis on providing supportive services such as family-centered care coordination, travel reimbursement and respite care services. 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 needs are budgeted as follows for FY 2020: $2,754,651 for federal funds (30 % of the total federal award), $1,447,111 for total non-federal funds (21% of total non-federal funds).

Administrative Costs
Administrative costs expended thus far are $832,116, 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 2021 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, Perinatal High-Risk Management 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 FY23 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 FY23 budget complies with the state match as below:

- FY23 Anticipated Federal Allocation: $9,272,183
- FY23 Budgeted State Match: $6,954,138.

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.

- Comprehensive Opioid Abuse Site Program (COSSAP) and Comprehensive Opioid Overdose Reduction Program (CORP) – This funding helps the MSDH coordinate with counties in the state to work with women with substance use disorders, who need treatment, prenatal care, and/or other resources to connect them to systems of support with both short and long-term interventions.

- Family Planning – This extended funding coordinates with child and women's health programs to educate adolescents, women, and men about preconception and preventive health. The program provides contraceptive access and refers participants to other needed programs and services.

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 leading and support 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 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.

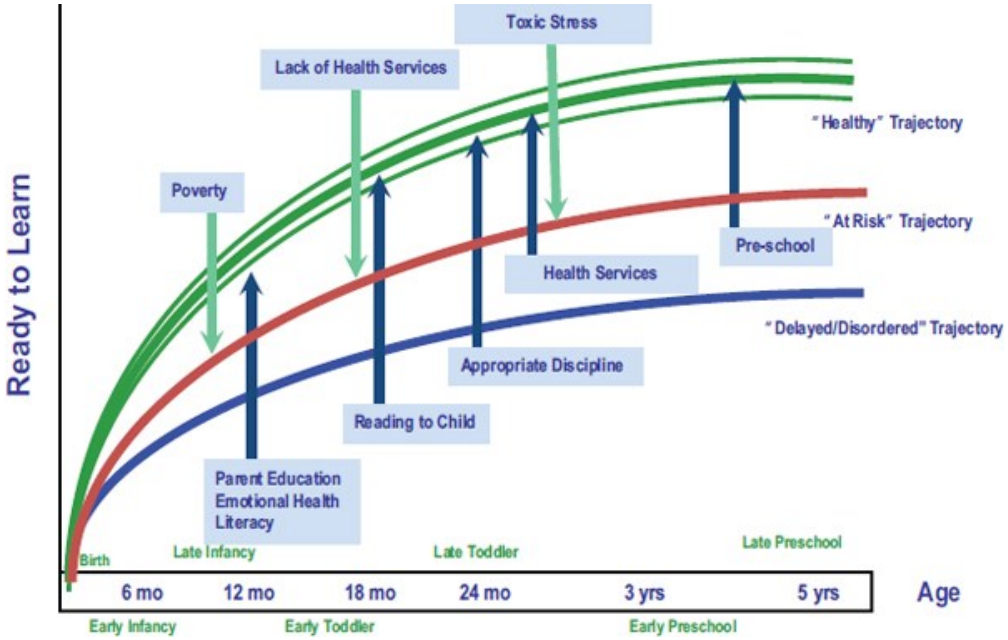
The Maternal and Child Health Advisory Board is composed of 13 members, external partners, medical professionals like pediatricians, family representatives of both children and children and youth complex health care needs, and adolescents. The role of the advisory board is to promote the health and well-being 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, 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.

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

Address the Social Determinants of Health

- Reduce Poverty
- Increase Educational Attainment

Strengthen Public Health Infrastructure

- Create a culture of health
- Improve access to care
- Shared public health agenda

Improve Health Status and Reduce Health Disparities

- Improve mental health

- Reduce rates of chronic disease
- Improve sexual health
- Improve infant health

UProot: Building a Healthier Mississippi from the Ground UP

In 2019, the SHIP was further narrowed from nine priorities to four with the release of *UProot: Building a Healthier Mississippi from the Ground UP*:

- Increase Educational Attainment
- Create a culture of health
- Reduce rates of chronic disease
- Improve infant health

For more information about the SHIP, link to the UProot Mississippi website by clicking here (https://uprootms.org/).

Training and Professional Development Needs

Since the beginning of the COVID-19 pandemic, the agency has undergone staff changes that have called for ongoing training for both new and existing staff members to better support them in performing effectively in their roles. It has been recognized that for programs, not just the Division of Health Services which houses the MCH program, to serve the community effectively, the needs of our staff will have to be addressed at the agency and program level. Many programs have begun exploring new methods for ongoing professional development, including the individual coaching, virtual Grand Rounds, EHDI-MS Virtual Conference, and Early Intervention online credential.

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 Programs. With the new program, MSDH is looking to improve its programs and MCH health outcomes by:

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

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

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

MSDH plays a critical role in advancing the health and well-being of our state. The communities we serve depend on a diverse, skilled, and highly motivated public health workforce. However, MSDH faces a myriad of workforce challenges including building ethnic and racial diversity; recruiting and retaining qualified employees; personnel shortages and anticipated retirements; nursing shortages; improving training, education, and credentialing; and ensuring an environment that fosters worker satisfaction and effective service delivery. With the increased demand for public health professionals, it is imperative for MSDH to expand the scope and reach of public health by investing in a more diverse, competent, and skilled workforce. The state of Mississippi is divided into three Public Health Regions and each Public Health Region is overseen by a Regional Administrator who collaborates with a Regional Health Officer. Regional Administrators manage the county health departments in 80 of the 82 counties. The most recent Human Resource internal review reported that the average number of years of service is 10.5 years and the average employee age is 48.18 years. As of FY2021, 10.2% of MSDH employees are eligible for retirement, and 16% are eligible for retirement in the next 5 years. The FY2021 turnover rate at MSDH is 17.5%, 68% of which were due to retirements.

Creation of the MCH Workforce Development Office

MSDH's Office of Health Services established the Maternal and Child Health (MCH) Workforce Development Office in July 2021. This office is responsible for assessing, coordinating, and providing the Health Services/Title V staff and interns with foundational knowledge about public health, maternal and child health, and health services. The office is focused on developing educational and training modules and opportunities for professional development, looking at the current and future needs of the workforce. A total of three and a half personnel is designated to the MCH Workforce Development Office. Upon creation, program staff began orienting themselves to workforce development concepts through self-paced learning, on-line training courses, and review of online workforce resources such as MCH Navigator and Public Health Regional Training Centers. The Workforce Development Office is creating a manual, logic model, orientation packet, survey, and seeking to identify additional funding sources to support the office. The survey will serve as a baseline regarding identification of who makes up the Health Service Staff; who makes up the MCH staff; what training needs do the staff have; and what are the staff's perceptions regarding the workplace culture (Diversity, Equity, and Inclusion) and their role within the work of the agency.

Internship Opportunities with Maternal and Child Health

The MCH Workforce Development Office provides guidance for the student internship process for several of the MCH/Health Service offices. The purpose is to enhance the agency's access to student interns and support the development of future public health professionals. As part of this process, the office renewed two Memoranda of Understanding with two Mississippi institutions of higher education: the Schools of Social Work at Jackson State University and the University of Southern Mississippi.

Several MCH programs hosted residents and interns during FY21. These programs increase the MCH workforce, while students learn about MSDH Health Services, MCH and public health. The following are the various programs and a summary of the intern's experiences.

In the winter 2020/2021, the Maternal and Infant Health Bureau staff and three master's level students from Harvard University's T.H. Chan School of Public Health participated in the two-week CDC-Harvard Evaluation Practicum Project. The purpose of this project was to provide students the opportunity to integrate and apply public health knowledge and skills learned in the classroom to real-world public health problems. The students worked with the

Maternal and Infant Health Bureau staff to develop an evaluation plan to the MSDH project, Sisters United. This project was designed to support community programs aimed to promote equity in birth outcomes and to further the MSDH's efforts to reduce infant mortality in the state.

The Public Health Pharmacy also works to increase workforce capacity through a pharmacy resident program. Each July, the Public Health Pharmacy hosts two residents from the University of Mississippi School of Pharmacy. Residents in the Pharmacy Program are exposed to the following learning opportunities: Specialty Pharmacy Practice (HIV, Tuberculosis, Disease Outbreak), Health Protection (Emergency Planning and Response), Women's Health, Maternal and Child Health, Chronic Diseases, Antibiotic Stewardship, Telehealth, and Community Pharmacy Practices. In addition, the Pharmacy residents participate in a number of activities beyond pharmacy staffing, such as academic detailing for the lead poisoning prevention program, the pharmacy's opioid program, and antibiotic stewardship, participating in emergency planning and response, assisting with diabetes self-management education and support, and conducting an analysis of HPV vaccination rates among Mississippi youth 11-17 years.

The agency hosts third year medical students from the University of Mississippi Medical Center for two-week rotations to show the students the broad scope of public health as it relates to the individual and community, particularly the medically underserved, and expose the students to the various programs and services provided by the MSDH. Additional opportunities include a tour of the public health laboratory, participation in TB outreach activities to the homeless, restaurant and wastewater inspections, disease intervention investigations, and involvement with some direct patient care programs.

The Office of Oral Health hosted three interns within their program. One was a Dental Hygiene Student with the University of Mississippi Medical Center's School of Dental Hygiene whose focus was on oral health and pregnancy related issues. This intern worked for 20 service hours where she helped with dissemination and distribution of oral hygiene products and completed a literature review on dental health and pregnancy. The second intern was from Tougaloo College and 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 and is now one of the MSDH DAT Scholarship Recipients. The third intern was from Jackson State University's School of Public Health. This intern would like to attend dental school. Currently she is a teacher and working on finishing a Master's degree in Public Health. While in the Office of Oral Health, her project centered around learning more about the Brush, Book, Bed program. Due to her short internship, the project was not implemented.

- The MCH Pediatric Consultant was the preceptor for a graduate student from the Master of Science in Public Health program at Meharry Medical College.
- 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.

Interagency Collaboration on Workforce Development

The Early Intervention Program has had a multiyear engagement with partners in the Mississippi Department of Education, Institutions of Higher Learning, the Mississippi Department of Human Services, and Head Start to implement a multidisciplinary leadership team for a comprehensive system of personnel development (CSPD). In 2020-2021, a new leadership team, receiving intensive technical assistance from the Early Childhood Personnel Center, a technical assistance center funded by the Office of Special Education Programs, continued to work to develop a new comprehensive state plan for educating early intervention and early childhood special education providers and related health professionals. The CSPD looks at personnel standards, preservice and inservice

education, recruitment and retention, and evaluation of personnel. As a part of this effort, a new Early Intervention master's degree program was implemented in the state and an entry-level credential for all early intervention personnel was developed.

Workforce Training and Development

MSDH and Division of Health Services are committed to creating a learning culture where not only employees have access to professional development opportunities and resources, but health care providers and community partners have the same access. The overall goal is to build competency and capacity across the state. Training opportunities are provided for departmental employees, public health partners and community members. These opportunities result in strengthening the skills and knowledge to deliver high quality public health services. MSDH programs sponsor trainings or annual conferences for internal and external partners to receive updates on programmatic policies, research, best practices, and data. Some examples are listed by sponsoring offices below.

In FY21, nine MCH staff members participated in internal and external trainings to help improve their knowledge of Motivational Interviewing (MI) to support and enhance the Overdose to Action (OD2A) pilot case management program and learn more about this best practice to strengthen their skills for case management services. Working with an external partner, MSPHI, several staff participated in a day-long training in February 2021 with monthly follow-up sessions. For the following 10 months, the cohort of staff participated in one hour "booster" sessions on various MI topics: Four Fundamental Processes, Ambivalence, OARS, DARN, CATS, and use of the 1-10 rating scale. Internally, the staff participated in monthly learning sessions, giving employees the change to reinforce knowledge provided by MSPHI, discuss use in their daily work activities, and support the growth and development of staff. Additional training on Motivational Interviewing (MI) was provided by the Southeast Addiction Technology Training Center at Morehouse School of Medicine to supplementary staff to introduce the concepts and to encourage other programs to incorporate MI in their programs.

The Health Services Director invested in continuous workforce development and provided coaching services, via an Organizational Change Coach, as an essential tool to grow skills and develop tools to enhance organizational successes. During FY21, the Organizational Change Coach provided fourteen group trainings for Health Service Leadership and 67 individual coaching sessions. The individual sessions are for employees to develop a Coaching Action Plan customized to address the employee's needs, including training, guidance, and education with the goal to positively impact on the job performance and skill development. The Coaching dialogue is a give-and-take between the Coach and the Employees in which the employee freely shares his or her concerns, struggles, perceptions, doubts, mistakes, and successes so that together, they reflect on what is happening to dictate trainings, tools, and an education plan using best practices and proven practices to influence effective coaching outcomes. This coaching, holistic approach helps employees to self-actualize, develop their own expertise, build on existing skill sets, apply new approaches, and build confidence.

The Office of Human Resources and Office of Health Data, Operations and Research provides monthly Grand Rounds, which provides trainings and webinars to staff on topics such as cultural competency and the use of various databases used within the agency. Sessions have been held via zoom for all MSDH staff to participate and included topics such as REDCap – What is it and How it Can Be Used?; Adverse Childhood Experiences in Mississippi, An Exploration of BRFSS Data; and Overview of the Mississippi COVID-19 Vaccine Confidence Survey: insights into who is hesitant, why, and how surveyed hesitancies compare with actual vaccine uptake. Through these opportunities staff have enhanced their knowledge regarding the various public health and tools topics.

The Office of Women's Health, Breast and Cervical Cancer Program provided six different trainings to BCCP community providers regarding program forms, policies, and procedures. In addition to the virtual training, the

program provided all the BCCP community providers with a follow up compiling of question and answer from the six trainings. For MSDH staff who were not able to attend the trainings, the BCCP program worked with federal partners and internal MSDH Office of Communications to develop an unpublished link on YouTube for recordings of the trainings. MSDH staff can access this training through the unpublished link.

The newly formed Maternal and Child Health/Title V Advisory Board hosted three different trainings for the newly appointed board members and MCH staff. The topics included MCH 101 webinar, review and adoption of by-laws, presentations from Health Service programs and family engagement presentations.

The Oral Health Program spent time this year completing employee trainings, community trainings, and trainings for health care providers. The employee trainings focused on related knowledge and skills regarding oral health subjects, new information and research updates. Besides monthly professional development trainings for internal staff, the Office of Oral Health provided community members trainings on the following topics: Dental Hygiene 101 and Cavity Free in MS Oral Health training. To address the dental provider shortage, the Office of Oral Health Director, Dr. Filzen, partnered with Dr. Sreenivas Koka, the new Dean of the UMMC school of dentistry, to leverage funds to support dental student rotations, which allowed dental students to gain hands-on experience in the clinics in underserved communities throughout the state. Scholarship opportunities were also offered to dental students to better prepare students for the Dental Admissions Test (DAT).

The EHDI program provided multiple activities focused on improving the capacity of the MCH Workforce, including access to state and national annual conferences, trainings, and other learning opportunities. In 2021, the EHDI-MS offered a three-day virtual conference targeting screening, diagnostic, and intervention personnel, as well as families, advocates, and related health and education fields. The conference featured national speakers including Dr. Johnnie Sexton, The CARE Project, Inc., and Janet DesGeorges and Sara Kennedy, Hands & Voices. In addition, the conference featured 12 additional general and concurrent sessions. The conference was attended by over 162 MCH providers, making it the largest conference to date with over 40 first-time attendees. In addition, the program provides targeted technical assistance to support the MCH workforce in implementing best practices.

The Maternal and Infant Health Bureau (Perinatal and Infant Health) office facilitated the viewing and participation in the Birth Equity Elevation three-part series held June 10th, 17th, 24th and 25th, 2021 for interested MSDH staff and external partners. This series was facilitated by Dr. Karen Scott of the Birthing Rigor, LLC, who at the time was the Associate Professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences with a joint appointment in the Department of Humanities and Social Sciences at the University of California, San Francisco (UCSF) School of Medicine. She implemented the Birth Equity Elevation Series which was developed from the SACRED Birth Study. The SACRED Birth Study is the most culturally and scientifically rigorous perinatal Patient Reported Experience Measure of Obstetric Racism © (PREM-OB Scale©) that operationalized reproductive justice, research justice and black feminism in survey development and validation through application of four modalities of culture rigor. Mississippi had four hospitals which participated in this study: University of Mississippi Medical Center, Merit Health Hospital, Greenwood Leflore Hospital and Baptist Hospital – Golden Triangle. They were invited to participate in the three-part series and final day summit. The 3-part series concluded with Dr. Joia Crear-Perry, Founder and President of the National Birth Equity Collaboration hosting a summit which addressed solutions to support Black Maternal Health in Mississippi and eliminating inequities through systematic and obstetric racism, advancing respectful care, and centering the voices of black mothers. A total of 36 participants attended this virtual summit.

The Title X Comprehensive Reproductive Health program offers an ongoing Colposcopy Mentoring Program/Training provided by the American Society of Colposcopy and Cervical Pathologists (ASCCP). This

project has been very successful in facilitating access to care for clients who have abnormal Paps and addressing transportation barriers to care by reducing the need to travel long distances for services. In additional, the Title X Comprehensive Reproductive Health program provides yearly training to all Title X staff per the requirements under the “annual training requirements for all family planning staff working with family planning clients and family planning programs.” Topics include but not limited to: voluntary and non-coercive services, personnel awareness, cultural competency, confidentiality, and non-discriminatory services. the program uses a virtual platform for the trainings.

The WIC program provided community vendor trainings for grocery and pharmacy WIC vendor authorization, including policies, procedures, and responsibilities for WIC vendors. A total of 13 trainings occurred with 33 grocery stores and pharmacies. WIC also provided trainings to all 248 WIC staff regarding the implementation of eWIC. Within the WIC office is the MSDH Breastfeeding Bureau. This Bureau partnered with the Mississippi Breastfeeding Coalition and MSPHI to implement an International Board of Lactation Consultation (LBCLC) Mentorship and Scholarship program to benefit 20 WIC peer counselors. They received assistance with training and study materials. Eight of the 20 will be sitting for the exam in Spring 2022. The other twelve will continue in the training program. The goal is to increase patients’ access to certified lactation consultants.

The CYSHCN program provided professional development through monthly technical assistance calls to CYSHCH Cares 2 Initiative parent consultants and care coordinators. The professional development topics included how to use the electronic reporting tool to document client encounters when clients come to an MSDH clinic, or the parent consultant and/or care coordinator is completing a follow-up call/encounter. The CYSHCN program provides new parent consultant and care coordinators with an orientation training.

The Healthy Moms/Healthy Babies of Mississippi program (formally called Perinatal High-Risk Management / Infant Services System – PHRM/ISS) has a partnership with Teen Health Mississippi (THMS), which developed a five-part training series using medically accurate and evidence-based information for the course. This training was provided to 162 individuals within 37 different community partner agencies. The topics include provider self-awareness and values in working with expectant and parenting teens (EPT), building rapport, and trusting relationships with EPTs, using trauma-informed approaches when serving EPTs, confidentiality, informed consent, and tips for making effective referrals. The funding for this partnership/training was offered through the Pregnancy Assistance Program Grant and ended June 2021.

As the PHRM/ISS transforms into the Healthy Moms/Healthy Babies of Mississippi program, the program staff are working to develop provider specific trainings and orientation for new and existing staff. Strategic plans and protocols are being developed, recruitment strategies to address the shortage of nurses are being crafted, 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. Beginning the 1st quarter of the next grant cycle, Healthy Moms/Healthy Babies of Mississippi will begin to implement new evidence-based and evidence-informed approaches. The overall goal is to increase capacity, training, and accountability to better serve pregnant women and infants in the state of MS.

The MSDH Quality Improvement Office provided MCH staff the opportunity to participate in trainings focused on the QI process. They were designed to be light, entertaining, and interactive for the engagement and retention of the QI process. The trainings introduced group activities to demonstrate the general benefits and reasoning behind quality improvement, provided the introduction of eleven analytical tools and group activities for hands on learning. Over the course of the year, there were 250 participants in the QI Introduction Training and 135 in the QI Intermediate Training.

The Office of Tobacco Control (which is no longer in Health Services, but still an important internal partner in MCH) provided all funded partners and stakeholders with information and training as applicable regarding tobacco control initiatives that address maternal-child health. All trainings, including the Tobacco Treatment Specialist Workshops,

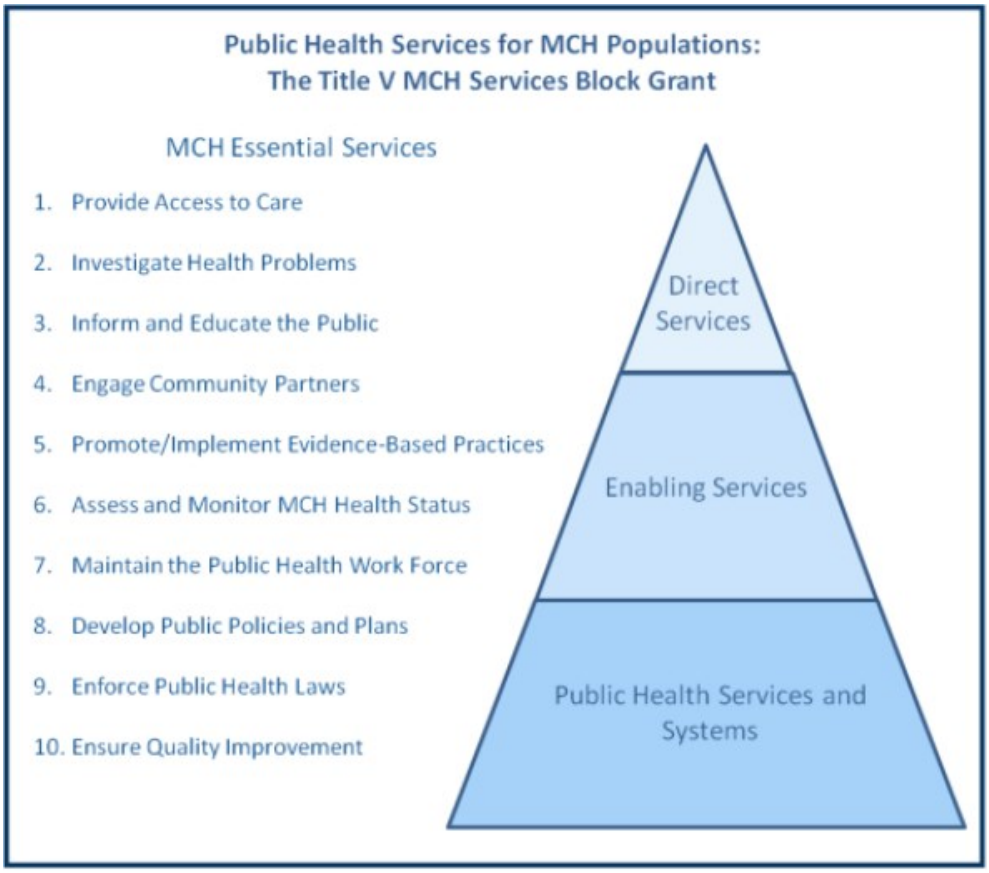
are based on the U.S. Public Health Service Guidelines for Tobacco Cessation, and include, pharmacotherapy updates, treating disparate populations, pregnant women, etc. These trainings ensure that all staff have a sufficient level of awareness, skills, education, and resources to effectively implement programmatic activities that impact tobacco prevalence. In addition, the Office of Tobacco Control hosted the 2021 Virtual Vaping Summit. For the first time, this summit was recorded to be viewed outside the dates of the training. This allowed for more participants than those scheduled for the original summit. Of the 597 participants in the 2021 Virtual Vaping Summit, 173 participants (28.9% of participants) joined the Virtual Vaping Summit by watching the recordings later.

The Genetics program held six virtual newborn blood spot collection trainings in the spring and fall for hospital and health department staff focusing on proper specimen collection and timely transit to improve the quality of screening and reporting. Previous Genetics program staff trainings were held in person; however, the May 2020 training was the program's first attempt at hosting virtual training because of the pandemic. A total of 111 participants including hospital nursery and laboratory staff, and midwives, attended were one of the trainings. Participants were equipped with information and resources to assist in improving newborn bloodspot specimen collection, reporting, and shipping procedures. Overall evaluations were positive. Results from a pre-assessment reflected 42% of participants did not receive training from their employer on newborn screening and only 26% indicated they were extremely confident with the bloodspot card shipping process. Results from a post assessment indicated 76% of attendees demonstrated a change in knowledge after training. Evaluations from the virtual trainings will inform the planning of subsequent trainings are planned to be held virtually through the agency online learning platform. To measure the long-term effectiveness of the newborn screening program and to determine workforce development needs, the program monitors hospital performance each quarter noting hospitals exceeding or meeting expectations regarding specimen collection as well as those performing less than expected or needing improvement.

MSDH mandates yearly training for all MSDH employees. This training includes annual HIPAA, Privacy Policy Training, and IT Security Policy training. Title V staff were encouraged to attend professional development conferences throughout the year. Staff members 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.

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

Due to the Covid-19 pandemic, MCH programs have been limited in their ability to conduct face-to-face activities. However, MCH programs have utilized various social media platforms to educate and strengthen family voices throughout their work. Programs such as Oral Health 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).

Family/consumer voices have also been instrumental in guiding MSDH in developing family centered programs, policies, and strategies. In 2021, the MCH Engagement Coordinator developed two surveys to gain input from families and consumers. In August 2021, the family/consumer survey was established with the intent to survey families and consumers to identify the needs to increase recruitment and retention of families in MCH program. The family/consumer engagement survey will be used to assess the level of engagement families are interested in and the needs of families to gain buy-in and establish relationships with families needed to create family-centered programs. In addition to the family engagement survey, a public input survey was created to allow families and consumers to provide feedback regarding Title V program services and priorities.

Contractual Relationships with Family Organizations

In 2020-2021, Mississippi Early Hearing Detection and Intervention (EHDI-MS) Program established a new family support program, involving Family Advisors, who are parents of children who are DHH, and DHH Role Models, who are adults who are DHH using a variety of communication modalities. Six Family Advisors and two DHH Role Models were identified, trained, and engaged in contracts to provide peer-to-peer support for families of infants and toddlers with confirmed hearing loss. Initial contacts by Family Advisors are focused on providing emotional and informational support and connecting families to larger support systems. Families are also offered opportunities to meet with DHH Role Models who can share with families their life experiences, challenges, and successes growing up as a child with hearing loss to offer an additional perspective. These supports are essential as 95% of parents of a children with hearing loss have no family history of hearing loss and are often unfamiliar with Deaf Culture.

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.

MSDH provided enhanced, teen-focused PHRM/ISS services in 15 counties as proposed in the PAF grant

application. Services are provided through case management staff stationed in county health departments. Those staff members serve as “teen specialists” to provide teen-focused direct services and to provide consultation on best-practice approaches to serving expectant and parenting teens for third party-reimbursed staff in the additional 67 counties. Each staff member received in-person training on interactions with expectant and parenting youth and providing interactive health education. Existing MSDH-funded staff in the counties provide an enhanced version of MSDH’s traditional model of case management to the PAF grant target population. This approach allows for a broader program reach of all 82 Mississippi counties. The traditional case management program incorporates a wrap-around team model, nurse, nutritionist, and social worker, addressing the needs of the expectant teen, the parenting teen, the high-risk infant, and the family.

The Maternal and Infant Health Bureau established a 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 Mississippi Perinatal Quality Collaborative partners with birthing hospitals throughout the state of Mississippi to elevate and implement safe and quality care to birthing persons. Specific activities implemented by the MSPQC and MMRC include hosting four birth equity trainings, dissemination of home monitoring blood pressure cuffs kits, implementing safety bundles within hospitals on severe Maternal Hypertension in Pregnancy and the Initiative to Support Vaginal Births, providing education on the development and use of birthing plans, hosting events in which doulas provide education to mothers, initiating community-based partnerships that increase health literacy, enhance postpartum care coordination, mental health support, anti-racism education, and education and resources distribution.

The Office of Oral health has also used family engagement practices to build protective factors against poor dental health through education and outreach. Through their collaboration with WIC, the Office of Oral Health provided 765 WIC participants and their children received with Oral Health 101 training as well as oral health kits which include an

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, oral health services were provided to:

- Jackson County WIC -100 OH kits for kids, 50 OH kits for adults and Health Smiles Brochures in English and Spanish. (November 2020)
- Hinds County WIC – 20 OH kids kits and dental referrals. (January 2021)
- Lincoln County and Copiah WIC – 75 OH kids kits each. (February 2021)
- Hinds WIC – 192 OH kits, Immunization (86 kits), Family Planning (17 kits) and TB (7 kits) – March 2021
- Hinds, Simpson, Copiah, Rankin, and Jackson WIC locations- distributed OH kits (144 tb, 144 floss, 72 training brushes, 72 children's tb, 144 finger brushes to each location). March 2021
- Wilkinson County WIC (25 kits/25 finger brushes/25 training brushes) March 2021
- Warren County WIC (40 kits/40 finger brushes/20 training brushes). March 2021
- Hinds County WIC – 21 OH kits, Immunization (2 kits) – April 2021
- Hinds County WIC – 21 OH kits – May 2021
- Lowndes County WIC (27 participants), Noxubee County WIC (20 participants), & Oktibbeha County WIC (26 participants) & Winston (16 participants) Co. Health Department WIC participants – May 2021
- Lowndes County WIC, Noxubee County WIC, Oktibbeha WIC – June-September.

Dental services were also extended to children who were not enrolled in WIC-covering counties, including Jackson, George, Madison, Jefferson, Harrison, Lauderdale, Hinds, Prentiss, and Scott counties.

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.

Advisory Committees

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 representation, 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.

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.

In 2021, Director of Healthy Moms/Healthy Babies, Jillian Harper, has begun the process of recruiting families and consumers in establishing a Maternal and Child Health advisory board. This board will work in conjunction with Health Services' general Maternal and Child Health Advisory Board with more emphasizes on addressing birth equity and other perinatal and infant health outcomes. In contrast, the General Maternal and Child Health Advisory will assist 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

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.

In the summer of 2021, the Office of Oral health reconvened the Community Water Fluoridation Advisory Board Committee to better strategize on ways to improve acceptance of community water fluoridation in our 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 works in close collaboration with the Office of Environmental health to share the benefits of community fluoridation. As a result, a community water fluoridation liaison was hired to work more closely with the Office of Environmental Health. Oral Health is also working on a community water fluoridation plan and planning a few town hall meetings to discuss this program with community partners in hopes of increase the rates of fluoridation across the state as only about 40% of Mississippians are receiving fluoridation water which is below the Health People 2030 goal of 77%.

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

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

The MSDH epidemiologic workforce in the Office of Health Data and Research (OHDR) 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 seven 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, sexual harassment, security, human subjects research, EPIC (for those using the EPIC health electronic records), emergency preparedness training, and implicit bias training. MSDH also supports and encourages additional training and skills building opportunities for analytic skills.

Over the past 2-1/2 years, the MSDH non-communicable epidemiologic workforce has faced numerous challenges. Many of the epidemiologists were on orders and providing either full-time or part-time assistance on pandemic-related activities. As pandemic-related needs eased, MSDH experienced what many other public health departments have across the nation—some epidemiologists returned to their former primary work activities, some transitioned to new positions within the agency, and many left the agency. This transition of the epidemiology workforce was further compounded by a severe shortage in the workforce. For more than one year, OHDR has been trying to fill approximately 5-7 vacant epidemiologist positions but has been able to hire and onboard only one individual.

In 2020-2021, OHDR reorganized and hired a new office director and three other directors to support the epidemiologists who work on expanding the scope of work that includes maternal and child health, oral health, chronic disease prevention within the MCH population, injury prevention, behavioral health, rural health, population surveillance, REDCap administration, data visualization, Epic data and reporting, and evaluation. This reorganization and expansion reflect the more complex and varied work of MSDH and the need for greater epidemiologic capacity and support to existing and new program areas.

Presently, the MCH epidemiology workforce is composed of three full-time epidemiologists and are supported by two surveillance epidemiologists (one full-time and one part-time), and two full-time systems and operations staff. In addition to these state staff, MSDH was assigned an MCH Epidemiologist from the CDC in October of 2020. The state has also been fortunate to match with a CSTE Applied Epidemiology Fellow in 2021. These MCH epidemiologists, surveillance epidemiologists, and technical staff support MCH-related analytic activities spanning oral health, WIC, newborn screening / birth defects, early hearing detection and intervention, early intervention, lead prevention, infant mortality, child mortality, maternal morbidity and mortality, home visiting, family planning, breast and cervical cancer prevention, BRFSS, PRAMS, and the Title V Block Grant application and needs assessment activities. In addition, these staff also assist in responding to data requests and grant writing. The need for additional MCH analytic support is clearly recognized.
OHDR recommends that MCH epidemiologists use the MCH Navigator, access AMCHP, ASTHO, HRSA/MCHB live and archived training materials as well as the course in MCH Epidemiology Training (both archived materials and applications to future training opportunities). Through AMCHP, ASTHO, MCHB, CSTE and CDC, many MSDH epidemiologists are taking part in training and hands-on learning opportunities.

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

Overall Accomplishments and Barriers

In 2019, the State Health Officer created the Offices of Health Data, Operations and Research (HDOR), which includes: Data Governance; EPIC (electronic health record); Health Data and Research (non-communicable disease epidemiology); Information Technology Operations; Information Technology Security; Information Technology Support; Revenue Cycle; and Vital Records and Statistics. This reorganization and expansion reflect the more complex and varied work of MSDH and the need for greater data capacity and support to existing and new program areas.

With the creation of HDOR, the Title V Director, MCH program staff, OHDR and SSDI staff have expanded and maintained a productive partnership dedicated to supporting MCH programs. Data Governance has established processes for requesting and sharing data. A renewed partnership with the Office of Vital Records and Statistics has enabled better data sharing of the critical data needed for many of the MCH programs. Many of the legacy data systems in Health Services have been replaced by EPIC. This transition allows MSDH to have a singular, unified electronic health record for individuals that MSDH serves across the agency. Data can then be pulled for surveillance and program reports. The Revenue Cycle and EPIC teams also assisted in further strengthening the relationship with the Mississippi Division of Medicaid by implementing UView, a state-of-the-art chart review platform within the agency's electronic medical record system, EPIC. The Revenue Cycle and EPIC staff were able to improve the quality and functional use of maternal and child health records at MSDH and to better partner with data exchange with the Division of Medicaid.

The SSDI funding continues to provide software, hardware, and professional development opportunities for analysts and staff in OHDR to advance data capacity. MSDH continues to make modernization, data accessibility and collaborative evidence-based approaches a focus of efforts to enhance the capacity to obtain and use critical maternal and child health data in Mississippi.

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 the building of Mississippi MCH data capacity to support Title V program efforts and contributes to data driven decision making in public health and clinical programs. This includes needs assessment and Title V MCH Block Grant data support, identification of structural and process measures for 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:

- Provide data support to MCH programs;
- Provide data support for the Title V Block Grant application and reporting processes;
- Develop/review structural/process measures;
- Implement a statewide Needs Assessment for the Title V Block Grant;
- Establish/review performance objectives for all measures; and
- Provide data and technical support for timely and accurate submission of the Title V MCH Block Grant.

Activities in the previous year focused on implementing and analyzing the Title V Needs Assessment, identifying priority needs, selecting national performance measures (NPMs) and state performance measures (SPMs), developing Evidence-based Measures (ESMs), and expanding partnerships with community public health, clinical, family, patient, and academic partners.

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 MCH/SSDI leadership and partners identified state priorities not addressed by the existing Title V NPMs. MCH/SSDI epidemiologists and program managers assisted MCH program staff in revising the existing NPMs, developing new SPMs and ESMs to align with new priorities. MCH/SSDI epidemiologists also provided epidemiological and statistical support for MCH programs to establish SMART performance objectives for all the MCH Block Grant measures. After finalizing the objectives, MCH/SSDI epidemiologists and program managers recommended the objectives to the State Title V Director for inclusion in the MCH Block Grant.

During the previous grant cycle, the Title V/SSDI workgroup convened to review their existing ESMs and develop new ESMs or revise the current ESMs based on their capacity. Through several meetings, Title V/SSDI work group and partners decided to retire some of the existing ESMs, and proposed new ESMs based on 2020 need assessments results. The current ESMs are being reviewed to assess fit for NPMs and determine if the ESMs align with program priorities and staff capacity.

The Title V/SSDI workgroup provided epidemiological and statistical support for MCH programs to establish SMART performance objectives for all the MCH Block Grant measures. This involved: reviewing recent Mississippi trend data and comparing to Healthy People 2020 objectives, where available. If no Healthy People 2020 objective was available for a specific measure, 1.0% annual relative growth compared to the previous year was determined as a target. After finalizing the objectives, Title V/SSDI epidemiologist and programs' director recommended the objectives to the State Title V Director for inclusion in the MCH Block Grant.

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 focus on improving its collaboration with internal and external partners. The goals are to identify existing data gaps to meet the Minimum or Core Datasets (M/CDS), initiate all necessary MOUs to close data gaps and access the data elements necessary to meet the M/CDS, and to implement a new data linkage between birth and death records and hospital discharge data or Medicaid eligibility data; and improve the availability and timeliness of linked MCH data reporting and the utilization.

In previous years, the SSDI epidemiologists supported efforts to obtain access, and make available, minimum or core datasets (M/CDS) through various sources. Many of these indicators are utilized, as needed, for the Title V Needs Assessment and various reporting activities. To meet M/CDS, an assessment to evaluate Mississippi's capacity for reporting on the M/C Indicators was conducted. Much of the data are captured through the Office of Vital Statistics and the Mississippi Department of Medicaid, the two major stakeholders of the MCH programs. To expand SSDI partnerships with the Office of Vital Statistics, no MOU was required. However, to capture data from Department of Medicaid 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 the Division of Medicaid and increase collaboration with internal and external partners to assess data gaps.

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 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.

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

Increasing Data Capacity Efforts

In November 2020, the MSDH Office of Data Governance launched the MSDH Data Request Online Form. This online form provides a centralized method for both the public and MSDH employees to submit requests for data and records managed by the agency. The online form enables the agency to track where and how agency data is being shared and used. Because of this, the MCH staff will be able to collaborate across programs throughout the agency in sharing and obtaining data.

MCH Epidemiologist / CDC Assignee

In October 2020, MSDH was assigned a Senior MCH Epidemiologist from the Centers for Disease Control and Prevention (CDC). Since coming to MSDH, Dr. Kasehagen has been working in the Office of Health Data, Operations & Research (HDOR) to: (1) facilitate HIPAA secure virtual environments for epidemiologists where they can maintain and analyze data; (2) inform data governance regarding data standards and data sharing; (3) review and provide scientific oversight of analyses and analytic products of the epidemiology staff; (4) provide technical assistance to program staff and epidemiologists on grant or cooperative agreements, data analyses, evaluations, and performance and outcome monitoring; and (5) provide technical assistance to MSDH on the review and design / selection of a pregnancy care coordination program and an evidence-based case management program for pregnant women, postpartum women and infants to replace the state's current case management program. Dr. Kasehagen revised standardized process and outcome measure definitions and a standardized report to the state's Division of Medicaid; reviewed and developed the infant mortality report for 2019-2020; conducted a perinatal periods of risk analysis for the state overall and by race-ethnicity in 2021; analyzed data from the state's Vaccines for Children database on human papillomavirus (HPV) vaccination in 2020-2021; and assumed the preparation of reproductive health / family planning data for federal and Division of Medicaid reports. Dr. Kasehagen also leads a racial equity project that will improve how hospitals consistently collect race and ethnicity data and develop a standardized process for data aggregation / disaggregation and guidelines around the use and reporting of small numbers. In addition, Dr. Kasehagen sits on the Mississippi Maternal Mortality Review Committee and conducts analysis of MMRIA data, analysis of hospital discharge data on severe maternal morbidity, collaborates with external and internal partners to provide data to support AIM-related performance measures, conducts analyses on infant and maternal morbidity and mortality and adverse experiences, and mentors staff on analytic methods and communication product design and development.

CSTE Applied Epidemiology Fellow and Epidemiology Interns

In her role as a CDC assignee, Dr. Kasehagen also is responsible for building epidemiologic capacity. Three universities in Mississippi (University of Southern Mississippi, Jackson State University, and the University of Mississippi Medical Center) offer advanced degrees in public and population health, epidemiology, and biostatistics. MSDH has a strong working relationship with these universities as well as Harvard University's TH Chan School of Public Health with the Harvard-Mississippi Delta Fellowship in Public Health. OHDR is incredibly successful in bringing in epidemiology interns and persons to learn and support analytic capacity at MSDH. Since her assignment to MSDH, Dr. Kasehagen and her state colleagues have successfully participated in two CDC-Harvard Evaluation Practicums, secured two CSTE applied epidemiology fellows, and two Harvard University epidemiology student interns. In addition, Dr. Kasehagen is mentoring two public health pharmacy residents on their analytic projects in 2021-2022 and will be mentoring four public health pharmacy residents in 2022-2023.

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.

MS-BCCP has expanded its partnerships in more deliberate ways and has identified several already positioned to serve high priority populations. MS-BCCP leadership has leveraged its partnerships with community-based partners, subgrantees, and its expansive participating provider network to make data-informed decisions about which geographic areas and which strategies to use for promoting screenings and early detection. Through their collaboration, the program has obtained a full-time Outreach Coordinator, who is directly responsible for providing training and technical assistance to partners at the community, population-level who have more natural, organic relationships with the women MS-BCCP intends to serve. In June 2021, two mobile primary care providers partnered with two mobile mammography screening units to host events in separate Mississippi cities, allowing women to gain access to breast and/or cervical cancer screening. BBCP partnered with Plan A Health and Mary Bird Perkins Cancer Center mobile clinics to expand breast and cervical cancer screenings to women in rural areas of Mississippi. Women received their initial consultation with Mary Bird Perkins mobile clinic to assess for eligibility for BBCP enrollment. If eligible, women were enrolled in BCCP and received clinical breast and cervical screening. The cost of screenings was covered by Mary Bird Perkins while diagnostic procedures were covered by NBCCEDP funds. Both Plan A Health and Mary Bird Perkins will repeat these efforts in FY2022, offering additional joint screening events with their mobile mammography partners, expanding coverage to other areas. Plan A will be using MS-BCCP subgrant funding to expand its reach into Northeast MS into 4 counties with minimal to no BCCP enrollments for 2+ years. Mary Bird Perkins will use subgrant funding to expand its reach by three additional counties with underutilization of BCCP in Southwest MS. Both organizations, among others, have been selected as subgrantees under a competitive RFP. Internal program enrollment data, claims data, contracted provider locations, and other data sets (cancer incidence, social vulnerability, etc.) have been used to prioritize areas where MS-BCCP partners like Plan A and Mary Bird Perkins can focus their efforts to impact screening rates. The program will be monitoring performance and return-on-investment closely, providing support and technical assistance to assure these partners find success.

The Maternal and Infant Health Bureau collaborates with the Institute for the Advancement of Minority Health to help reduce the rates of infant mortality and pregnancy-related complications. The Institute is currently piloting an intervention to improve maternal and child health outcomes in the Jackson Metropolitan area through education, outreach, and linkage to care utilizing community health workers to reduce infant and mortality by 5% over the next 5 years. The Maternal and Infant Health Bureau also conduct monthly MSPQC team learning sessions / conference call with participating MSPQC facilities to provide evidence-based method to examine fetal and infant deaths,

determines preventability, and engage communities to act in improving infant health outcomes.

In addition, 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 to ensure that 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, those who are identified as low-income (below the federal poverty level), are enrolled in Medicaid. Through Medicaid, parents of children with disabilities or complex healthcare needs are connected to early intervention services offered through our CYSHCN program and EI/Early and Periodic Screening and Diagnostic Treatment program. Women are also able to receive breast and cervical cancer services as well family planning services. Of the 683,577 enrolled in Medicaid, 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 structure.

To transform the health care delivery system, the MSDH MCH programs has 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 its 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 responsibility of both MSDH and DOM in establishing, supporting, and promoting a collaborative effort to coordinate maternal and infant vital records data for research purposes. Maternal and infant mortality and morbidity in Mississippi has continued to be a public threat amongst mothers, infants, and their families. The rates of maternal and infant mortality and morbidity is disproportionately higher amongst Black mothers and infants compared to other races. In this data sharing and usage agreement, both parties will share and utilize appropriate, relevant data to improve the delivery of health care services and health outcomes for MCH and CYSHCN populations.

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 works within a life course framework represented by 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. Using information gathered through the comprehensive needs assessment, the Mississippi Title V/MCH programs identify priority areas, strategies and activities that will allow each program to address the needs of one or more population domains. Ideally, programs work together and contribute to at least one, but possibly several, domains and the strategies and activities work towards common objectives aimed to improve population health outcomes and to decrease risk factors that create barriers to optimal health outcomes. The program teams are responsible for developing action plans, measuring success, implementing the plans, and reporting on progress. All of this should be done collaboratively across Health Services and in conjunction with the advisory board members with team members and board members coming together several times throughout the year. However, in previous years, the objectives, strategies, and activities were developed by each of the programs independently without a common approach for the State Action Plan (SAP).

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 SAP development process needed to be revamped to be more collaborative. This effort was intended to break down siloed practices and increase collective efforts from multiple programs to address shared priorities. 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, the MCH Block Grant Team again discussed the transition from program-focused planning (e.g., EHDI-focused objectives, strategies, and activities) to Domain planning teams which would collectively develop priority-focused plans (e.g., objectives, strategies, and activities shared across programs to increase access to timely, appropriate, and consistent health and developmental screenings).

While the FY2022 SAP moved toward creating a united vision for MCH across Health Services programs, the Block Grant Team had limited opportunities to meet and communicate that vision with each of the programs in Health Services and to facilitate the Domain planning teams, resulting in a continuation of a more siloed approach. The implementation of this new approach to developing the SAP was further hampered by the loss of key staff on the Block Grant Team. In Spring 2022, a new MCH leadership team was formed to guide the planning, development, and implementation of the Block Grant. In creating the SAP for 2023, the new Block Grant Team working with programs to develop the annual report and application discovered the previous SAP did not accurately capture the work of

MCH programs and proposed objectives, strategies, and activities continued to be fragmented and program-specific.

This 2023 application and 2021 annual report represent a transition year for Mississippi. The annual report provides an update on the status of activities in 2021, and the application proposes measures and program activities for 2023. The new 2023 SAP attempts to look across programs and find the common elements that describe how the MCH programs are holistically addressing the priority needs of MCH populations in Mississippi. We view the SAP as a living document and have a plan for further refining the plan by engaging all program personnel and advisory group members. We expect to revisit the SAP's objectives, strategies, and activities and collaboratively create a more durable SAP. Our intention is, by the end of this Block Grant cycle, Mississippi will have a unified approach to improving health outcomes for women, children, and families.

Identified MCH Priorities

The priority needs identified by MCH population domain are listed below (priority needs identified for more than one MCH population domain are indicated with an *). Please note that these may not clearly align with the report or the plan this year.

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

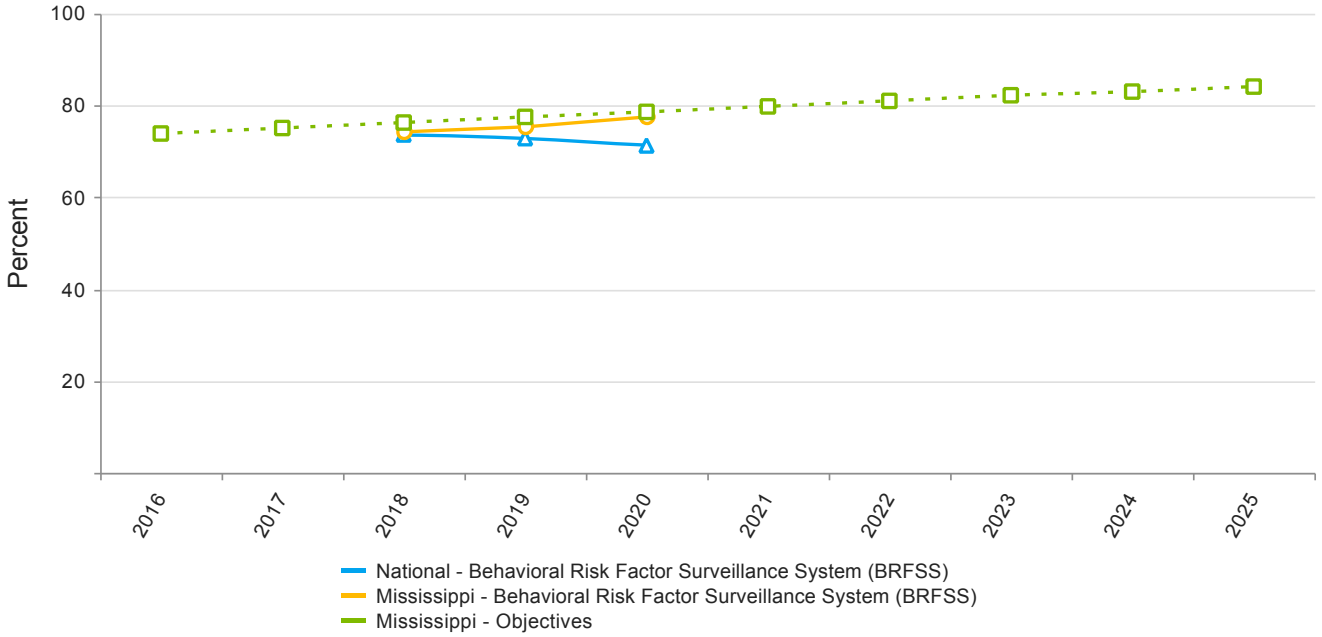
Cross-cutting/Systems Building:

- 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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				78.5	79.7
Annual Indicator			74.2	75.4	77.5
Numerator			389,320	390,297	403,215
Denominator			524,486	517,720	520,497
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	80.9	82.1	82.9	84.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Number of community group and activities program attends and partners with

Measure Status:	Inactive - Completed				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			50	55	60
Annual Indicator			0	100	100
Numerator					
Denominator					
Data Source			0	PHRM/ISS Outreach Marketing Activities sheet	PHRM/ISS Outreach Marketing Activities sheet
Data Source Year			0	2020	2021
Provisional or Final ?			Provisional	Provisional	Provisional

ESM 1.2 - Number of engaged users viewing social media messages delivered by MSDH social sites promoting women's preventive health services

Measure Status:	Inactive - Completed				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			90,202	92,006	93,846
Annual Indicator			0	97,440	30,000
Numerator					
Denominator					
Data Source			MSDH Office of Communications	MSDH Office of Communications	MSDH Office of Communications
Data Source Year			2019	2020	2021
Provisional or Final ?			Provisional	Final	Provisional

ESM 1.3 - Number of social media message months promoting women's preventive health services

Measure Status:	Inactive - Completed				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			9	10	11
Annual Indicator			0	7	7
Numerator					
Denominator					
Data Source			MSDH Womens Health Office	MSDH Womens Health Office	MSDH Womens Health Office
Data Source Year			2019	2020	2020
Provisional or Final ?			Provisional	Final	Provisional

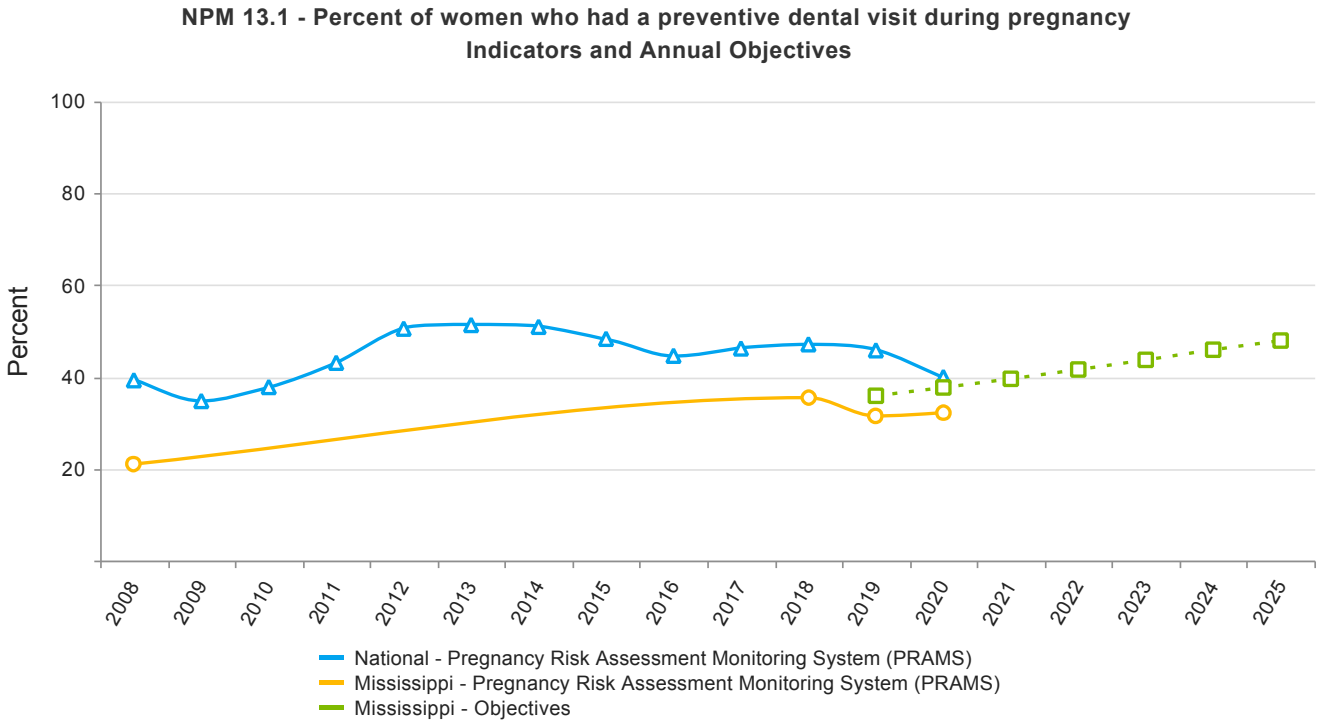
ESM 1.4 - Number of strategies or measures for racial equity related policy, practices and systems changes implemented at the program, division and department level.

Measure Status:	Inactive - Replaced

Baseline data was not available/provided.

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	
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	705.0	776.0	853.0



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			35.9	37.7	39.6
Annual Indicator	21.2	21.2	35.4	31.6	32.1
Numerator	7,953	7,953	12,028	10,696	10,493
Denominator	37,556	37,556	33,953	33,881	32,729
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2008	2008	2018	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			35.9	37.7	39.6
Annual Indicator	31.3	34.2	35.4		
Numerator	10,967	11,784	12,028		
Denominator	34,995	34,483	33,953		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	41.6	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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			600	650	700
Annual Indicator			409	347	0
Numerator					
Denominator					
Data Source			MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	750.0	800.0	850.0	900.0

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

Measure Status:	Inactive - The state has transitioned to eWIC which has resulted in changes to how oral health education is being distributed.

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			20	25	30
Annual Indicator			19	19	12
Numerator					
Denominator					
Data Source			Regional Oral Health Consultant monthly activity l	Regional Oral Health Consultant monthly activity l	Regional Oral Health Consultant monthly activity l
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

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

Measure Status:	Inactive - This ESM was added previously with collaboration with the Prenatal High Risk Management Program which no longer operates in the same way.

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			100	150	200
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

State Performance Measures

SPM 1 - Percentage of women who smoke in the last three months of pregnancy

Measure Status:	Inactive - Replaced

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	10.1	9.6	9.1	8.7	8.2
Annual Indicator	14.7	10.4	11.4	10	9.8
Numerator	5,092	3,521	3,842	3,381	3,197
Denominator	34,646	33,787	33,605	33,797	32,569
Data Source	Mississippi PRAMS	Mississippi PRAMS	Mississippi PRAMS	Mississippi PRAMS	Mississippi PRAMS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

SPM 2 - Reduce Maternal Mortality Rates and Disparities by promoting best practices in clinical care and strengthening the Maternal Mortality Review Committee (MMRC) efforts.

Measure Status:	Inactive - Replaced

Baseline data was not available/provided.

SPM 4 - Percent of women ages 15-44 years old that use family planning services

Measure Status:	Inactive - Replaced	
State Provided Data		
	2020	**2021**
Annual Objective		
Annual Indicator	3.1	2.8
Numerator	18,237	16,237
Denominator	581,196	581,196
Data Source	MS Title X data and March of Dimes	MS Title X data and March of Dimes
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

SPM 5 - Percent of Women ages 40-64 yrs. old screened for cervical cancer.

Measure Status:	Inactive - Women/Maternal Health Domain Team selected a new performance measure to align with activities.

Baseline data was not available/provided.

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

Measure Status:			Active
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
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, 2023, increase the percentage of women who have a preventive dental visit in pregnancy by 5%	
Strategies	
Provide education to women on the 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 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	

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, 2023, increase use of the family planning waiver by 5%

By September 30, 2025, increase access and utilization of quality family planning services in 100% of MSDH county health departments

By September 30, 2025, decrease the percent of women who report smoking during pregnancy by 1%

By September 30, 2023, increase breast cancer screening rates by 10% among Hispanic, African American, American Indian, Asian, and other underserved, uninsured or underinsured women

By September 30, 2023, increase cervical cancer screening rates by 10% among Hispanic, African American, American Indian, Asian, and other underserved, uninsured or underinsured women

Strategies

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

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

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

Implement worksite wellness programs aimed to increase breast and cervical cancer screening

Engage the support of external providers to increase screening among high priority populations

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, 2023, reduce the primary cesarean deliveries among low-risk mothers (NTSV) rate by 10% among participating hospitals

By September 30, 2023, hold 4 multidisciplinary maternal mortality case review committee meetings.

By September 30, 2023, review, synthesize, and disseminate recommendations for maternal mortality prevention

Strategies

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

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

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

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

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, 2023, reduce the percent of severe maternal mortality events related to hypertension by 5%

Strategies

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

Breast and Cervical Cancer Program

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 40-64 years screened for cervical cancer
- ESM 1: # of community groups and activities programs attended and worked with as partners
- ESM 2: # of engaged users viewing social media messages delivered by MSDH social sites promoting women's preventive health services
- ESM 3: # of social media message months promoting women's preventive health services
- ESM 4: # of expectant and parenting teens enrolled in PHRM/ISS program

Strategies and Activities (FY October 1, 2020 - September 30, 2021)

Objective 1: By June 30, 2022, establish a formal system with worksite wellness programs for breast and cervical cancer screenings

Strategy 1: MS-BCCP program staff will work with internal and external stakeholders to implement worksite wellness programs that aim to increase breast and cervical cancer screening uptake by women in Mississippi.

Activity 1a: Request invitation for the new Outreach Coordinator to join/serve on the MSDH Worksite Wellness Committee.

Due to changes brought on by the COVID-19 pandemic to the agency, external partners, and programs, all work plan activities, programmatic workflows, and day-to-day operations demanded continuous assessment and prioritization to assure the most critical and immediate services remained available, accessible, and were provided to the public. For MS-BCCP, the priority continuing into the fall of 2020 centered on ensuring a broad network of participating providers was available to provide cancer screening and diagnostic services throughout the state, that individuals in need were appropriately linked with those services, that data was collected according to CDC expectations, and that providers were consistently reimbursed for the services provided. Additionally, from October 2020 – February 2021, MS-BCCP's Outreach Coordinator role was vacant. This limited the program's ability to implement proposed activities until the new Outreach Coordinator started in March 2021. Shortly after starting, he learned the Worksite Wellness committee is not active within MSDH.

Central Mississippi Correctional Facility hosted a health fair May 4, 2021, in recognition of Correctional Officers Appreciation Week. The Outreach Coordinator participated in the event as an exhibitor and provided literature and discussion around the importance of screening with attendees.

Beginning late summer 2021, the MS-BCCP team began planning multiple worksite wellness activities to recognize October-Breast Cancer Awareness month within MSDH. Among the planned activities, a booth was to be setup every Wednesday during October 2021 in the MSDH main foyer where onsite employees could receive information about MS-BCCP, screening guidelines, and resources available for screenings.

Activity 1b: Research other state programs' approach to worksite wellness activities. Identify 2-3 activities that

could be considered for the MS-BCCP Program.

In the spring of 2021, the Outreach Coordinator researched and used success stories, one-pagers, and other available content from other states' who had successfully implemented worksite wellness activities to garner ideas for MS-BCCP. The Program also received guidance and resources from the NBCCEDP Program Consultant to support improvement in the Environmental Approaches Strategy.

Activity 1c: Identify 10 potential large employers with regional or state-wide reach and research related to existing worksite wellness policies, activities, and interest in engagement (i.e., banking institutions, institutions of higher learning, food chains, grocery store chains, temp staffing companies, etc.).

By the close of the reporting period, the Outreach Coordinator had connected with 8 major employers in Mississippi, including three in the banking industry (Bank Plus, Bancorp South-Regions, and Trustmark), two in manufacturing (Toyota and Nissan), two in agribusiness (Simmons Catfish and Americas Catfish), and one in the staffing industry (Staffing Innovation) to assess existing employer policies concerning health and wellness promotion and activities. He corresponded with the employers, who did not have policies established but showed interest, to provide information (one-pagers, materials from NBCCEDP) and consultation for supporting their momentum. Additionally, one of MS-BCCP's FY2021 subgrantees, Plan A Health - a mobile primary health clinic, partnered with a major employer in the MS Delta, Platte Chemical, on April 27, 2021 to offer an on-site wellness screening event in which the workers received primary care screenings, family planning services, STD testing, HIV testing, clinical breast exams, pelvic exams, pap smears, and referrals for mammograms. A total of 16 employees received care through the mobile unit. The success of those on-site events was well-received throughout the community where it was stationed. Later in the year, the Outreach Coordinator shared contact information with Plan A Health for key employers and community leaders in the MS Delta. Under its renewed subgrant for FY2022, Plan A Health had several events planned throughout the MS Delta in which the mobile clinic would offer services.

Activity 1d: Use research, a draft plan, and a schedule of activities to engage with 1 worksite or employer per month to inform and promote worksite wellness programs related to breast and cervical cancer.

Strategy 2: The MS-BCCP program staff will work with internal and external partners to identify opportunities for collaboration.

By the close of the reporting period, the Outreach Coordinator had connected with 8 major employers in Mississippi, including three in the banking industry (Bank Plus, Bancorp South-Regions, and Trustmark), two in manufacturing (Toyota and Nissan), two in agribusiness (Simmons Catfish and Americas Catfish), and one in the staffing industry (Staffing Innovation) to assess existing employer policies concerning health and wellness promotion and activities. He corresponded with the employers, who did not have policies established but showed interest, to provide information (one-pagers, materials from NBCCEDP) and consultation for supporting their momentum. Additionally, one of MS-BCCP's FY2021 subgrantees, Plan A Health - a mobile primary health clinic, partnered with a major employer in the MS Delta, Platte Chemical, on April 27, 2021, to offer an on-site wellness screening event in which the workers received primary care screenings, family planning services, STD testing, HIV testing, clinical breast exams, pelvic exams, pap smears, and referrals for mammograms. A total of 16 employees received care through the mobile unit. The success of those on-site events was well-received throughout the community where it was stationed. Later in the year, the Outreach Coordinator shared contact information with Plan A Health for key employers and community leaders in the MS Delta. Under its renewed subgrant for FY2022, Plan A Health had several events planned throughout the MS Delta in which the mobile clinic would offer services.

Objective 2: By June 30, 2022, collaborate with community organizations and businesses to include educational programs in their community outreach activities aimed at reducing risk for breast and cervical cancer.

Activity 2a: Consult with leaders of partner organizations (i.e., Susan G. Komen, Mary Byrd Perkins Cancer Center, Institute of Minority Health, MP3C Coalition Chair, etc.) to determine historical and contemporary outreach efforts and activities facilitated through them. Seek invitation to partner on future events and activities.

Despite the limited availability of the Outreach Coordinator for several months during the reporting period, key partnerships with leadership of the MS Comprehensive Cancer Control Program (MCCCP) and MP3C Coalition were leveraged to extend the promotion of breast and cervical cancer screenings and BCCP services through various venues, virtual events, and other opportunities. The State MP3C Coalition Chair served as a guest presenter at multiple virtual events scheduled in October 2020, in which she provided education on the importance of breast and cervical cancer screenings, as well as referral information for the BCCP Program. These events included:

- October 12, 2020, “A Dose of Reality: Breast Cancer Awareness Forum” co-hosted by Jackson State University and The Black Girl Social Club.
- October 14, 2020, “Breast Cancer in African American Women” podcast hosted by Women for Progress Radio Network.
- October 26, 2020, “Breast Cancer 101: Emotional Aspects of a Breast Cancer Diagnosis” co-hosted by Hinds Community College Utica Campus and Phi Theta Kappa Honor Society.

On November 17, 2020, the American Cancer Society, Mississippi Cancer Action Network sponsored a virtual Policy Forum meeting, which drew approximately 90 participants representing the business community, healthcare providers and systems, advocacy groups, state agencies, pharmaceutical companies, and health insurers. The State MCCCP Director and State MP3C Coalition Chair were guest speakers and shared health promotion messages on screening, early detection, and cancer prevention, as well as contact information for the program(s). The Susan G. Komen (SGK) organization implemented major infrastructure and business model changes effective Spring 2021. These systemic changes resulted in the dissolution of the three local/state level SGK Chapters that had been partners to MS-BCCP for decades – both in providing non-federal grant funds and in referring women directly to enrolling providers. In May 2021, the Program Director met virtually with representatives from the National SGK office to craft a plan for women to be referred to MS-BCCP should they access the National SGK helpline. To support the training of helpline workers, MS-BCCP developed and sent a short slide deck, describing the MS-BCCP and the process of linkage discussed, along with the most recent list of providers.

Activity 2b: Identify 4-6 potential community-based organizations/partners to outreach per month. Request opportunities to share information with “gatekeepers” of or to the target population (i.e., community health workers, patient navigators, care coordinators, faith leaders, non-profit social service workers, philanthropic organizations, sororities/fraternities, etc.).

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, and North Sunflower Medical Center used Facebook as an outlet to bring awareness to the availability of free breast screening services in the month of October 2020. Some sponsored special activities, such as pumpkin decorating contests, “Bling-Your-Bra” contests, and self-care basket giveaways to increase interest and attention. The BCCP Program provided printed materials for smaller scale events/projects as requested and available. These included:

- Jackson Heart Study Community Engagement Center's Health Fair/Screening held on October 21, 2020, whose target audience was Hinds County Sheriff's Department employees.
- Jefferson Davis County School District, Human Resources Department, who requested material in electronic format that could be dispersed to employees through the month of October 2020.

The Program Director was an invited guest speaker for a community education webinar for January 25, 2021, hosted by the Office of Community Outreach and Engagement of O'Neal Comprehensive Cancer Center - The University of Alabama at Birmingham. Co-presenters from the Alabama BCCP program also joined. The presentation was targeted for community health workers and lay professionals and covered the basics of how one can access the services of the MS-BCCP program, eligibility, how to link women with an enrolling provider, and services provided for enrolled participants. The hosting organization partners with the Alabama Department of Health on a cervical cancer screening project. This project is geared to promote screenings (Pap testing/HPV) at the local health department in 13 counties in Alabama and 4 counties of Mississippi, including Bolivar, Humphreys, Yazoo, and Panola counties. Resources for obtaining cervical cancer screenings in Mississippi were emphasized. About 60 people participated in the webinar. Throughout the reporting period, MS-BCCP worked with contracted evaluator, Dr. Daniel Sarpong, and with Ms. Robyn Taylor, a Health Equity Consultant with the National Association of Chronic Disease Directors, to assess breast health disparities among Mississippi women with particular focus to the counties in which they reside. Using program data and that available from other sources (i.e., CDC, Susan G. Komen Mississippi State Health Profile, Robert Wood Johnson County Health Rankings, etc.), this team identified three (3) Mississippi counties (Prentiss, Claiborne, and Amite) with lower county health profile rankings for health and socioeconomic status and higher rates of late-stage breast cancer diagnosis, particularly among African American women. These same counties were also identified to be "under-referring" women to the MS-BCCP program to assist with access to and payment for breast health services based on program enrollment and claims data. To begin solution-finding for improving access to care, the team presented these findings in an inaugural community engagement meeting held virtually on July 9, 2021. The participants of the meeting included approximately 30 health care professionals in public and private institutions, faith-based institutions, community-based organizations, and members of the public, including cancer survivors from the 3 focus counties and more broadly. The content of the meeting included an overview of breast cancer nationally, in Mississippi, and in the 3 counties, the impact of disparities, the importance of early screening and detection, and invited discussion amongst participants for identify possible needs, barriers, and challenges as seen by community members and stakeholders. Information gained from the meeting assisted the BCCP program to identify possible strategies, opportunities, and solutions to improving BC screening. The program focused on provider engagement in August 2021 and offered six (6) opportunities for virtual training on MS-BCCP processes for enrolment and patient navigation. 175 unduplicated individuals were trained across the 6 trainings (77 external providers, 98 MSDH employees). The program leveraged the success of the August virtual trainings and continued its focus on provider education and engagement in September 2021. A Provider Reference Guide, frequently asked question supplement, and recording of the training were made available and broadcast to the MS-BCCP provider listserv. By the close of the reporting period and only one week after the training video link was live, it had been viewed 29 times. On August 31, 2021, the Outreach Coordinator provided a virtual presentation to Alpha Kappa Alpha Sorority, Inc., Rho Lambda Omega Chapter leadership and was invited to present to the Health and Wellness Committee of the Chapter virtually at their September 27, 2021, meeting – there were 27 participants.

Additionally, over the course of the reporting period, the Outreach Coordinator received many requests for outreach materials from new external "gatekeepers," including:

- Clinton (MS) Alumnae Chapter of Delta Sigma Theta Sorority, Inc.
- Simmons Farm Raised Catfish, America's Catch Catfish,
- Oak Grove Church of God (Meridian), St. Peter MB Church (Utica),

- Federal Bureau of Prisons (Yazoo City), New Jerusalem Church (Jackson),
- Le Fleur Haven Senior Retirement Housing (Jackson),
- Celebrity Hair Designs (Jackson),
- Southwest MS Community College – Career and Technical Education (Summit), Merit Health (Madison),
- Canton Public Library (Canton),
- Fredonia M.B. Church (Coldwater),
- Unity Health Services/Community Beauty Shops (Jackson),
- Indian Run Estates (Pearl),
- MSDH Office of Preventive Health
- Central MS Planning and Development District
- Women's Empowerment summit
- Temple Reconstruction Fitness
- Hinds Community College (Raymond)
- Oak Grove church of God
- St. Peter MB Church
- Federal Bureau of Prisons
- Spanish Congregation North Campus
- Celebrity Hair Designs
- Career-Technical Education and Horace Holmes Student Union
- Canton Public Library Community Beauty Shops
- Northwood Village Apartment
- Joe Prichard Holmes
- Pearl Street A.M.E Church

Activity 2c: Identify 3 potential sources for new enrollments within assigned area to outreach per month. Request opportunities to share information with direct care providers of breast and cervical services. Refer inquires for new fee-for-service contracts to Contracts/SG Coordinator.

This activity is an ongoing activity and is captured in reporting on other activities.

Activity 2d: Work with BCCP team to revise intake process to capture data element for how the enrollee or patient learned about BCCP (i.e., outreach event, gatekeeper referral, website, social media, medical provider, etc.) to allow for assessing effectiveness of outreach activities.

This activity was not initiated during the reporting period.

Activity 2e: Refer BCCP enrollees diagnosed with breast or cervical cancer to Medicaid within 7 days of receipt of pathology report and all other required documentation.

During the reporting period, 52 patients enrolled in the Breast and Cervical Cancer Program were referred to the Mississippi Division of Medicaid within 5-10 days of receiving the results of a pathology report positive for cancer.

Activity 2f: Refer BCCP enrollees diagnosed with breast or cervical cancer to the MS Comp Cancer Control Program within 7 days of receipt of pathology report and all other required documentation.

Due to staffing changes in the MCCCP program and prioritization of other tasks, this activity was not attempted during the reporting period.

Activity 2g: Submit work requests to the Office of Communications to promote CDC-approved messaging related to breast and cervical health, cancer prevention, detection, etc. Prepare social media post schedules and templates for Cervical Cancer Awareness Month (January) and Breast Cancer Awareness Month (October).

The MS-BCCP program initiated a cervical cancer awareness social media campaign through the MSDH Office of Communications to run through January 2021. In September 2021, the Outreach Coordinator prepared a work request for a social media campaign to run through October 2021, which promoted breast cancer screening and early detection. Total of 11 Facebook posts and 8 Twitter posts were observed. Analytics for reach and impressions were as follows. Facebook/Instagram: Reached 91,705 users and produced 302 website visits. Twitter: Reached 53,840 users and produced 42 website visits.

Activity 2h: Develop a trainer/speaker/presenter request form to be completed when outside partners or stakeholders request representation from BCCP for any program, event, or agenda involving interacting with the target population and/or potential referral sources. This will assist in maintaining a record of community engagement.

Strategy 3: MS-BCCP will engage the support of external providers to increase screenings among high priority populations.

This activity was not initiated during the reporting period.

Objective 3: 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.

Activity 3a: Facilitate subgrant 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.

Starting in the fall 2020, the program worked with subgrantees to plan targeted, strategic interventions for increasing screenings of underserved women. The MS-BCCP executed subgrant agreements with six partners during the reporting period with funding support provided through June 30, 2021, which included Jackson Hinds Comprehensive Health Center, Family Health Care Clinic, Plan A Health, Mary Bird Perkins Cancer Center, Singing River Health Systems, and North Sunflower Health System to support activities that increase screening rates among high priority groups. 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 current subgrantees are located different areas of the state and are strategically positioned and working to reach underserved women. Some activities planned include 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.

FY2021 MS-BCCP program data reflects that among 3,935 participants served, 58.2% were Black/African American women, 30% white women, 1.5% Indigenous/Native Alaskan, Asian, or Pacific Islander women, and 0.5% were two or more races. For 9.8% of participants, no race was indicated, representing a major area for programmatic improvement. Ten-point eight percent (10.8%) of enrollees indicated their ethnicity was Hispanic, 85.9% non-Hispanic, and for 3.3% no response was recorded. With the race of nearly 10% and ethnicity of over 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.

Activity 3b: Continue contact with North MS Witness Project to assess progress and reach to date. Observe data for Northeast MS counties to determine enrollment and screening trends. Explore opportunities for more formal partnership through MOU.

There was no progress for this activity in the reporting period.

Activity 3c: Initiate contact with other MSDH programs on front line of COVID response, who have expert experience in reaching disparate communities. Leverage existing data, opportunities for joint messaging in health promotion, etc.

There was no progress for this activity in the reporting period.

Activity 3d Consult with Institute for the Advancement of Minority Health on strategies and best practices for engaging underserved populations. Explore opportunities for partnership.

A new partnership with the Institute for the Advancement of Minority Health was developed starting in September 2020. At the request of this partner agency, program staff provided consultation for organizing breast cancer screening promotion activities in October 2020, as well as more technical training for the Institute's Community Health Worker (CHW) on linking women directly with BCCP. The BCCP Nurse Consultant provided the Institute's CHW with the updated participating provider list, instruction on how to refer women for enrollment into the BCCP Program, and information related to navigation for diagnostic services. To bring awareness to the population served, the Institute developed a promotional graphic for posting on their website that encouraged women to make direct contact with the CHW for more info on free mammograms. The Program Director was an invited guest speaker for a Health Awareness webinar on January 25, 2021, hosted by the Institute for the Advancement of Minority Health. The presentation was targeted for community health workers with IAMH and covered the basics of how one can access the services of the MS-BCCP program, eligibility, how to link women with an enrolling provider, and services provided for enrolled participants. About 10 people participated in the webinar.

Activity 3e: Using e-blast list serv, send announcements to participating provider network of training and learning opportunities related to health equity, cultural sensitivity, and serving diverse populations.

Strategy 4: MS-BCCP will facilitate partnerships with institutions and sites that house women temporarily to promote awareness of breast and cervical cancer screening.

In May 2021, the Program Director developed a provider listserv to allow for timely announcements to the entire MS-BCCP provider network. The listserv has grown to more than 300 individual names and has been used routinely to broadcast targeted information to the MS-BCCP provider network. Throughout the year, the Program Director used the provider listserv to broadcast announcements of trainings, webinars, and online resources to support professional development targeting evidence-based interventions, health equity, health disparities, cultural competence, cultural responsiveness, etc. Materials shared were those from the CDC, American Cancer Society, Virtual National Health Equity Summit, Johns Hopkins Sidney Kimmel Comprehensive Breast Cancer Center, Black Breast Cancer Alliance, and other reputable agencies, organizations, and authorities.

Objective 4: 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.

Activity 4a: 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.

On April 6, 2021, the Program Director and Outreach Coordinator provided a virtual presentation to the Women's Program Director of the Central Mississippi Correctional Facility (CMCF). The focus of the presentation was how transition counselors and correctional case management staff can provide supportive help to link women with MS-BCCP providers as they approach their release dates. Throughout the year, the Outreach Coordinator stayed in contact with the Director to plan opportunities for him to meet with groups of women, who were scheduled to be released within 6 months or less, to provide direct information about accessing MS-BCCP. Visits to the facility were not possible due to ongoing COVID-related restrictions. However, this is still being explored for 2022.

Activity 4b: Initiate contact with other institutional case managers or community re-entry workers to provide information about BCCP resources and updates. Venues to target include transitional living facilities, community work programs, and probation/parole monitoring programs.

May 4, 2021, the Program Director and Outreach Coordinator provided a virtual presentation to the transition counselors of the Washington County Correctional Facility. The focus of the presentation was how transition counsellors and correctional case management staff can provide supportive help to link women with MS-BCCP providers as they approach their release dates.

Activity 4c: Work to ensure the BCCP Program is listed among services and resources in the Mississippi Re-entry Guide.

Strategy 5: MS-BCCP will initiate contact with former incarcerated women to promote awareness of the program and enrolling providers.

The Outreach Coordinator worked with contacts from the Foundation for the Mid-South and the Mississippi Reentry Council to have MS-BCCP listed among services and resources in the Mississippi Reentry Guide. The guide, available free of charge online and searchable by county and helps to connect ex-offenders with services and agencies that support successful transitions back to their communities. By close of June 2021, this task was successfully executed.

Objective 5: By June 30, 2022, upon release, link re-entry population to a medical home to increase breast and cervical cancer screenings

Activity 5a: Assess the list of 96 women who participated in the former Outreach Coordinator's educational presentation and voluntarily requested more information. Review ages and release dates to prioritize a schedule of mail-outs encouraging follow-up with a local provider for breast and cervical services.

Upon her departure, the former Outreach Coordinator provided a list of the 96 women, inclusive of their names, ages, projected release date, county, and mailing address which were voluntarily provided by the women during the

event. Because the women voluntarily offered this information, BCCP Program staff did not require additional support from the Restitution Center to make good on its plan to outreach these women. By the close of the reporting period, the Outreach Coordinator had identified 3 women from the list, who were already in MS-BCCP and had prioritized the “send-out” of brochures to the other women on the list. This is a staged and ongoing activity and has not been fully executed.

Activity 5b: Compare mail-out list to enrollee data to determine how many women were enrolled after they would have received a post card from BCCP.

Strategy 6: MS-BCCP will facilitate partnerships with agencies/organizations that house women temporarily to promote awareness of breast and cervical cancer screening.

See Activity 5a.

Objective 6: By June 30, 2022, establish partnerships with domestic violence shelter providers to assist in navigating women to medical homes, or health care systems to increase cancer screening, diagnostic, and treatment resources.

Activity 6a: Partner with Nursing Consultants and MSDH Social Services Director to make application for social work CE credit for a presentation specific to breast and cervical health, disparities preventing access to care, and resources available for social workers to refer women in need to for services.

By the close of the reporting period, the Outreach Coordinator had developed a draft presentation. The draft is pending review by other MS-BCCP staff and the Program Director. Plans to seek social work CE approval are not forecasted at this time.

Activity 6b: Initiate contact with MSDH Office Against Interpersonal Violence (OAIV) to determine opportunities to provide education to grantees (i.e., domestic violence shelters, victims service coordination sites, rape crisis centers, human trafficking programs, family violence prevention programs, etc.) as part of any annual or quarterly trainings. Plan logistics accordingly.

In March 2021, the Program Director and Outreach Coordinator met virtually with the Director of the Office Against Interpersonal Violence (OAIV) to begin strategizing how MS-BCCP could engage with domestic violence shelters throughout Mississippi. On April 28, 2021, and with the logistical assistance of OAIV, the Program Director and Outreach Coordinator provided a virtual presentation to the Mississippi Coalition Against Domestic Violence (MCADV) membership. The members in attendance were directors and leaders of women’s and family shelters across Mississippi. The focus of the presentation was how case managers and shelter staff can provide supportive help to link women with MS-BCCP providers. By close of summer 2021, the Outreach Coordinator had met virtually with both human trafficking navigators in Office Against Interpersonal Violence (OAIV) to share resources available through MS-BCCP.

Activity 6c: Initiate contact with MS Coalition Against Domestic Violence (MCADV) to determine opportunities to provide education to its shelter programs as part of any annual or quarterly trainings. Plan logistics accordingly.

See Activity 6b.

Activity 6d: Initiate contact with other social service agencies providing residential services or housing for women/families to offer information about BCCP resources and updates to staff. Venues to target include

homeless shelters, housing authorities, substance abuse treatment programs, etc.

Strategy 7: MS-BCCP will engage external partners to recruit women for enrollment in BCCP.

This activity has not been fully accomplished and is a priority for the remaining half of FY2022.

Objective 7: By June 30, 2022, increase the breast and cervical cancer screenings for the uninsured and underinsured targeted population.

Activity 7a: Facilitate subgrant 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.

Duplicate activity, different measure of performance. Targets were not met for this activity. In FY2021, MS-BCCP enrolled 3,734 unduplicated women between 18 and 75 years across Mississippi. The enrollment numbers were 0.7% less than that of the previous year (n=3,762). There was a total of 9,598 breast and cervical screening activities performed on 3,774 unduplicated women, with an average of screening of three (3) procedures per woman. The breast (clinical breast exam and screening mammogram) and cervical screening (pelvic exam and pap smear) activities distribution was 62.4% (n=5,997) and 37.5% (n=3,601), respectively. Of the 3,774 women, 64.5% (n=2,436) had both breast and cervical cancer screening. Compared to the last performance period (n=3,722), there was a 1.4% increase in women screened for breast and cervical cancer. Additionally, there were 1.5% more screening activities in FY2021 than FY2020, in which 9,457 breast and cervical cancer screening activities were performed. A total of 2,329 detection (diagnostic) activities were performed among 1,256 unduplicated women. The breast (additional mam views, diagnostic mammogram, ultrasound, MRI, film comparison, biopsy, fine need aspiration, surgical consult, and other breast services) and cervical diagnostic (colposcopy, ECC, LEEP, cervical biopsy, and other cervical services) activities distribution was 88.4% (n=2,058) and 11.6% (n=271), respectively. Compared to the FY2020 (n=2,728), there was a 2.5% decrease in women who received diagnostics tests. Starting in the fall 2020, the program worked with subgrantees to plan targeted, strategic interventions for increasing screenings of underserved women. The MS-BCCP executed subgrant agreements with six partners during the reporting period with funding support provided through June 30, 2021, which included Jackson Hinds Comprehensive Health Center, Family Health Care Clinic, Plan A Health, Mary Bird Perkins Cancer Center, Singing River Health Systems, and North Sunflower Health System to support activities that increase screening rates among high priority groups. Collectively, these subgrantees enrolled 1,100 unduplicated women residing in 54% (n=44) counties in MS-BCCP in FY2021. These enrollees accounted for 30% of all women enrolled. Among subgrantee enrollees, 52% (n=571) were new (no prior enrollments in any year) to the program. Collectively, these women received a total of 3,652 breast and/or cervical cancer screening and/or diagnostic activities.

Activity 7b: Continue contact with North MS Witness Project to assess progress and reach. Observe data for Northeast MS counties to determine enrollment and screening trends. Explore opportunities for more formal partnership through MOU.

There was no progress for this activity.

Activity 7c: Partner with UMMC for annual See, Test, and Treat event. Assist with planning and pre-enrollment of patients.

Due to COVID-19 restrictions, See, Test, and Treat organizers were forced to again cancel the event scheduled for

August 21, 2021, the third cancellation since the start of the COVID pandemic. All women who were initially given STT appointments were mailed a letter in August 2021 explaining the reason for the cancellation and future plans. Those women will be given priority scheduling when the next STT is scheduled in 2022. Women were also encouraged to contact the MS-BCCP should they need more immediate assistance in the interim

Activity 7d: Share information with providers on the use of social media campaigns and medically accurate messaging to increase awareness of the need for screenings and encourage uptake of BCCP services.

There was no progress for this activity.

Activity 7e: Establish contact with MS Insurance Commissioner's Office to assure staff are aware of and know how to refer individuals to BCCP-supported services.

Strategy 8: MS-BCCP will use language, images, graphics, and messaging that is both responsive to diversity and health literacy.

There was no progress for this activity.

Objective 8: 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.

Activity 8a: Collaborate with the Office of Health Equity and Office of Policy and Evaluation to develop material in accordance with health literacy guidelines for the program's health literature disseminated at outreach events.

From April through June 2021, the MS-BCCP staff worked with the Office of Communications to redesign its outreach materials. By June 15, 2021, the brochure and poster were redesigned to reflect current eligibility requirements, provide better contact information and ways to connect with the BCCP program and providers, and reflect more diverse and accessible images and language. Both pieces were translated to Spanish. An online request process was designated for providers and partners to request materials and went live on June 15, 2021. By close of the reporting period, 112 requests for materials had been received since MS-BCCP implemented the online request process in mid-June 2021.

Activity 8b: Explore resources for translating program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information.

New outreach materials and two MS-BCCP forms requiring patient signature were translated to Spanish through intra-agency resources.

Activity 8c: Initiate contact with other MSDH programs on front line of COVID response, who have expert experience in reaching disparate communities. Leverage existing data, opportunities for joint messaging in health promotion, etc.

There has been no progress for this activity.

Activity 8d: Consult with Institute for the Advancement of Minority Health on strategies and best practices for engaging underserved populations. Explore opportunities for partnership.

The Outreach Coordinator learned that the IAMH did not offer any specific services or programming for Asian, Hispanic, or Native American women during the reporting period.

Activity 8e: Using e-blast list serv, send announcements to participating provider network of training and learning opportunities related to health equity, cultural sensitivity, and serving diverse populations.

In May 2021, the Program Director developed a provider listserv to allow for timely announcements to the entire MS-BCCP provider network. The listserv has grown to more than 300 individual names and has been used routinely to broadcast targeted information to the MS-BCCP provider network. Throughout the year, the Program Director used the provider listserv to broadcast announcements of trainings, webinars, and online resources to support professional development targeting evidence-based interventions, health equity, health disparities, cultural competence, cultural responsiveness, etc. Materials shared were those from the CDC, American Cancer Society, Virtual National Health Equity Summit, Johns Hopkins Sidney Kimmel Comprehensive Breast Cancer Center, Black Breast Cancer Alliance, and other reputable agencies, organizations, and authorities.

Activity 8f: As recommended by CDC Program Consultant in site visit (July 2019), consult www.miyoworks.org for best practices and ideas on developing culturally sensitive and appropriate materials.

Strategy 9: MS-BCCP will partner with providers who are able to provide mobile breast and cervical cancer screening providers.

By the close of the reporting period, this website was no longer active. Neither the Outreach Coordinator nor the Program Director can sign in using credentials and have not received technical support despite requests.

Objective 9: By June 30, 2022, collaborate with other entities to promote/offer mobile mammography services in underserved areas of the state.

Activity 9a: Formalize partnership with Mary Byrd Perkins Cancer Center to recognize this organization as a legitimate BCCP enrollment site for women whose screening services are paid by other resources. Train the mobile unit's patient navigator and clinical provider on BCCP enrollment processes.

In June 2021, two mobile primary care providers partnered with two mobile mammography screening units to host events in separate Mississippi cities allowing 31 women to gain access to breast and/or cervical cancer screening. To reach women "where they are" Plan A Health and the Mary Bird Perkins Cancer Center mobile clinics leveraged existing relationships with mobile mammography units local to the areas they served. Plan A Health, a mobile primary health clinic serving the lower MS Delta, partnered with MS Baptist Medical Center's Mobile Mammography Unit of Jackson, MS. Mary Bird Perkins, a mobile cancer screening provider serving Southwest MS, partnered with Woman's Hospital's Mobile Mammography Unit of Baton Rouge, LA. On June 16, 2021, Mary Bird Perkins and Woman's Hospital held a joint screening day in Natchez, MS (Adams County). Women were seen first by the Mary Bird Perkins mobile clinic staff to assess BCCP eligibility, enroll in BCCP, receive clinical breast exams, and screening or diagnostic mammogram orders. Those with screening orders were immediately seen by the Woman's Hospital mobile unit for mammograms and received initial results. Because Woman's Hospital is not a contracted MS-BCCP provider, Mary Bird Perkins leveraged its own grant funding to cover the screening mammograms for all women seen on the unit. Any women in need of diagnostic procedures were navigated by the Mary Bird Perkins clinic staff to an approved MS-BCCP provider local to their area, specifically River Park Imaging. All diagnostic procedures for enrolled women were covered by NBCCEDP funds. On June 18, 2021, Plan A Health and Baptist held a joint screening day in Louise, MS (Humphreys County). Women were seen first by the Plan A clinic staff to

assess BCCP eligibility, enroll in BCCP, receive clinical breast exams, pap smears, and screening or diagnostic mammogram orders. Those with screening orders were immediately seen by the Baptist mobile unit for mammograms and received initial results. Any women in need of diagnostic procedures were navigated by the Plan A clinic staff. Screening mammograms for women ages 50-64 years old were covered by NBCCEDP funds. Screening mammograms for women 40-49 years old were covered by special non-federal funds, which MS-BCCP reserved in advance to eliminate the necessity of the routine pre-approval process (to prevent any delays in the women receiving the same-day mammograms). All diagnostic procedures for enrolled woman were covered by NBCCEDP funds. MS-BCCP provided small subgrants to Plan A Health and Mary Bird Perkins to support outreach and promotion of the events through small media, local newspapers, radio, and sponsored social media in days and weeks prior to the events and salary support for community health worker and patient navigator staff to assure BCCP deliverables were prioritized. From these two events, 31 women gained access to breast and/or cervical cancer screening. 31 women received clinical breast exams, 27 received screening mammograms, and 9 received pap smears. None of the 4 women ineligibles for BCCP enrollment required any diagnostic follow-up after their screenings.

Of the 27 women enrolled in MS-BCCP:

- 89% (n=24) were new to the program or Cycle 1 enrollees,
- 60% (n=16) were Black/African American women between 40-64 y/o, a high priority population for MS-BCCP,
- 23 women received screening mammograms with 8 requiring diagnostic follow-up,
- 5 women received pap smears with 1 requiring diagnostic follow-up,
- 18% (n=5) had received a mammogram 3 or more years ago,
- 30% (n=8) had never received a mammogram, and
- and none of these women were diagnosed with breast or cervical cancer.

The Mary Bird Perkins screening event drew women only from Natchez, MS (Adams County) showing effective targeted outreach local to that community in the days/weeks prior. The Plan A Health event drew women from 11 cities across 8 counties – the furthest 66 miles north of the screening location – showing effective outreach among several MS Delta towns and cities in the days/weeks prior. Given the ongoing and persistent demands to the healthcare system posed by the COVID-19 pandemic, MS-BCCP providers throughout the state have been challenged to keep breast and cervical cancer screening and BCCP enrollment a top priority. Through the direct outreach of these two mobile providers, these 31 women were able to receive timely screening and navigation that may otherwise have not been available or accessible to them for many additional weeks or months, if at all, in areas they were able to travel.

Both Plan A Health and Mary Bird Perkins will repeat these efforts in FY2022, offering additional joint screening events with their mobile mammography partners, expanding coverage to other areas. Plan A will be using MS-BCCP subgrant funding to expand its reach into Northeast MS into 4 counties with minimal to no BCCP enrollments for 2+ years. Mary Bird Perkins will use subgrant funding to expand its reach by 3 additional counties with underutilization of BCCP in Southwest MS. Both organizations, among others, have been selected as subgrantees under a competitive RFP. Internal program enrollment data, claims data, contracted provider locations, and other data sets (cancer incidence, social vulnerability, etc.) have been used to prioritize areas where MS-BCCP partners like Plan A and Mary Bird Perkins can focus their efforts to impact screening rates. The program will be monitoring performance and return-on-investment closely, providing support and technical assistance to assure these partners find success.

Activity 9b: Formalize partnership with MS Baptist Medical Center Mobile Mammography Unit to recognize this organization as a legitimate BCCP enrollment site for women whose screening services are paid by other resources. Train the mobile unit's staff on BCCP enrollment processes.

This activity was not needed. MS Baptist Medical Center's Mobile Mammography Unit is already recognized as a BCCP contracted provider, under its headquartered hospital in Jackson, MS. Pending some error corrections in enrollment documentation submitted directly from Plan A Health and MBPCC patient navis, all of the patients referred who were found eligible will be enrolled in BCCP.

Activity 9c: Assist with promotion of mobile mammography events hosted by these providers through e-blast distribution announcements, social media posts, etc.

Strategy 10: MS-BCCP will monitor the performance of contracted providers and subgrantees to assure eligible women receive the expected services within the guidelines of the program and in locations accessible to their county of residence.

These were small scale events with limited space. Promotion by Outreach Coordinator was not needed.

Objective 10: By June 30, 2022, continue implementation of continuous quality improvement strategies to assure high quality services are being provided to patients in partner sites and data quality is acceptable.

Activity 10a: Provide telephonic or web-conferencing technical assistance regarding BCCP policies, procedures, and protocols at least once annually or more often as needed to all provider sites.

The MS-BCCP staff provided virtual training to existing and orientation to newly onboarded providers as follows:

- Plan A Health – April 28, 2021 – 2 participants
- Family Health Care Clinic, Inc. – April 30, 2021 – 125 participants
- Open Arms Healthcare – May 25, 2021 – 5 participants
- Off Main Street Clinic – May 25, 2021 – 1 participant
- Mary Bird Perkins Cancer Center – June 2, 2021 – 5 participants

The program focused on provider engagement in August 2021 and offered six (6) opportunities for virtual training on MS-BCCP processes for enrolment and patient navigation. One hundred seventy-five (175) unduplicated individuals were trained across the 6 trainings (77 external providers, 98 MSDH employees). Participants represented 54% (n=76) of MS-BCCP's contracted providers. The program leveraged the success of the August virtual trainings and continued its focus on provider education and engagement in September 2021. A Provider Reference Guide, frequently asked question supplement, and recording of the training were made available and broadcast to the MS-BCCP provider listserv. By the close of the reporting period and only one week after the training video link was live, it had been viewed 29 times.

Activity 10b: Review all new enrollment and other documentation received to determine missing information or errors. Return documentation in need of correction to providers for revision and updating within 3 business days. Provide visual or verbal instructions to guide corrections.

In May 2021, the Program Director assisted the MSDH East Central Public Health Direct nursing leadership and the Meridian Free Clinic to develop a protocol for referring patients to the local health departments for enrolment in MS-BCCP. The Meridian Free Clinic does not provide breast or cervical cancer screening services, thus is not eligible to become a MS-BCCP enrolling provider. However, this clinic does women from the MS-BCCP priority population and can serve as a community-clinical linkage partner. Throughout the reporting period, the nurse consultants provided ongoing, daily feedback to providers as enrollment documents were received. If corrections needed to be made, the

forms were sent back immediately – rather than being held until the “batch” the forms were in were able to be keyed. This reduced the amount of time between enrollment and special funding approvals, as well as reduced the need for data and billing staff to track down the necessary information before keying a patient’s cycle and paying claims.

Activity 10c: Use queries produced by Data Manager to identify patients pending complete navigation. Follow-up with providers accordingly to assure follow-through.

MS-BCCP’s Data Manager role has been vacant from October 1, 2020, through present. Any data support has been provided through the Office of Health Data and Research. Queries to identify patients’ with incomplete navigation began in January 2021 continuing through the reporting period. As patients were identified, the nurse consultants reached out to providers to remind them the patient needed attention.

Office of Tobacco Control (OTC) - Annual Report

Priority: Maternal Morbidity and Mortality

NPMs, NOMs, SPM, and ESMs:

- NPM 1: Percent of women who smoke during pregnancy
- SPM 1: Percentage of women who smoke in the last three months of a pregnancy
- ESM 1: # of women ages 18 - 44 who access the Quitline for cessation services.
- ESM 2: # of Mississippi communities (cities, counties, etc.) with comprehensive smoke-free ordinances.

Strategies and Activities (FY October 1, 2020 - September 30, 2021)

Objective 1: By September 30, 2022, enroll at least 25 pregnant smokers in the Baby & Me Tobacco Free Program.

Strategy 1: The OTC, in collaboration with its partners, will continue to work to reduce the prevalence of tobacco / alternative tobacco products among women ages 18-44 years.

Activity 1a: Promote the availability of Baby & Me Tobacco-Free in the ten clinics that offer the program.

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, community events (drive thru baby showers and by sharing program brochures/flyers with stakeholders, providers, and community partners such as Central MS Homeless Coalition Membership, MS ACA Stakeholders, MCH Coalition, Oak Hill Healthy Kids Parents Education Hour Live on Facebook, OTC State-wide Grantees, Institute of Minority Health, churches, DOM, legislators, community health workers. Promoted Baby & Me Tobacco-Free on billboards in targeted areas: 3/3/20 social media, June 15, 2021 - August 14, 2021 (billboards south Jackson). Baby & Me Tobacco-Free digital ads ran June 2021 – Aug 2021 state-wide – driving traffic to CHCs.

Activity 1b: Promote Baby & Me Tobacco-Free Telehealth services in the Northeast MS Baby & Me pilot.

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.

Strategy 2: OTC will 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.

The trainings conducted have focused on delivery of an evidence-based smoking cessation program with pregnant women to reduce the burden of tobacco on pregnant women and the unborn child. Clinical participants were provided a one-day training that equipped health center staff with the information, materials, and resources to successfully enroll participants in the Baby & Me telehealth program and implement program activities. The implementation phase includes prenatal counseling sessions for mother, carbon monoxide reading to confirm quit, and follow up for up to 12-months to ensure patients remain quit. There is also a referral component of the training that supports clinical telehealth implementation.

Objective 2: By September 30, 2022, increase the number of Mississippi smoke-free ordinances from 174 to 177.

Activity 2a: Provide education, awareness, and resources to municipalities regarding the importance of local ordinances to protect citizens from the dangers of second-hand smoke.

The MTFC disseminated educational materials to 188 events to include over 10,000 people.

Activity 2b: The OTC continues to work through the Mississippi Tobacco-Free Coalitions (MTFCs) to educate and empower local elected officials on the health and economic impact and the benefits of implementing smoke-free ordinances within their municipalities.

The MTFCs conducted over 200 events educating municipalities on the benefits of a smoke-free environment. The MTFC have presented to 62 municipalities to educate local officials on the importance of reducing exposure to second-hand smoke and the importance of including electronic nicotine devices to their current ordinance.

Family Planning

The Title X Family Planning Program promotes awareness and assures access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives. The program is currently working to improve the overall management and administration of the Family Planning Program. Areas of improvement include improving administrative functions, fiscal oversight and responsibility, contraceptive access, high quality family planning services, and increasing collaborations and partnerships.

The Title X network structure in Mississippi consists of 21 federally qualified health centers (FQHCs) facilities with 189 satellite centers and 203 rural health centers within the state. There are 35 rural health clinics (RHCs), some of which are also community health centers (CHCs). The health care organizations that partner with the Mississippi Title X Family Planning Program are generally open Monday through Friday from 8:00 am to 5:00 pm and accept walk-in appointments.

Efforts to improve the health of male, female, and adolescent clients during their reproductive years are tailored and integrated into every family planning encounter at the time of service. Client education also includes:

- Educating women on risk prevention before pregnancy (counseling).

- Sexual health assessment based on CDC guidelines: a sexual history is taken during a patient's initial visit, during routine preventive exams, and when physicians see signs of STIs. The dialogue provides an opportunity for risk reduction counseling and sharing information about behaviors that may place a patient at risk of contracting STIs. A sexual history allows physicians to identify those individuals at risk for STIs, including HIV, and to identify appropriate anatomical sites for certain STI tests.

- Educating patients on the topic of exercise, obesity, nutrition, occupational hazards, family support, and financial issues related to pregnancy to better prepare patients for healthy outcomes (reproductive life planning).

- Promoting reproductive life planning as a tool in assisting individuals to set and achieve reproductive life goals (counseling).

- Providing clinical services that address the preconception health of women and men to promote positive pregnancy and birth outcomes (counseling).

- Educating females and males of reproductive age on the importance of preconception health (knowledge).

- Assistance with self-management approaches for avoiding adverse birth outcomes (behaviors).

- Providing information and encouragement on accessing community resources and health care for improved wellbeing (self-efficacy).

- Promoting the role of family planning in preconception care programs, including incorporating preconception care in the scope of work for clinics and sub-grantee agencies and monitor progress during site visits.

- Integrating reproductive life planning and core preconception messages in family planning visits, including information on provision of or referral for services regarding (1) folic acid intake; (2) rubella vaccination prior to pregnancy; (3) impact of diabetes on pregnancy; (4) impact of substance abuse during pregnancy; (5) healthy weight, nutrition, and exercise; (6) hepatitis B vaccination; and (7) impact of hypertension.

The Family Planning Program selected three strategies that have the highest return on assuring access to reproductive health benefits, including:

Strategy 1: Guarantee access to a broad range of family planning methods, including fertility methods and preventive health services.

- Coordinate with MSDH Pharmacy to provide contraceptive inventory to all clinics.

Strategy 2: Assure the delivery of the highest standard of evidence-based family planning and preventive health services to all Title X clinic users.

- Recertify with 340B Drug Pricing Program annually to access a broad range of family planning methods at a discounted rate.
- Provide funding to delegate agencies.
- Collaborate with MSDH regional and county wide staff to develop promotional strategies to increase family

planning users.

- Assess the number of new clients served per clinic.
- Provide technical assistance to clinical staff on how to properly document family planning visits in EPIC.

Strategy 3: The Family Planning Program will develop materials, trainings, and protocols for the implementation of person-centered family planning telehealth services to all Title X clinics.

- Collaborate with the STD/HIV Office to ensure STD/HIV patients receive Title X services.
- Develop clinic protocols for person-centered family planning telehealth services.
- Develop telehealth workflows.
- Connect the protocol for real work cases and person-centered contraceptive care as a slide deck and or manual.
- Provide two webinars to Title X clinics on telehealth protocols.
- Provide technical assistance to Title X clinics on the implementation of telehealth protocols.

Women/Maternal Health - Application Year

The following strategies and activities are planned for FY23 to address the identified priorities:

Priority: Improve Oral Health

Objective W1: By September 30, 2023, increase the percentage of women who have a preventive dental visit in pregnancy by 5%

Strategy W1.1: Provide education to women on the importance of proper oral health during pregnancy and postpartum

- Activity W1.1a: Increase oral health awareness regarding oral disease indicators [link to Activity C.o]
- Activity W1.1b: Coordinate efforts with the WIC program to improve access for WIC recipients (both children and pregnant mothers) to dental care indicators [link to Activity C.q]
- Activity W1.1c: Collaborate with faith-based organization to promote oral health visits in underserved populations indicators [link to Activity C.r]

Priority: Improve Access to Care

Objective W2: By September 30, 2023, increase use of the family planning waiver by 5%

Strategy W2.1: Expand the use of One Key Question to promote pregnancy intent screening and targeted preconception and family planning counseling

Objective W3: By September 30, 2025, increase access and utilization of quality family planning services in 100% of MSDH county health departments

Strategy W3.1: Increase training for clinicians on how to effectively communicate with parents and patients. [link to Activity A2.1c]

Strategy W3.2: Empower low-income users to make informed decisions about family planning and preventive health services [link to Strategy A2.1]

Objective W4: By September 30, 2025, decrease the percent of women who report smoking during pregnancy by 1%

Strategy W4.1: Partner with the Office of Tobacco Control and other state and community agencies to promote awareness of risks of nicotine use in all forms (e.g., cigarettes, cigars, e-cigarettes, vaping) during pregnancy, and promote resources for quitting

Strategy W4.2: Promote the availability of Baby & Me Tobacco-Free in clinics

Objective W5: By September 30, 2023, increase breast cancer screening rates by 10% among Hispanic, African American,

American Indian, Asian, and other underserved, uninsured or underinsured women

Strategy W5.1: Implement worksite wellness programs aimed to increase breast and cervical cancer screening [link to Strategy W6.1]

- Activity W5.1a: Submit work requests to the Office of Communications to promote CDC-approved messaging related to breast and cervical health, cancer prevention, detection, etc. [link to Activity W6.1a]
- Activity W5.1b: Prepare social media post schedules and templates for Cervical Cancer Awareness Month (January) and Breast Cancer Awareness Month (October). [link to Activity W6.1b]
- Activity W5.1c: Collaborate with Office of Women's Health on similar activities for Women's Health Month (May) and Office of Immunization/HPV (August). [link to Activity W6.1c]

Strategy W5.2: Engage the support of external providers to increase screening among high priority populations [link to Strategy W6.2]

- Activity W5.2a: Partner with UMMC See, Test, and Treat program on 1-2 screening events to receive referrals for women who qualify for MS-BCCP enrollment. [link to Activity W6.2a]

Strategy W5.3: Collaborate with at least 10 community-based, faith-based, social service agencies, or volunteer service organizations to increase screening among high priority populations in rural and urban counties. [link to Strategy W6.3]

- Activity W5.3a: Identify 3-4 potential community-based, faith-based, social, volunteer service organizations, homeless/domestic violence shelters, residential programs, treatment programs, housing complexes, etc. to outreach per month. [link to Activity W6.3a]
- Activity W5.3b: 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. [link to Activity W6.3b]

Strategy W5.4: Collaborate with providers to promote/offer mobile mammography services to expand access to African American and Hispanic women in underserved rural and urban areas of the state.

Objective W6: By September 30, 2023, increase cervical cancer screening rates by 10% among Hispanic, African American, American Indian, Asian, and other underserved, uninsured or underinsured women

Strategy W6.1: Implement worksite wellness programs aimed to increase breast and cervical cancer screening [link to Strategy W5.1]

- Activity W6.1a: Submit work requests to the Office of Communications to promote CDC-approved messaging related to breast and cervical health, cancer prevention, detection, etc. [link to Activity W5.1a]
- Activity W6.1b: Prepare social media post schedules and templates for Cervical Cancer Awareness Month (January) and Breast Cancer Awareness Month (October). [link to Activity W5.1b]

- Activity W6.1c: Collaborate with Office of Women's Health on similar activities for Women's Health Month (May) and Office of Immunization/HPV (August). [link to Activity W5.1c]

Strategy W6.2: Engage the support of external providers to increase screening among high priority populations [link to Strategy W5.2]

- Activity W6.2a: Partner with UMMC See, Test, and Treat program on 1-2 screening events to receive referrals for women who qualify for MS-BCCP enrollment. [link to Activity W5.2a]

Strategy W6.3: Collaborate with at least 10 community-based, faith-based, social service agencies, or volunteer service organizations to increase screening among high priority populations in rural and urban counties. [link to Strategy W5.3]

- Activity W6.3a: Identify 3-4 potential community-based, faith-based, social, volunteer service organizations, homeless/domestic violence shelters, residential programs, treatment programs, housing complexes, etc. to outreach per month. [link to Activity W5.3a]

- Activity W6.3b: 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. [link to Activity W5.3b]

Priority: Reduce Maternal Morbidity and Mortality

Objective W7: By September 30, 2023, reduce the primary cesarean deliveries among low-risk mothers (NTSV) rate by 10% among participating hospitals

Strategy W7.1: Provide guidance and technical assistance to birthing hospitals on reducing nulliparous, term singleton, vertex (NTSV) caesarean rate

Objective W8: By September 30, 2023, hold 4 multidisciplinary maternal mortality case review committee meetings.

Strategy W8.1: Provide evidenced-based education, training, and/or technical assistance to internal and external partners to decrease risk factors for adverse outcomes, morbidity and mortality

Strategy W8.2: Provide leadership and technical assistance in the state on Alliance for Innovation on Maternal Health (AIM) initiatives and Maternal Mortality Review activities [link to Strategy W9.2; W10.1]

Objective W9: By September 30, 2023, review, synthesize, and disseminate recommendations for maternal mortality prevention

Strategy W9.1: Provide guidance and evidenced-based trainings to participating Mississippi Perinatal Quality Collaborative (MSPQC) birthing hospitals and community partners to reduce severe maternal morbidity

- Activity W9.1a: Conduct monthly webinars and trainings for MSPQC Maternal and Neonatal initiatives.

- Activity W9.1b: Conduct at least 5 Advanced Life Support in Obstetrics (ALSO) courses.
- Activity W9.1c: Conduct birth equity trainings with MSPQC participating hospitals.
- Activity W9.1d: Host MSPQC Statewide Annual Meeting/Conference.

Strategy W9.2: Provide leadership and technical assistance in the state on Alliance for Innovation on Maternal Health (AIM) initiatives and Maternal Mortality Review activities [link to Strategy W8.2; W10.1]

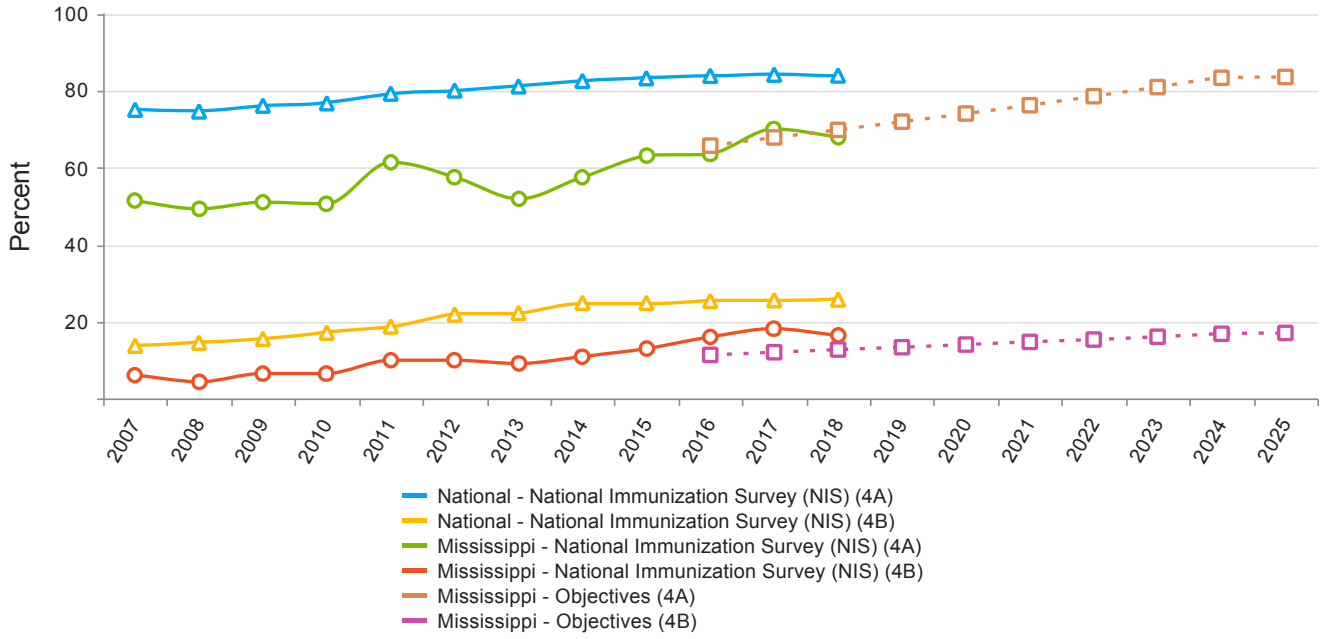
Objective W10: By September 30, 2023, reduce the percent of severe maternal mortality events related to hypertension by 5%

Strategy W10.1: Provide leadership and technical assistance in the state on Alliance for Innovation on Maternal Health (AIM) initiatives and Maternal Mortality Review activities [link to Strategy W8.2; W9.2]

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	67.8	69.8	71.9	74	76.2
Annual Indicator	57.5	63.2	63.4	70.0	68.0
Numerator	19,614	22,091	22,722	22,777	21,999
Denominator	34,098	34,981	35,813	32,539	32,351
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	78.5	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	12.1	12.8	13.4	14.1	14.8
Annual Indicator	11.1	13.0	16.0	18.1	16.4
Numerator	3,657	4,455	5,507	5,651	5,200
Denominator	32,945	34,243	34,464	31,217	31,729
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	15.4	16.1	16.9	17.1

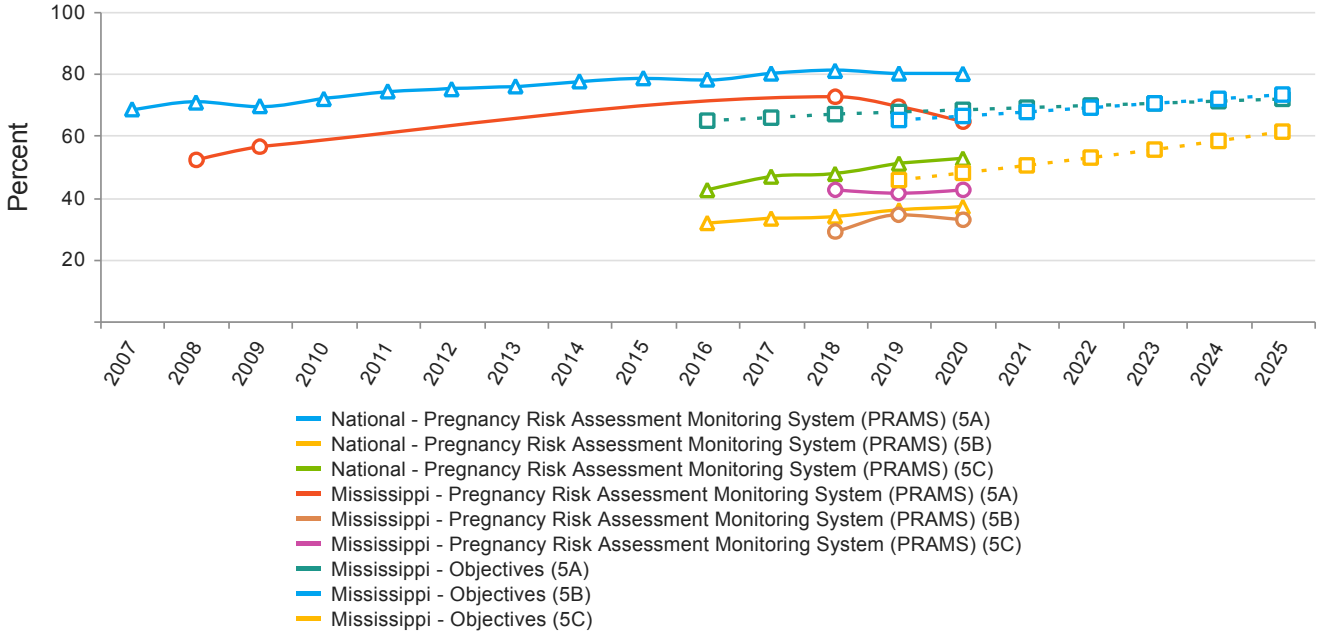
Evidence-Based or –Informed Strategy Measures

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	2	3	4	5	6
Annual Indicator	2	11	18	21	22
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	24.0	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	65.7	66.8	67.5	68.2	68.9
Annual Indicator	56.1	56.1	72.2	69.4	64.3
Numerator	21,733	21,733	23,861	22,384	20,451
Denominator	38,760	38,760	33,042	32,256	31,790
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2009	2009	2018	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	65.7	66.8	67.5	68.2	68.9
Annual Indicator	62	63.6	72.2		
Numerator	21,089	21,016	23,861		
Denominator	34,025	33,023	33,042		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	69.6	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**
Annual Objective	64.9	66.2	67.5
Annual Indicator	28.8	34.4	32.7
Numerator	9,167	10,964	10,154
Denominator	31,841	31,829	31,010
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			64.9	66.2	67.5
Annual Indicator	62	63.6	28.8		
Numerator	21,089	21,016	9,167		
Denominator	34,025	33,023	31,841		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	68.9	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**
Annual Objective	45.6	47.9	50.3
Annual Indicator	42.3	41.3	42.4
Numerator	13,523	12,948	13,078
Denominator	31,973	31,323	30,870
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			45.6	47.9	50.3
Annual Indicator	39.4	43.4	42.3		
Numerator	13,941	15,145	13,523		
Denominator	35,407	34,882	31,973		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	52.8	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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	20,000	25,000	20,200	20,450	20,700
Annual Indicator	25,000	20,000	10,000	14,880	9,560
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
2022	**2023**	**2024**	**2025**	
Annual Objective	21,000.0	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		
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		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	84.0	84.5	85.0

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, 2023, increase the number of women who enroll in WIC and initiate breastfeeding by 5%	
By September 30, 2023, increase the number of children enrolled and participating in the WIC program by 5%	
Strategies	
Assist birthing hospitals on attaining the Baby Friendly designation	
Assist in the creation and maintenance of Baby Cafés 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, 2025, decrease fetal mortality rate by 3%

By September 30, 2025, decrease infant mortality rate by 5%

Strategies

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

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

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

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

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

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 enrollment of pregnant women in the Healthy Moms/ Healthy Babies of MS program by 5%

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

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

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

Strategies

Promote / Advocate for prenatal medical visits

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

Promote / Advocate for interconception care

Promote annual preventive medical visits for women of reproductive age

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, 2023, increase the number of women who enroll in WIC and initiate breastfeeding by 5%

By September 30, 2023, increase the number of children enrolled and participating in the WIC program by 5%

Strategies

Assist birthing hospitals on attaining the Baby Friendly designation

Assist in the creation and maintenance of Baby Cafés across the state of Mississippi

Genetics Bureau/Newborn Screening (NBS)

Newborn Screening (NBS) is a public health service completed prior to discharge of the newborn from the birthing facility. The primary goal of the Newborn Screening Program is to screen every infant born in the state and refer infants with abnormal results to appropriate centers for medical evaluation, confirmatory testing, and initiation of medical and/or nutritional treatment if indicated. This short-term follow-up process assists in the identification of certain serious or life-threatening conditions that may cause organ damage, developmental delay, or death if left undiagnosed and untreated.

The newborn screening system includes birthing hospitals, a screening laboratory, public health staff, and tertiary care centers. MSDH contracts with an outside laboratory to perform newborn screen blood spot testing and, when indicated, second tier DNA testing for some disorders. Evaluation and confirmatory testing are performed at a tertiary care center by medical subspecialists.

The MS Genetics Advisory Committee recommends to the MS Board of Health genetic conditions for inclusion on the MS NBS Panel. Spinal Muscular Atrophy (SMA) and Mucopolysaccharidosis I (MPS I) were added November 1, 2019. The program screens for genetic disorders and point of service screening which includes, but is not limited to:

- Amino Acid Disorders
- Hemoglobin Disorders
- Endocrine Disorders
- Cystic Fibrosis
- Fatty Acid Oxidation Disorders
- Galactosemia
- Pompe
- Critical Congenital Heart Disease
- Spinal Muscular Atrophy
- Mucopolysaccharidosis I (MPS I)

Sections 41-21-201 and 41-21-203 of the Mississippi Code of 1972 require all newborns born in Mississippi be screened prior to discharge from the birthing facility regardless of age of the newborn or feeding status. Through collaboration with all stakeholders in the newborn screening system, almost all infants born in Mississippi are screened. Reasons for lack of newborn screening include: transfer of the newborn to an out of state facility for a higher level of care shortly after birth, home birth, death prior to specimen collection, or parents of a newborn objecting on grounds that screening conflicts with religious practices.

Timely newborn screening is imperative to the early identification of genetic diseases or disorders. Ensuring that babies with a positive diagnosis for a genetic disease or disorder allows for appropriate follow-up and action. This may include additional testing, referral to programs, linkage to services and resources, disease management and treatment. However, genetic diseases or disorders not detected in a timely manner can result in disability or even death. The Mississippi Newborn Screening program consistently monitors state birthing facilities screening performance to identify areas of improvement and determine ways to provide assistance and support. As a result of quarterly program monitoring, review and hospital visits, the program identified the need for hospital staff training about timely specimen collection and transit. The state performance measures were chosen to measure timeliness of specimen collection and transit of blood specimens, which ultimately allows for a timely diagnosis. The activities with which we were engaged consisted of regional trainings that provided a baseline for comparison and then determine change in knowledge, attitude, and beliefs among hospital and health department staff related to

specimen collection and transit. These activities allowed our program to pinpoint, address, and prevent bottlenecks that can dramatically affect the screening results, which may, in turn, warrant immediate follow-up or action if a positive diagnosis is confirmed.

The purpose of our establishing a Quality Improvement (QI) program was to develop a continuous tracking and monitoring tool to measure operations such as workflow and staff workload.

Genetics- Annual Report

NOMs, NPMs, SPMs and ESMs

NPM 6: Developmental Screening
SPM 1: Percent of infants born in Mississippi who screen positive for a condition mandated by Mississippi newborn screening statutes and receive timely diagnosis.
SPM 2: Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection.
ESM 1: Monitor on a monthly, quarterly, and annual basis time of initial screen to results.
ESM 2: Number of annual training/in-services for hospital staff conducted.

Strategies and Activities (FY October 1, 2020 - September 30, 2021):

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

Objective 1: By December 31, 2022, conduct nine (9) hospital staff quality improvement trainings/in-services in the Northern, Central, and Southern regions of the state.

Strategy 1: Improve newborn bloodspot, CCHD, and hearing screening and reporting, including specimen collection procedures among hospital nurseries and laboratory staff

Activity 1a: Schedule monthly meetings with PerkinElmer staff to collaborate and develop a workplan to conduct (9) virtual trainings for hospital and health department staff.

A total of six (6) virtual newborn blood spot collection trainings were successfully held in the spring and fall for hospital and health department staff. The purpose was to provide staff with training on proper specimen collection and timely transit to overall increase diagnosis reporting. Meetings between MSDH program and PerkinElmer Genetics staff was held to plan three trainings conducted May 20th, 24th, and 26th and three trainings conducted October 19th, 20th and 21st. During planning meetings, it was expressed although using a virtual platform, that trainings were to be as interactive as possible. This would allow participants to actively engage and participate oppose to being lectured for the duration of the trainings.

Activity 1b: Develop a training agenda and flyers to include speakers, presentation topics, CEs hours for nurses and social workers and other logistics.

As a result of planning meetings between MSDH and PerkinElmer staff, an agenda and an evaluation tool were developed (see attached). Feedback received from participants who attended the spring trainings resulted in adjustments to the training agenda held in October. One major change as a result of the spring evaluation results, was increasing the time of the training from one hour to two hours to allow participants more time to ask questions

and complete the evaluation. CEUs for nurses and social workers were planned to be offered however, was not provided during the spring or fall trainings. In lieu of CEUs, certificates of completion were provided and sent to all training participants.

Strategy 2: Increase timely screening and referral to tertiary centers for babies diagnosed with a positive genetic condition

Activity 2a: Monitor and identify bottle necks that prevent timely screening of newborns within 24-48 hours.

Review of reports pulled from the database were reviewed and identified hospitals who were screening babies prior to 24 hours of birth or after 48 hours of birth. Ensuring that babies are screened during this timeframe prevents the delay in meeting the timeliness of other metrics. Hospitals who were not conducting screenings within the 24–48-hour timeframe were contacted to schedule a virtual hospital visit. Feedback from hospital visits highlighted several factors that affected meeting the 24-48 specimen collection metric. These factors included: staff turnover, staff having to do multiple roles due to staff shortage as a result of COVID, and the need for training for new staff.

Activity 2b: Monitor and identify bottle necks that prevent timely transit of specimens to the laboratory within 1 day after collection.

Review of reports pulled from the database revealed that a few hospitals did not meet the transit of specimens to the laboratory within 1 day after collection. Hospitals where specimens did not reach the laboratory within 1 day after collection were contacted to conduct a virtual hospital visit. Feedback from hospital visits that highlighted factors that prevented the receipt of specimens within 1 day after collection included: specimens were lost during transit; specimens were damaged during transit all of which had to be rescreened and delayed timely diagnosis reporting.

Activity 2c: Monitor and identify bottle necks that prevent timely screening to reporting time within 7 days.

Review of reports pulled from the database showed that final diagnosis of newborn screens were generated within the 7-day reporting period. Results of the report showed that hospitals met this metric and there were no identified bottlenecks observed that prevented reaching this goal.

Activity 2d: Monitor and identify bottle necks that prevent timely referral and confirmation of disease by tertiary centers and the linkage to services, resources, and long-term follow-up care coordination.

Review of reports pulled from the database in addition to monitoring staff workload showed that improvement is needed related to making referrals to tertiary centers for confirmation of disease, linkage to services, resources, and long-term coordination. Some of the factors identified were tertiary staff not being able to contact families to comply with follow-up appointments. Additionally, the COVID-19 pandemic has also played a role where families did not feel comfortable bringing their babies in to hospitals for additional testing etc.

Strategy 3: Develop a Quality Improvement (QI) program utilizing the PDSA Cycle and frameworks/tools to manage and monitor all aspects of the Newborn Screening program

Activity 3a: Develop monthly and quarterly status reports that track workflow operations.

A report was developed that was broken down by each regional coordinator to monitor their newborn screen caseloads. In addition to the report being broken down by coordinator, information that included the county along with a detailed status related to follow-up action was added. Including the status, allowed the program director an

opportunity to monitor timeliness of closing cases as well as identifying factors that prevent timely movement or closure of cases. The report was reviewed weekly to monitor the status of babies in need of closure.

Activity 3b: Develop a status report that outlines whether the program is operating at maximum aptitude and meeting outlined goals and objectives of the program.

There have been changes to staff, the addition of new databases in addition to changes in processes related to newborn screen follow-up as a result of staff changes and the need to reorganize. Therefore, the report that outlines the programs performance however, more specifically staff workflows is still under development.
Activity 3c: Develop a list of recommended changes and actions to improve operation flow which may include but not limited to modifying staff roles and responsibilities, hiring of new staff, creation of resources etc.

The list of recommended changes that look at workflow and operation is still under development due to staff shortages and changes in staff roles and responsibilities.

Strategy 4: Improve hospital collection and screening performance

Activity 4a: Conduct state-wide quarterly hospital visits for the state's 41 birthing facilities (in-person/virtual) to review their quarterly collection data report generated from the screening laboratory database.

A hospital performance report is generated on a quarterly basis which highlights hospitals performance (see attached) related to specimen collection and hospitals in need of technical assistance. Hospitals designated as "needing improvement" are contacted where staff schedule an in-person or virtual hospital visit.

Activity 4b: Provide technical assistance and introduce a corrective action plan tailored to each hospital specific need.

Hospitals receive quarterly visits (4 visits per year) by the program's regional nurse coordinator. The quarterly visits consist of a review of each hospitals screening performance, discussion about their data reports generated from the PerkinElmer database and identification of areas in need of improvement, training, professional development, resource needs, in addition to assessing barriers and challenges. Depending on the result and findings from the quarterly visits, a corrective action plan is developed and discussed as follow-up before the next scheduled hospital visit if needed.

Activity 4c: Create a newsletter and highlight hospital performance on the program's website and in the Hospital Association's newsletter.

A hospital performance report is generated on a quarterly basis which highlights hospitals performance (see attached) related to specimen collection and hospitals in need of technical assistance. Hospitals designated as "needing improvement" are contacted where staff schedule an in-person or virtual hospital visit.

Activity 4d: Quarterly send a letter to CEOs of hospitals who are not performing or not meeting screening requirements to make them aware of the status of their hospital's performance to assist with affecting change.

The development of a letter to send to hospitals CEOs is still under development and will be added as an activity for the current application year.

Perinatal High Risk Case Management/Infant Services System (PHRM/ISS)

In 2020, Mississippi had the highest teen birth rate in the nation at 27.9 births per 1,000 females 15 to 19 years of age. Lack of access to care, socioeconomic factors, and lack of comprehensive sex education are large contributors to the high birth rate. While Mississippi's teen birth rate has decreased dramatically over the past decade, more work should be done to prevent teen pregnancies and decrease the teen birth rate. Under a funding opportunity of the Pregnancy Assistance Fund, MSDH sought to maintain, expand, and operate programs and services designed for expectant and parenting teens in high schools and community service centers throughout the state. This funding ended June 30, 2021.

MSDH identified the three goals: (1) increase expectant and parenting teens access to youth-friendly, high quality medical, social, educational, and other services they need to be physically and emotionally healthy; (2) increase provider capacity to deliver youth-friendly, high-quality services to expectant and parenting teens; and (3) provide or link expectant and parenting teens to services that improve educational, health, and social outcomes.

Several focus groups for expectant and parenting teens and providers were formed across the state to determine the needs of expectant and parenting teens as well as those who provide services to them. In response, Perinatal High Risk Case Management/Infant Services System (PHRM/ISS) created a three-tier model of intervention to guide the development and expansion of services for the target population. In support of the goal to increase expectant and parenting teens access to and utilization of youth-friendly, high quality medical, social, educational, and other services, MSDH supported the development of a comprehensive resource directory that aids in linking expectant and parenting teens to needed resources (Tier 1). In the second tier of proposed interventions, MSDH focused on the goal of increasing provider capacity to deliver youth-friendly, high-quality services to expectant and parenting teens. Lastly, in the final and most intensive level of the intervention, MSDH directed its attention to the goals of providing expectant and parenting teens to services that improve educational, health, and social outcomes, and reducing the number of repeat pregnancies and births to teens. To support these goals, MSDH provided enhanced case management services to expectant and parenting teens. MSDH expanded its existing PHRM/ISS program, which currently provides enhanced case management services for medically high-risk pregnant women and infants throughout the state (Tier 3). A sub-award to Teen Health Mississippi provides financial support and technical assistance for Tiers 1 and 2 activities. MSDH is exclusively responsible for all Tier 3 activities.

The Maternal and Infant Health Bureau (MIHB)

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 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. MIHB programs and initiatives include the following:

Mississippi Perinatal Quality Collaborative.
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.

Mississippi Child Death Review Panel.
Legislatively mandated, the Mississippi State Child Death Review Panel (CDRP) is charged with improving our understanding of risk factors and circumstances surrounding child deaths so that we can ultimately improve child health, safety, and protection through effective policy, education, and public awareness. The CDRP is responsible for the following:

- Review and better understand the deaths of children less than eighteen years of age whose death occurs in Mississippi and report the accurate cause and manner of death in which the death was unexpected and/or unexplained.
- Identify preventable child deaths and improve our understanding of risk factors and circumstances surrounding these deaths with an emphasis on future protection from childhood fatalities.
- Improve communication, coordination, and linkages of agencies and organizations in response to child deaths.
- Collect and translate relevant and pertinent data on Mississippi childhood fatalities in a meaningful way in the form of an annual report to the legislature with a focus on strategies for prevention.

Fetal Infant Mortality Review.
Fetal and Infant Mortality Review (FIMR) is an action-oriented, community-based process that examines the factors and issues that influence fetal and infant mortality in a community. The mission of FIMR is to identify and create systemic change that results in the reduction of Mississippi's fetal and infant mortality rate. MSDH facilitates the FIMR in eight coastal counties of Mississippi. The FIMR process brings together key members of the community to review information from individual cases of fetal and infant deaths to identify factors associated with those deaths and establish if they represent systemic problems that require change. If so, the FIMR then develops recommendations for change, assists in the implementation of those changes, and determines community effects of those changes.

Safe Sleep.
Sleep-related deaths (SIDS and SUID) are the third-leading cause of death for Mississippi infants. Fortunately, parents and caregivers can take steps to reduce the risk of sleep-related deaths. MSDH offers counseling, referral, resources, and training on prevention of sleep-related deaths and helping those affected by SIDS and SUID.

Priority: Decrease infant mortality

NOMs, NPMs, SPM and ESMs:

NPM 5: A) Percent of infants placed to sleep on their backs
NPM 5: B) Percent of infants placed to sleep on a separate approved sleep surface
NPM 5: C) Percent of infants placed to sleep without soft objects or loose bedding
SPM 4: Percent of women ages 15-44 years old that use family planning services
ESM 1: # of FIMR Case Review Team meetings held
ESM 2: # of FIMR Community Action Team meetings held
ESM 3: # of safe sleep resources distributed to families, including fathers, and birthing hospitals
ESM 4: # of technical assistance meetings held for participating MSPQC hospitals
ESM 5: # of birth equity trainings held for Maternal and Infant Health staff and birthing hospitals
ESM 6: # of Advanced Life Support in Obstetrics trainings
ESM 7: Cumulative proportion of OB nurses receiving education on severe maternal hypertension
ESM 8: # of hospitals participating in I-Support Vaginal Births Project
ESM 9: # of I-Support webinars and trainings held
ESM 10: # of participants attending I-Support webinars and trainings
ESM 11: # of women completing intake assessments
ESM 12: # of perinatal and postpartum program (MOM.ME) webinars and workshops conducted
ESM 13: # of participants attending the perinatal and postpartum program (MOM.ME) webinars and workshops
ESM 14: # of women completing maternal mental health counseling through perinatal and postpartum program (MOM.ME)
ESM 15: # of cases identified and abstracted for Maternal Mortality Review Committee Meeting
ESM 16: # of Maternal Mortality Review Committee Meetings held
ESM 17: # of maternal mortality outreach events conducted
ESM 18: # of participants reached during maternal mortality outreach events
ESM 19: # of maternal mortality factsheets disseminated
ESM 20: # of Number of MMRC clinical recommendations/maternal mortality reports disseminated

Strategies and Activities (FY October 1, 2020 - September 30, 2021):

Strategy 1: Continue monitoring the FIMR Coordinators through the new reporting template

Activity 1a: Host two Community Action Team meetings per year.

The Coast FIMR program, covering counties Harrison, Hancock, Jackson, George, Stone, and Pearl on the Mississippi Gulf Coast, held seven case review meetings during the reporting period. Two COVID-19 surges (November 2020-January 2021 and July 2021-October 2021) hinder some hospital sites from participating in case review meetings.

The Coastal FIMR reviewed a total of 66 cases. From these reviews, the following topics were discussed as recommendations to reduce infant and fetal deaths in the area:

- Centering pregnancy or some type of group prenatal education class
- Substance abuse counselling and treatment for women and birthing people prenatal and postpartum
- Placental pathologies and stillbirths
- Revisiting the 39-week initiative from ACOG
- Encouraging women and birthing people who are pregnant or plan to become pregnant to take the COVID-19 vaccine

Activity 1b: Host two Case Review Team meetings per year.

The Coastal FIMR held four community action team meetings. Three of the action team meetings were held virtually. This was a new endeavor for the Coastal FIMR. Since the beginning of the pandemic, community action team meetings have been halted due to public health mandates.

- October 7, 2020 (virtual meeting) 70 attendees; topic: Human Trafficking
- February 9, 2021 (virtual meeting) 65 attendees; topic: MS Department of Child Protection Services: Parenting Together for Stability of Families
- August 13, 2021 (in person meeting) 24 attendees; topic: Interpersonal Partner Violence and Its Impact on Women, Infants, and Families
- September 17, 2021 (virtual meeting) 47 attendees; topic: Interpersonal Partner Violence and Its Impact on Women, Infants, and Families

Activity 1c: Inform stakeholders of the efforts of FIMR program over a trend period of 3 to 5 years.

Strategy 2: Assist the Mississippi Child Death Review Panel with continuing to develop recommendations for state leaders and other stakeholders

During this reporting period, the Maternal and Infant Health Bureau experienced personnel changes that resulted in the epidemiologist position becoming the vacant. At this time, the position has not been filled and there has been a delay in the data analysis for the report.

Activity 2a: Invite representatives from the National Center for Fatality Review and Prevention will attend a Mississippi Child Death Review Panel meeting.

During this reporting period, the MS Child Death Review Panel held six case review meetings:

- October 29, 2020; 28 cases reviewed
- November 19, 2020; 26 cases reviewed
- March 3, 2021; 20 cases reviewed
- May 20, 2021; 16 cases reviewed
- July 15, 2021; 15 cases reviewed
- September 16, 2021; 15 cases reviewed

On May 4th, the presiding chairs of the Mississippi Child Death Review Panel, the director for the National Center for Fatality Review and Prevention (NCFRP), and the CDR coordinator meet to discuss a potential site visit. The meeting allowed for the chairs to learn more about the NCFRP and challenges and barriers of other state review teams. The meeting concluded with establishing a time for the NCFRP to meet with the MS Child Death Review Panel and a draft meeting outline focused on the case abstraction process, case review process, current membership, and using case findings to craft recommendations.

Strategy 3: Collaborate with partners to disseminate infant safe sleep messaging that discouraged co-sleeping / bedsharing among at-risk populations

During the May CDRP case review meeting, the NCFRP site meeting meet was discussed. The Panel members agreed the site visit could be beneficial since there have been several new appointees. A survey to determine the best time and date for the meeting was distributed to the members. The dates of October 26 and 27, 2021, were selected as the best dates. On August 11th, a follow-up meeting was held with the NCFRP to finalize the meeting

agenda.

Activity 3a: Collaborate with Infant Safe Sleep partners and birthing hospitals to disseminate infant safe sleep messaging that discourages co-sleeping/bedsharing.

Strategy 4: Collaborate with fatherhood initiative programs to target fathers to provide infant safe sleep education

During this reporting period, 9,560 infant safe sleep messages were distributed to partners and hospitals state-wide either via educational materials or training sessions.

Activity 4a: Collaborate with 2 to 3 fatherhood initiatives to provide safe sleep resources.

Activity 4b: Disseminate safe sleep resources to 3 barber shops, 2 churches, and 1 business.

Strategy 5: Support quality improvement efforts to improve perinatal outcomes

No activity to report during this period.

Activity 5a: Provide monthly technical assistance and trainings to participating MSPQC hospitals.

Monthly Conference calls were held with hospitals on Severe Maternal Hypertension on the following dates:

- October 13, 2020 – 51 attendees
- December 8, 2020 – 43 attendees

In lieu of the Severe Maternal Hypertension monthly conference calls, MSPQC asked hospitals to attend the Institute for Healthcare Improvement – Reducing Harm for Hypertension Sprint. The IHI Sprint was a six-week series of webinars that were held on the following dates:

- January 12, 2021
- January 19, 2021
- January 26, 2021
- February 2, 2021
- February 9, 2021
- February 26, 2021

Monthly conference calls for Severe Maternal Hypertension resumed on the following dates:

- March 16, 2021 – 39 attendees
- April 27, 2021 – 43 attendees
- May 11, 2021 – 33 attendees
- June 29, 2021 – 27 attendees
- August 25, 2021 – 182 attendees

Monthly I-Support conference calls are held with teams to provide guidance, present the latest evidence, and research, and allow teams to share and learn from each other.

During this reporting period the following conference calls were conducted with participating hospitals.

- October 20, 2020 – 17 attendees
- December 1, 2020 – 19 attendees

- January 19, 2021 – 17 attendees

In lieu of the I-Support Vaginal Births c-section reduction monthly conference calls, MSPQC encouraged hospitals to attend the Institute for Healthcare Improvement – Safe Reduction of Primary Cesarean Births sprint. The IHI Sprint was a six-week series of webinars that were held on the following dates:

- March 30, 2021
- April 6, 2021
- April 13, 2021
- April 20, 2021
- April 27, 2021
- May 4, 2021

Monthly conference calls for I-Support Vaginal Births c-section reduction resumed on the following dates:

- April 20, 2021 – 16 attendees (*for newly participating hospitals*)
- May 18, 2021 – 23 attendees
- June 15, 2021 – 21 attendees
- July 20, 2021 – 15 attendees
- September 21, 2021 – 27 attendees

The Neonatal Team hosts bi-monthly webinars on Neonatal Abstinence Syndrome (NAS). Webinars were hosted on the following dates:

- October 12, 2020 – 12 attendees
- November 9, 2020 – 31 attendees
- March 8, 2021 – 15 attendees
- May 10, 2021 – 25 attendees
- September 13, 2021 – 38 attendees

MSPQC hosted its 7th Annual Conference on November 12 -13, 2020. The conference was held virtually with the technical assistance of DCE Productions. A report of attendance per session is listed below.

- Breakout Room 1 – Thursday, November 12, 2020; 100 attendees
- Breakout Room 2 – Thursday, November 12, 2020; 42 attendees
- Breakout Room 1 – Friday, November 13, 2020; 64 attendees
- Breakout Room 2 – Friday, November 13, 2020; 34 attendees
- Plenary Session – Friday, November 13, 2020; 69 attendees

Strategy 6: Partner with a national organization to provide training, assessment, and technical assistance in building a strategic plan to address birth equity

Activity 6a: Coordinate equity trainings for Maternal and Infant Health Bureau staff, hospitals participating in MSPQC Quality Improvement Initiatives and the Maternal Mortality Review Committee (MMRC).

MSPQC partnered with Dr. Karen Scott, whom at the time was Associate Professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences with a joint appointment in the Department of Humanities and Social Sciences at the University of California, San Francisco (UCSF) School of Medicine to implement the Birth Equity Elevations Series. The SACRED Birth Study is the most culturally and scientifically rigorous perinatal PREMs that operationalizes reproductive justice, research justice, and Black feminism in survey development and validation through application of the four modalities of culture rigor. Four Mississippi hospitals participated in the Sacred Birth

Study. Each of these hospitals that participated in the SACRED Birth Study were invited to participate in the Birth Equity Elevation series along with Maternal and Infant Health Bureau staff and MMRC members.

The Birth Equity Series webinars were held on the following dates:

- June 10th – 25 participants
- June 17th – 23 participants
- June 24th – 15 participants

To conclude this series of events MSPQC partnered with the Dr. Joia Crear-Perry, Founder and President of the National Birth Equity Collaborative to host a summit that addressed solutions to support Black Maternal Health in MS and eliminate inequities through addressing systemic and obstetric racism, advancing respectful care, and centering the voices of Black mothers. The Birth Equity Summit was held on June 25, 2021. A total of 36 participants attended the virtual summit.

Activity 6b: Conduct a strategic assessment to identify needs, gaps, and opportunities to strengthen the MSPQC and MMRC in addressing birth equity.

Strategy 7: Provide evidence-based trainings to MSPQC birthing hospitals to reduce severe maternal morbidity

Planning Phase: MSPQC held preliminary discussion with the National Birth Equity Collaborative on conducting a focus group, 3-5 key informant interviews and a birth equity assessment to understand the strengths, needs, opportunities and threats posed by staff and the care population. However, delays in contract execution required the scope of services provided by NBEC be tailored and therefore this activity was postponed to a later date.

Activity 7a: Conduct ALSO trainings with birthing hospitals throughout the state.

To improve the response to obstetric emergencies, MSPQC hosted Advanced Life Support in Obstetrics (ALSO) simulation trainings. ALSO is an evidence-based, interprofessional, and multidisciplinary training program that equips the entire maternity care team with skills to effectively manage obstetric emergencies. Trainings are conducted with hospitals upon request. Trainings were conducted in small groups due to COVID-19 recommendations and guidelines. A total of nine ALSO courses were conducted during this reporting period with 63 providers trained on response to obstetric emergencies.

Training was conducted with hospitals on the following dates:

- 10/19/2020 – 6 attendees
- 10/21/2020 – 6 attendees
- 3/15/2021 – 11 attendees
- 4/23/2021 – 8 attendees
- 5/13/2021 – 5 attendees
- 5/14/2021 – 5 attendees
- 6/21/2021 – 11 attendees
- 7/15/2021 -- 6 attendees
- 7/16/2021 -- 5 attendees

Strategy 8: Provide education of the treatment of severe maternal hypertension

Activity 8a: Facilitate the implementation of AIM Severe Maternal Hypertension e-modules.

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. 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. One component and process measure of the severe hypertension in pregnancy safety bundle is to educate nursing safe on the 4 domains: readiness, recognition, response, report. The Severe Hypertension in Pregnancy AIM e-module educates nursing staff on strategies and tools that are available to support evaluation and management of women with severe hypertension in pregnancy, standardized measurement and assessment strategies and key principles in educating women and their families during the prenatal and postpartum periods, facility-wide standard protocols with checklists and escalation polices and patient, family and staff support for ICU admission and serious complications, how a culture of huddles and post even debriefs can demonstrate successes and opportunities for system learning, and how multidisciplinary quality improvement and review of serious hypertension, preeclampsia and eclampsia cases can improve outcomes. MSPQC encouraged hospitals to educate nursing staff and providers by assigning the AIM e-modules in Health Stream and or creating a system for tracking completion of educations. MSPQC also created a QR code flyer to post around the labor and delivery units. Hospitals utilized the AIM Data Center to input data on the cumulative proportion of OB nurses (including Labor and Delivery and Postpartum) that have completed within the last two year an education program on Severe Hypertension and Preeclampsia. In Quarter 4 (October – December) of 2019, 62% of nursing staff had been educated on Severe Hypertension and Preeclampsia. In Quarter 4 (October – December) of 2020, 82% of nursing staff had been educated on Severe Hypertension and Preeclampsia. At the end of this reporting period and Quarter 3 (July-September) of 2021, 90% of nursing staff had been educated on Severe Hypertension and Preeclampsia.

Activity 8b: Conduct monthly Severe Maternal Hypertensions webinars with MSPQC participating birthing hospitals.

Monthly Conference calls were held with hospitals on Severe Maternal Hypertension on the following dates:

- October 13, 2020 (51 attendees)
- December 8, 2020 (43 attendees)

In lieu of the Severe Maternal Hypertension monthly conference calls, MSPQC encouraged hospitals to attend the Institute for Healthcare Improvement – Reducing Harm for Hypertension Sprint. The IHI Sprint was a six-week series of webinars that were held on the following dates:

- January 12, 2021,
- January 19, 2021,
- January 26, 2021,
- February 2, 2021,
- February 9, 2021, and
- February 26, 2021.

Monthly conference calls for Severe Maternal Hypertension resumed on the following dates:

- March 16, 2021 – 39 attendees
- April 27, 2021 – 43 attendees
- May 11, 2021 – 33 attendees
- June 29, 2021 – 27 attendees
- August 25, 2021 – 182 attendees

Strategy 9: Provide guidance to hospitals on reducing nulliparous, term, singleton, vertex (NTSV) cesarean

Activity 9a: Conduct monthly MSPQC I-Support Vaginal Births webinars with participating pilot hospitals.

The Initiative to Support Primary Vaginal Births (I-Support) is a pilot quality improvement project to support Mississippi hospitals in implementing evidence-based practices that promote vaginal births and the safe reduction of primary cesarean births among low-risk women.

Monthly I-Support conference calls are held with teams to provide guidance, present the latest evidence, and research, and allow teams to share and learn from each other. During this reporting period the following conference calls were conducted with participating hospitals.

- October 20, 2020 – 17 attendees
- December 1, 2020 – 19 attendees
- January 19, 2021 – 17 attendees

In lieu of the I-Support Vaginal Births c-section reduction monthly conference calls, MSPQC asked hospitals to attend the Institute for Healthcare Improvement – Safe Reduction of Primary Cesarean Births sprint. The IHI Sprint was a six-week series of webinars that were held on the following dates:

- March 30, 2021,
- April 6, 2021,
- April 13, 2021,
- April 20, 2021,
- April 27, 2021, and
- May 4, 2021.

Monthly conference calls for I-Support Vaginal Births c-section reduction resumed on the following dates:

- April 20, 2021 – 16 attendees
- May 18, 2021 – 23 attendees
- June 15, 2021 – 21 attendees
- July 20, 2021 – 15 attendees
- September 21, 2021 – 27 attendees

Four additional health systems (cohort 2) were added to the Initiative to Support Vaginal Births, totaling nine hospitals. An introductory webinar was held on January 25, 2021, with each new hospitals receiving the I-Support toolkit by mail, the QR scan codes for AIM eModule education, and access to the repository of educational resources. The first kick off call was held on April 20, 2021.

The implementation of the I-Support project is broken down in to three phases.

- Phase I - Readiness (3-6 month timeframe for completion of this phase). Develop the QI team and begin educating staff on AIM e-modules.
- Phase II – Recognition and Reporting (3-9 months timeframe for completion of this phase is). Encourage to share unblinded provider rates for their delivering population and conduct multidisciplinary case reviews that aid in recognizing practice variations that impact delivery outcomes.
- Phase III – Response Phase (9-12-month timeframe for completion of this phase). Identify and update policies and protocols and integrating these changes into the Electronic Medical Record.

During this reporting period, virtual one-on-one phase meetings were held with individual hospitals teams for the cohort 1 (five hospitals). These meetings supported the progression of safety bundle implementation, data collection, and provided solutions to barriers and challenges and offered praise for successes. Phase meetings were conducted in collaboration with Blue Cross Blue Shield of Mississippi as this insurer has a vested interest and maternal quality model initiative that overlaps and coincides with initiatives implemented by MSPQC.

Phase I meetings with the cohort 1 took place before this reporting period in June 2020.

Phase II meetings with cohort 1 of hospitals were held on:

- October 20,2020
- October 27, 2020
- October 28, 2020
- October 29, 2020
- October 30, 2020.

Phase III meetings with cohort 1 hospitals were held on:

- March 22, 2021
- March 24, 2021
- March 29, 2021
- March 30, 2021
- March 6, 2021

Phase I meetings with cohort 2 hospitals were held on August 3, 2021, and August 4, 2021.

Activity 9b: Maintain and update a repository of I-Support Vaginal Births tools included evidence-based research, clinical recommendations, and education tools for patients, providers, and nursing staff.

Strategy 10: Provide mental health services to women in the perinatal and postpartum period

A repository of resources was developed and is continually updated with the latest research articles and evidence to support standardized care, tools to educate staff, and recordings of monthly webinars.

Activity 10a: Conduct mental health intake assessment for women participating in perinatal/postpartum program.

A partnership was established with community-based program to offer mental health services to women perinatally and or postpartum. MOM.ME is a non-profit community-based organization that serves to uplift and normalize the struggles of motherhood. The organization is a community for moms, run and operated by moms to help them become their very best self, ultimately improving the functionality of the entire family. MOM.ME provides mental health services, webinars, and workshops.

Mental health services offered during this reporting period are offered through a program called MOM.ME Cares program. This is a 6-8 week coordinated care program designed to provide the care mothers need, where they want it: in the home, community, or office. Participants of the program received (1) 1-hour weekly individual session with therapist, (2) 1-hour weekly group session led by a peer or therapist, (3) weekly mood assessments conducted by a Care Coordinator via zoom, and (4) post-program follow-ups (up to 6 months).

Mothers are referred to MOM.ME Cares directly or by referral. The first point of contact is initiated by a phone call to

introduce the program and discuss the process with the client. To be eligible the participants must be either pregnant or within 16 months postpartum, self-identify as experiencing mental health complications, and under or uninsured. If the participant is eligible and agrees to enter the program, an enrollment application and mood assessment is completed. The completed information is then given to a therapist at which the therapist contacts the client to schedule their initial therapy session.

A total of 16 intake assessments were conducted for Cohort 1.

Cohort 2 of the MOM.ME Cares program will begin Oct. 1, 2021. Thus far, five mothers have completed intake assessments.

Activity 10b: Host webinars and workshops on maternal health topics.

In addition to the MOM.ME Cares program mothers also participate in webinars and workshops on mental health and other topics related to parenting. Below is a list of the eClasses and trainings offered by MOM.ME.

Postpartum Mother & Baby Care eClass.
Dates: Months of January 2021 and March 2021 (13 attendees).
Content included:

- Postpartum care and warning signs of Lochia, after pains, perineal healing tips, constipation, hemorrhoids, getting rest, cesarean recovery, signs of infection.
- Baby blues and postpartum mood & anxiety disorders: Tips for simplifying life during the first few weeks, signs of PPD, partner's emotions, getting support.
- Baby care and warning signs: Umbilical cord and circumcision care, diapering, stools, jaundice, dehydration, signs of illness, bathing tips, playing with baby.
- Crying and safety: Responding to cries, abusive head trauma (shaken baby syndrome), SUID, car seats, other safety tips
- Breastfeeding basics: Skin-to-skin contact, hunger signs, feeding guidelines, positioning and latch, engorgement, signs of mastitis, sore nipples, avoiding artificial nipples, signs of poor feeding.
- Formula feeding: Formula preparation, feeding guidelines, feeding position, propped bottle warning

Infant and Child Safety eClass.
Dates: Months of January 2021 and March 2021 (12 attendees).
Content Included:

- Car Safety: Infant car seats, hot cars, carbon monoxide, back over & front over safety
- Safe Baby Care: Safe sleep, abusive head trauma, food safety, outdoor safety, pets, siblings
- Safety Products: JPMA certification, baby-gear safety, baby gates, avoiding tip-overs, toy safety, childproofing products
- Home Safety: Choking, suffocation, & strangulation hazards, falls, water safety, burn prevention
- Poisons: Common household poisons, poison safety & hotline, poison "look-alikes"
- Emergency Preparedness: Gun safety, fire safety, disaster preparedness, importance of learning infant CPR & first aid

Understanding Fatherhood eClass.
Date: February 2021 (5 attendees)
Content Included:

- The Importance of Fathers: Why dads make a difference, benefits of being involved for children and dads

- The Pregnant Dad: Involved from the Start: Feelings about having a baby, how dads can be involved during pregnancy, baby gear essentials, planning ahead, childcare research
- Labor & Delivery, A Dad Is Born: Birth preference list, packing for the hospital, labor and birth basics, reality versus movies/TV, how to be a supportive partner during labor, making the most of the postpartum hospital stay
- Baby Care, Dad in Action: Coming home, breastfeeding basics, why Dad's breastfeeding support is important, creating a safe sleep environment, why babies cry and soothing techniques, abusive head trauma, bonding
- The Postpartum Dad, Emotions & Your Relationship: Self-care, relationship after baby, importance of good communication, perinatal mood and anxiety disorders and paternal postpartum depression
- Parenting, A Dad's Life: Parenting truths, dad as a safety manager, looking ahead, understanding developmental milestones and positive discipline, joys of fatherhood

Understanding Your Newborn eClass.
Date: February 2021 (10 attendees).
Content Included:
- Newborn traits: Skin-to-skin contact, newborn procedures, appearances, reflexes, senses, play and development.
- Newborn behaviors: States of alertness and how to interact, sleep, room-sharing, gagging, and choking, and breathing patterns.
- Crying and comforting: Why babies cry, infant crying patterns, comfort techniques, coping with crying, Abusive Head Trauma, postpartum emotions (baby blues and PPD).
- Feeding: Breastfeeding basics, latching on, when to feed, hunger cues, burping, how to tell if baby is getting enough milk.

Additional trainings, conferences and outreach activities offered during the reporting period included:

Mental Health Virtual Conference.
Date: March 27, 2021 (41 attendees)
Theme: "Let's Get Mental Mississippi."
Objectives: The purpose of the conference was to address the issues facing communities of color.
Host: MOM.ME partnered with Mississippi Minority Farmers Alliance
Topics discussed:
- COVID-19/The Stress of the Pandemic in Parents
- Mental Health and COVID-19
- The Importance of Fathers Seeking Mental Health Treatment
- Understanding your Finances and the Importance of Creating a Monthly Budget
- Your Child's Mental Health.

The Importance of the COVID-19 Vaccination.
Date: April 10, 2021 (57 attendees)
Objectives: The purpose of the workshop was to bring awareness to the communities of color about the importance of being vaccinated against COVID-19 and to also administer vaccines.
Host: Mississippi Minority Farmers Alliance in collaboration with a team of doctors and nurses in North Mississippi. MOM.ME. assisted with registration and exhibited at the event to bring awareness to Maternal Mental Health. MOM.ME also met one-on-one with families to discuss COVID-19 related anxieties and depression and assisted with creating action plans.

Black Maternal Health Week- Community Action for Change Facebook Live Event

Date: April 12, 2021
Host: Six Dimensions with MOM.ME participating
Objectives: The purpose of the event was to highlight community organizations working to address Black Maternal Health in Mississippi. MOM.ME discussed the importance of mothers seeking the necessary mental health treatment pre and post pregnancy.

Virtual Diaper Drive.
Date: April 19, 2021 (7 attendees)
Host: MOM.ME hosted the virtual event
Objectives: The virtual Diaper Drive was held for the mothers enrolled in the MOM.ME Cares Program. Because some of the women were not local, the diapers were packaged and mailed to the mothers. Some of the mothers had multiple children in diapers and were unemployed making it difficult for them to purchase diapers for their children. Through our partnership with the Delta Diaper Bank, MOM.ME was able to distribute approximately 500 diapers to the mothers who participated in the MOM.ME Cares Program.

MOM.ME Social Engagement Workshop.
Date: April 26, 2021 (38 attendees)
Host: MOM.ME hosted in-person
Objectives: MOM.ME Social Engagement Workshop give mothers and their families a chance to engage together. During the workshop the mothers took time to get to know each while their children played together. MOM.ME provided journals to each of the mothers and discussed why Moms benefit from journaling.

Merit Health Woman's Hospital Birthing Workshop.
Dates: April 13, 2021 (13 attendees); May 18, 2021 (11 attendees)
Objectives: MOM.ME presented virtually at Merit Health Woman's Hospital Birthing Workshop. Signs and symptoms of perinatal mood disorders was the focal topic of this training. Information provided included topics of womb care for cesarean births, childcare practices such as bathing and diaper changing techniques, health risk indicators and response notification, lactation positions, perinatal mood disorders, and more. We also informed the mothers of ways MOM.ME could help them navigate the challenges of motherhood.

Perinatal Mood Disorders Workshop.
Date: June 26, 2021 (45 attendees)
Objectives: The purpose of the event was to bring awareness to Postpartum Depression and to reassure the mothers that they are not alone in the battle. MOM.ME also highlighted partner organizations throughout the state of Mississippi and their services that they provide to mothers. This event was totally free for the mothers and their families that attended. The event was such a great success that MOM.ME was asked by the Mississippi Children's Museum staff to host the event quarterly.

Activity 10c: Provide mental health counselling to women participating in perinatal/ postpartum program

There were 16 participants who collectively received 12 group sessions in addition to being signed up to attend weekly one-on-one therapy sessions. Participants received therapy sessions from 5 therapists with 2 intern care coordinators conducting follow-ups. The follow-up process included the Care Coordinators calling and or emailing the mothers weekly to discuss their mood and the therapeutic process.

In June 2021, the program partnered with four graduate students from Mississippi College-Psychology and Counselling and added an additional contract therapist to assist with MOM.ME Cares Program. Of the 16

participants participating in Cohort 1:

- 95% had 2 or more children
- 90% had children between the ages of 0-5
- 58% reported being predisposed to a mental health disorder with themselves or a family member
- 75% were not using medication
- 57% had Medicaid
- 93% were unaware of mental health coverage provided by insurance.
- 36% reported experiencing a pregnancy related complication (21% opting out of this question)

Some common themes and trends that emerged in group sessions:

- Unaware of individual medical benefit coverage
- Hesitant to counselling for various reasons: stigmatism, time constraints, financial cost
- Lack of childcare support (participants have multiple children) financial restraints
- Isolation- lack of family & community support (just momma & baby)
- Lack of Purpose (feeling lost, “only a mother”, longing for purpose, want to work)
- Technical difficulties with technology (E-forms & internet reception in rural areas)

Strategy 11: Identify, abstract, and review maternal deaths up to 365 days postpartum

Activity 11a: Identify and abstract medical records for MMRC case review.

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.

Activity 11b: Host MMRC case review meetings

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 rise in COVID-19 cases.

MMRC meetings were conducted virtually on:

- December 3, 2020
- March 26, 2021
- June 18, 2021
- August 20,2021

Strategy 12: Increase the number of information interviews that assist the Maternal Mortality Review Committee in understanding the family's perspective of the mother preceding death

Activity 12a: Disseminate outreach packets to families identified during MMRC abstraction process.

The MMRC Social Worker disseminated 34 outreach packets to families that were identified during the abstraction process

Activity 12b: Conduct outreach phones calls with prospective informants or next of kin.

The MMRC Social Worker conducted 41 outreach calls with prospective informants or next of kin

Activity 12c: Conduct MMRC informant interview with next of kin.

The MMRC Social Worker conducted informant interview 13 with next of kin.

Strategy 13: Implement community outreach events to address maternal mortality disparities and promote clinical recommendations of the MMRC

Activity 13a: Collaborate with community partners to host maternal mortality outreach events.

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.

- January 28, 2021: MS Black Women's Roundtable 2021 Advocacy Day: The Power of the Pocketbook. This was a Facebook Live event. The event had approximately 750 views.
- February 10, 2021: Toyota Motor Manufacturing Mississippi- Mississippi Forward Panel. We discussed the issue of maternal mortality in Mississippi. 50 attendees
- February 22, 2021: Jackson Advocate & MS Free Press-Solutions Circle about Healthcare in Mississippi. The discussion was around healthcare in Mississippi and some feasible solutions for change. 8 attendees
- February 23, 2021: Clarksdale-Marks Alumnae Chapter Delta Sigma Theta Sorority, Inc.- Increasing Social Action in Black Homes & Communities (Healthcare). The discussion focused on maternal mortality and some strategies for communities to implement. 60 attendees
- April 9, 2021: Maternal Health Discussion at MS State University: Minority Health Summit. 32 attendees
- April 8, 2021: Pink out the Halls Post Legislative Review. 501 views

- April 12, 2021: Black Maternal Health Week – Community Action for Change. 793 views
- April 26, 2021: Journey to Motherhood session. 5 Participants
- May 17, 2021: Journey to Motherhood session. 17 participants
- May 19, 2021: National Women's Health Week- Dept. of Health and Human Services/Office of Minority Health. 100 attendees
- June 8, 2021: Motherhood Circle with Pregnant moms (face-to-face). 15 attendees
- June 10, 2021: NICHQ -NAPPSINN Community of Practice Webinar. 60 attendees
- June 21, 2021: Journey to Motherhood session. 10 attendees
- June 21, 2021: Unita Blackwell Young Women's Leadership Institute. 38 attendees
- July 22, 2021: Rose Breastfeeding Summit (Virtual screening of Laboring with Hope Documentary). 200 registered
- August 12, 2021: Labor & Delivery discussion with pregnant and parenting mothers. 10 attendees
- August 25, 2021: Black Breastfeeding Week Kick-off (FB live), "The Business of Breastfeeding." 458 views
- August 30, 2021: National Maternal Health Innovation Symposium (Virtual screen of Laboring with Hope Documentary). 600 registered
- September 20, 2021: Breastfeeding & Nutrition Discussion with pregnant and parenting mothers. 12 attendees
- "Let's Doula This" Doula (FB Live Discussion), September 29, 2021. 551 views; 1,041 people reached

Activity 13b: Disseminate factsheets that depicts maternal mortality disparities and causes of death to community partners.

During this reporting period, there were no factsheets developed or disseminated. The latest Maternal Mortality report is referenced while conducting outreach activities.
View the Maternal Mortality report at: https://msdh.ms.gov/msdhsite/_static/resources/8127.pdf

Activity 13c: Disseminate MMRC clinical recommendations/maternal mortality report to community partners.

The Maternal Mortality Report is currently in the process of being updated. The last published report is utilized when conducting outreach activities.

Women, Infant, and Child (WIC)

Priority: Increase Child Nutrition and early childhood obesity prevention.

NOMs, NPMs, SPM, and ESMs:

NPM 4: A) Percent of infants who are ever breastfed
NPM 4: B) Percent of infants breastfed exclusively through 6 months.
SPM 1: Number of children enrolled and participating in the MS WIC Program and percent of WIC mothers initiating breastfeeding to reduce childhood obesity.
ESM 1: # of children enrolled in the WIC Program.
ESM 2: # of children participating in the WIC Program
ESM 3: # of Baby Café's supported in MS
ESM 4: Breastfeeding initiation rate

Strategies and Activities (FY October 1, 2020 - September 30, 2021)

Objective 1: By 2022, Increase enrollment and participation in the WIC program by 5%.

Strategy 1: Evaluate the effectiveness of the WIC-Head Start Partnership

Activity 1a: Conduct an evaluation to determine difference in child enrolment and participation increases.

There have been many challenges with the COVID-19 pandemic including Head Starts temporarily closing or allowing WIC staff on-site. Historically, having staff on-site for parent meetings has increased program awareness and helped with recruiting. MS WIC has had numerous staffing issues related to the COVID-19 pandemic, which limited our ability to provide adequate, consistent coverage to area Head Starts. MS WIC has been awarded physical presence waivers from USDA FNS so participants do not need to be seen in-person or measured so it's easier for participants to be enrolled. MS WIC is in the process of renewing existing partnerships with area Head Start programs, which will be completed by March of 2022. The only partnerships that will not be renewed are not in operation.

Strategy 2: Assist in the maintenance of the Baby Cafés across the state of Mississippi

Activity 2a: Provide referrals and assistance with facilitation of Baby Café meetings.

COVID-19 has crippled in-person Baby Café' support group meetings. The Delta Baby Café' in Greenwood, Let's Talk Baby Café' located in Indianola, and the Gulf Coast Baby Café' were able to pivot to virtual meetings on the Zoom platform. Participant numbers were higher on the virtual platform because program participants expressed that it was easier for them and supporting family members to attend. They did not have to leave the comfort of their home, find a ride or adjust schedules to meet in person. These Baby Café' locations plan to continue offering support via Zoom after in-person meetings can be resumed safely. MS WIC continued to promote the meetings and refer WIC participants. WIC peer counselors continued to provide facilitation support for meetings.

Strategy 3: Increase breastfeeding initiation and duration rates through prenatal breastfeeding, education, and post-discharge support

Activity 3a: Create community partnerships as referral sources to the MSDH WIC Program.

The MSDH WIC Program established a Memorandum of Understanding (MOU) to provide support for Step 3 (prenatal breastfeeding education) and Step 10 (post-discharge breastfeeding support) of the Baby Friendly Hospital Initiative. The MOU has been signed by 26 of the 41 delivering hospitals in the state. Several of the MOU agreements were set to expire; however, renewals were processed during this time period. One of the important strategies in the agreement is the referral partnership between the hospitals and MSDH WIC. As a part of supporting Step 3, WIC staff provide support in teaching prenatal breastfeeding education classes' onsite at partnering hospitals. As a part of Step 10, WIC staff promote Baby Café's to mother's for access to post-discharge breastfeeding support. Beginning March 2020, breastfeeding classes and Baby Café' facilitation were paused due to COVID-19 restrictions. Several Baby Café' locations have transitioned to virtual meetings to continue providing breastfeeding promotion and support in this uncertain time. We have maintained 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 Mother and Baby Time groups for additional referrals to the MSDH WIC Program.

Activity 3b: Provide breastfeeding education and support to prenatal WIC participants.

In-person breastfeeding group classes remain on pause due to COVID-19 restrictions. WIC peer counselors continue to provide education through individual telephone counseling sessions and virtual platform when applicable. WIC participants also have access to the Pacify Mobile App for assistance and real time education when breastfeeding issues and questions arise.

Activity 3c: Provide WIC participants access to certified lactation consultants

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 20 WIC peer counsellors. Participants have received assistance with training and study materials. We have 8 WIC peer counselors who will be sitting for the exam Spring 2022 with the exam fee paid for by the program. The remaining 12 candidates continue to work on completing pre-requisites for the exam.

Perinatal/Infant Health - Application Year

The following strategies and activities are planned for FY23 to address the identified priorities:

Priority: Increase Breastfeeding, Healthy Nutrition and Healthy Weight

Objective I1: By September 30, 2023, increase the number of women who enroll in WIC and initiate breastfeeding by 5%

Strategy I1.1: Assist birthing hospitals on attaining the Baby Friendly designation [link to Strategy I2.1]

Strategy I1.2: Assist in the creation and maintenance of Baby Cafés across the state of Mississippi [link to Strategy I2.2]

Strategy I1.3: Increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support [link to Strategy C14.1]

- Activity I1.3a: Maintain and create additional community partnerships as referral sources to the MSDH WIC Program [link to Activity C14.1a]
- Activity I1.3b: Provide breastfeeding education and support to prenatal WIC participants [link to Activity C14.1b]
- Activity I1.3c: Provide WIC participants access to certified lactation consultants [link to Activity C14.1c]

Objective I2: By September 30, 2023, increase the number of children enrolled and participating in the WIC program by 5%

Strategy I2.1: Assist birthing hospitals on attaining the Baby Friendly designation [link to Strategy I1.1]

Strategy I2.2: Assist in the creation and maintenance of Baby Cafés across the state of Mississippi [link to Strategy I1.2]

Strategy I2.1: Partner with Head Start Centers on enrolling children in WIC

Priority: Improve Access to Family-Centered Care

Objective I3: By September 30, 2025, increase enrollment of pregnant women in the Healthy Moms/ Healthy Babies of MS program by 5%

Strategy I3.1: Conduct outreach and promote the family-centered case management available to Medicaid-eligible pregnant women through Healthy Moms/Healthy Babies [link to Strategy I5.1]

- Activity I3.1a: Promote / Advocate for prenatal medical visits

Objective I4: By September 30, 2025, increase retention of women in the Healthy Moms/Healthy Babies of MS program by 10%

Strategy I4.1: Provide family-centered case management to Medicaid-eligible pregnant women through Healthy

Moms/Healthy Babies [link to Strategy I6.1]

- Activity I4.1a: Promote / Advocate for postpartum medical visits for women 2-4 weeks following delivery
- Activity I4.1b: Promote / Advocate for interconception care
- Activity I4.1c: Promote annual preventive medical visits for women of reproductive age

Objective I5: By September 30, 2025, increase enrollment of infants in the Healthy Moms/Healthy Babies of MS program by 5%

Strategy I5.1: Conduct outreach and promote the family-centered case management available to Medicaid-eligible pregnant women through Healthy Moms/Healthy Babies [link to Strategy I3.1]

Objective I6: By September 30, 2025, increase retention of infants in the Healthy Moms/Healthy Babies of MS program by 10%

Strategy I6.1: Provide family-centered case management to Medicaid-eligible pregnant women through Healthy Moms/Healthy Babies [link to Strategy I4.1]

Priority: Reduce Infant Mortality

Objective I7: By September 30, 2025, decrease fetal mortality rate by 3%

Strategy I7.1: Provide evidenced-based education, training, and/or technical assistance to internal and external partners to decrease risk factors for adverse outcomes, morbidity, and mortality [link to Strategy I8.1]

Strategy I7.2: Conduct multidisciplinary case review meetings to understand the drivers of fetal and infant deaths in Mississippi [link to Strategy I8.2]

- Activity I7.2a: FIMR coordinators will conduct case review meetings. [link to Activity I8.2a]
- Activity I7.2b: FIMR coordinators will conduct community action team meetings. [link to Strategy I8.2b]

Strategy I7.3: Support and assist the Mississippi FIMR Panel and CDR Panel in case review and developing and disseminating reports and recommendations for the legislature, state health department, community leaders, and families [link to Strategy I8.3]

Objective I8: By September 30, 2025, decrease infant mortality rate by 5%

Strategy I8.1: Provide evidenced-based education, training, and/or technical assistance to internal and external partners to decrease risk factors for adverse outcomes, morbidity, and mortality [link to Strategy I7.1]

Strategy I8.2: Conduct multidisciplinary case review meetings to understand the drivers of fetal and infant deaths in Mississippi [link to Strategy I7.2]

- Activity I8.2a: FIMR coordinators will conduct case review meetings. [link to Activity I7.2a]
- Activity I8.2b: FIMR coordinators will conduct community action team meetings. [link to Strategy I7.2b]

Strategy I8.3: Support and assist the Mississippi FIMR Panel and CDR Panel in case review and developing and disseminating reports and recommendations for the legislature, state health department, community leaders, and families [link to Strategy I7.3]

- Activity I8.3a: Annual CDR report completed and published on MSDH website.

Strategy I8.4: Conduct multidisciplinary case review meetings to understand the drivers of child deaths in Mississippi

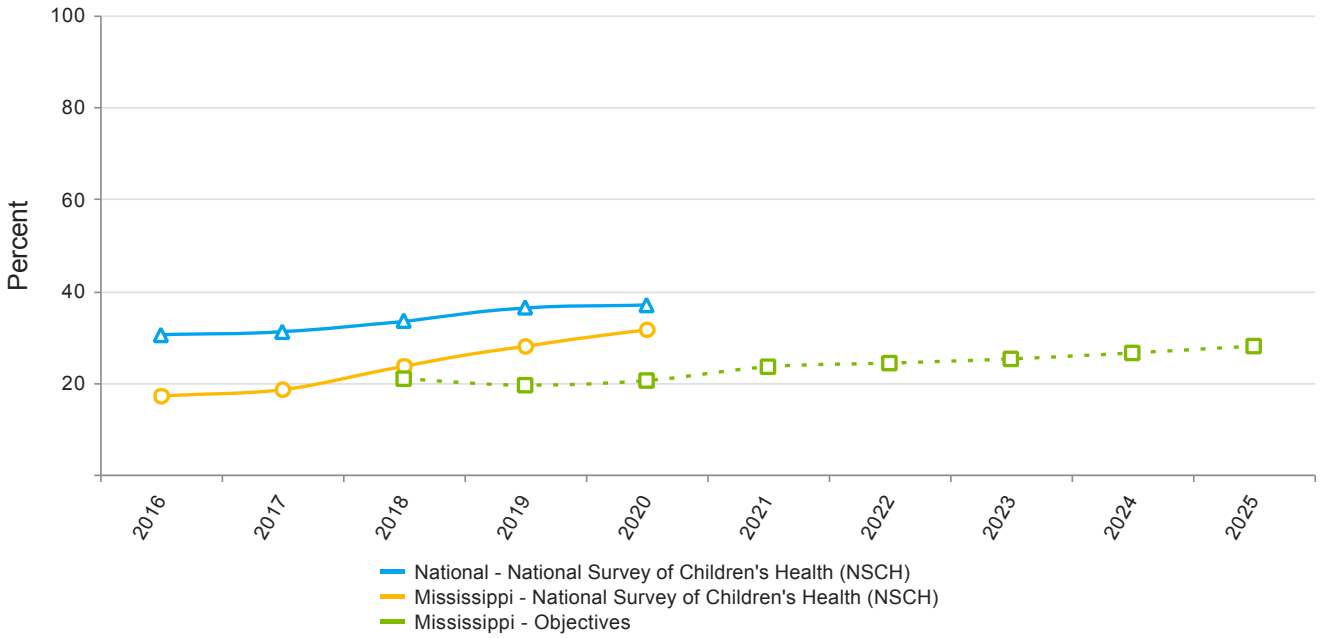
- Activity I8.4a: CDR coordinator will host case review meetings.

Strategy I8.5: Increase public awareness of preventable infant deaths due to suffocation or a sleep-related death

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		20.9	19.5	20.5	23.5
Annual Indicator	17.2	18.6	23.7	28.0	31.5
Numerator	11,967	13,102	16,993	19,663	25,115
Denominator	69,709	70,253	71,794	70,109	79,686
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	24.3	25.2	26.5	28.0

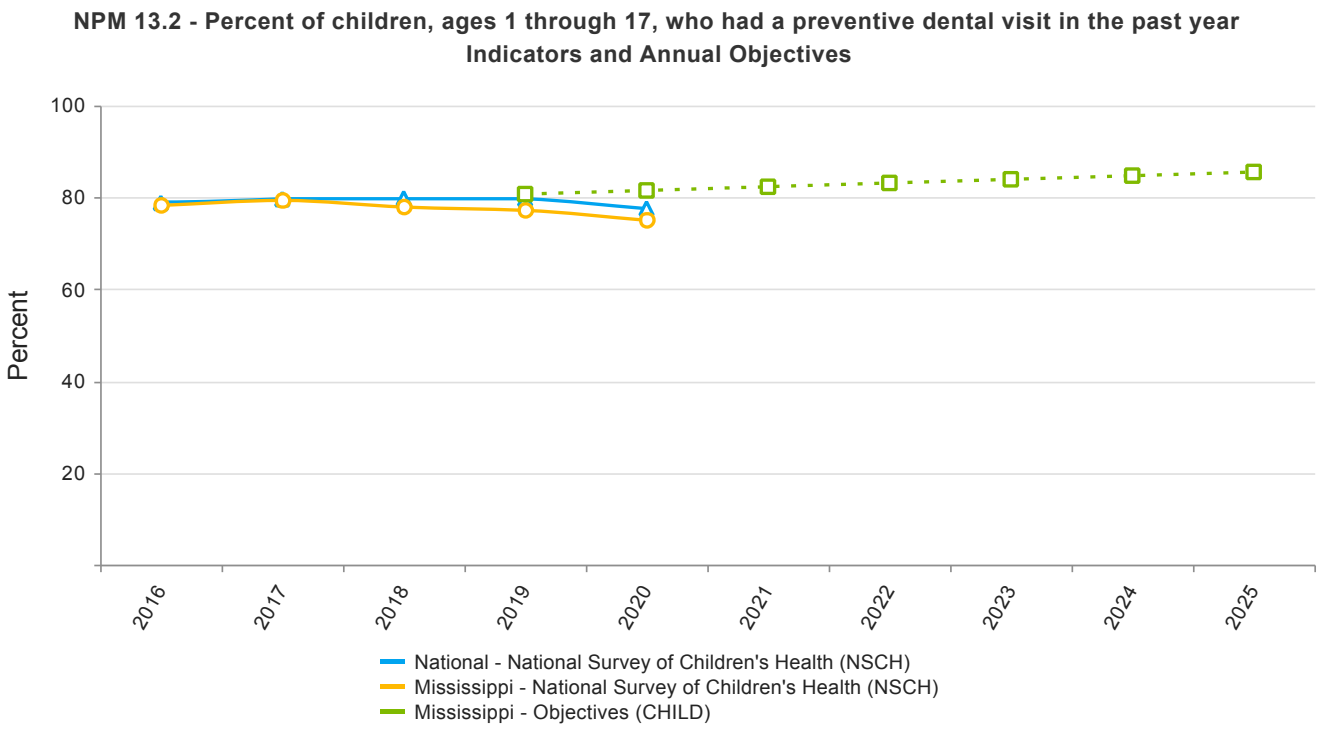
Evidence-Based or –Informed Strategy Measures

ESM 6.1 - The number of participants who received training about Bright Futures Guidelines for Infants, Children, and Adolescents.

Measure Status:	Inactive - Completed			
State Provided Data				
	2018	**2019**	**2020**	**2021**
Annual Objective			415	457
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Office of Child and Adolescent Health	Office of Child and Adolescent Health
Data Source Year			2020	2021
Provisional or Final ?			Final	Final

ESM 6.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	20.0	30.0	40.0



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			80.6	81.4	82.2
Annual Indicator	78.2	79.1	77.8	77.1	75.0
Numerator	536,054	544,787	525,080	500,754	484,100
Denominator	685,414	689,107	675,079	649,719	645,270
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	83.0	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					
	2017	2018	2019	2020	2021
Annual Objective			1,000	2,000	3,000
Annual Indicator			0	903	0
Numerator					
Denominator					
Data Source			Office of Oral Health	Office of Oral Health	Office of Oral Health
Data Source Year			2019	2020	2021
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	4,000.0	5,000.0	5,500.0	6,000.0

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					
	2017	2018	2019	2020	2021
Annual Objective			1,000	2,000	3,000
Annual Indicator			0	976	424
Numerator					
Denominator					
Data Source			EPIC	EPIC	EPIC
Data Source Year			2019	2020	2021
Provisional or Final ?			Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	4,000.0	5,000.0	5,500.0	6,000.0

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			60	65	70
Annual Indicator			10	2	8
Numerator					
Denominator					
Data Source			Office of Oral Health	Office of Oral Health	Office of Oral Health
Data Source Year			2019	2020	2021
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	75.0	80.0	85.0	90.0

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
Annual Objective		
Annual Indicator		3.8
Numerator		5,554
Denominator		144,844
Data Source		Medicaid and Lead Poisoning Prevention Program
Data Source Year		2021
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.9	4.0	4.1	4.2

SPM 9 - Dried blood spot specimens received by labs within 48 hours of collection.

Measure Status:	Inactive - Replaced

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		3,567
Numerator		
Denominator		
Data Source		Bureau of Genetics
Data Source Year		2021
Provisional or Final ?		Final

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile

Measure Status:			Active
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
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
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
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
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, 2023, increase the knowledge of health professionals on collecting and submitting newborn screening for genetic/metabolic, critical congenital heart disease (CCHD), and hearing
By September 30, 2025, increase the number of children receiving developmental screenings by 3% annually
By September 30, 2025, increase screening rates in low-resource areas of the state
Strategies
Develop a comprehensive, coordinated and integrated system of services for children
Provide professional development opportunities for health professionals to learn about best practices and state requirements for newborn screening (genetic/metabolic, CCHD, and hearing), lead screening, and developmental screening
Improve newborn bloodspot, CCHD, and hearing screening and reporting, including specimen collection procedures among hospital nurseries and laboratory staff
Increase timely screening and referral to tertiary centers for newborns and infants diagnosed with a genetic or metabolic condition
Develop and implement plans to increase coordination and integration with early childhood programs to improve timely identification
Expand infrastructure to conduct hearing screenings of children up to 36 months of age to identify late onset hearing loss, and to promote project sustainability
Work with Medicaid to identify rate of screenings and identify low-resource areas with gaps to be addressed through collectively through program improvement or development

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, 2023, increase the percent of children with a preventive dental visit by 1%

Strategies

Promote the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals

Support trainings on use of fluoride varnish in the primary care setting

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 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

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 number of infants and toddlers enrolled into family-centered services in a medical home to 2.15%

By September 30, 2025, increase the percentage of the children who exit early intervention at or near age expectations: (1) in cognitive and language/ communication skills to 52.5% (2) in social-emotional development to 64.5% (3) in motor and adaptive skills to 58%

By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5%

By September 30, 2025, increase the number of families of children who have access to peer-to-peer support and role models by 5%

Strategies

Improve hospital and primary care provider family-centered care practices

Develop and distribute resources among early childhood partners and families regarding early identification of infants and toddlers who may be eligible for services

Collaborate with the Mississippi Department of Education to implement a statewide Child Find public awareness campaign

Implement family-centered early intervention practices to improve development outcomes, including school readiness

Implement interventions with families to reduce children’s exposure to lead and other environmental hazards

Link children exposed to lead to recommended family-centered services

Recruit a diverse team of family advisors located in each of the three regions of the state to provide assistance and support to families

Expand the EHDI family peer support program with Family Advisors and Deaf/Hard of Hearing Role Models

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, 2023, increase the knowledge of health professionals on collecting and submitting newborn screening for genetic/metabolic, critical congenital heart disease (CCHD), and hearing

By September 30, 2025, increase the number of children receiving developmental screenings by 3% annually

By September 30, 2025, increase screening rates in low-resource areas of the state

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Provide professional development opportunities for health professionals to learn about best practices and state requirements for newborn screening (genetic/metabolic, CCHD, and hearing), lead screening, and developmental screening

Increase timely screening and referral to tertiary centers for newborns and infants diagnosed with a genetic or metabolic condition

Develop and implement plans to increase coordination and integration with early childhood programs to improve timely identification

Expand infrastructure to conduct hearing screenings of children up to 36 months of age to identify late onset hearing loss, and to promote project sustainability

Work with Medicaid to identify rate of screenings and identify low-resource areas with gaps to be addressed through collectively through program improvement or development

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, 2023, increase the knowledge of health professionals on collecting and submitting newborn screening for genetic/metabolic, critical congenital heart disease (CCHD), and hearing

By September 30, 2025, implement 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, 2023, increase the number of infants with confirmed hearing loss who received confirmation of hearing status by 3 months to 67%

By September 30, 2023, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, increase screening rates in low-resource areas of the state

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Provide professional development opportunities for health professionals to learn about best practices and state requirements for newborn screening (genetic/metabolic, CCHD, and hearing), lead screening, and developmental screening

Improve newborn bloodspot, CCHD, and hearing screening and reporting, including specimen collection procedures among hospital nurseries and laboratory staff

Develop and implement plans to increase coordination and integration with early childhood programs to improve timely identification

Expand infrastructure to conduct hearing screenings of children up to 36 months of age to identify late onset hearing loss, and to promote project sustainability

Work with Medicaid to identify rate of screenings and identify low-resource areas with gaps to be addressed through collectively through program improvement or development

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, 2023, increase the knowledge of health professionals on collecting and submitting newborn screening for genetic/metabolic, critical congenital heart disease (CCHD), and hearing

By September 30, 2023, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2025, increase the number of children receiving developmental screenings by 3% annually

By September 30, 2025, increase screening rates in low-resource areas of the state

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Provide professional development opportunities for health professionals to learn about best practices and state requirements for newborn screening (genetic/metabolic, CCHD, and hearing), lead screening, and developmental screening

Improve newborn bloodspot, CCHD, and hearing screening and reporting, including specimen collection procedures among hospital nurseries and laboratory staff

Increase timely screening and referral to tertiary centers for newborns and infants diagnosed with a genetic or metabolic condition

Develop and implement plans to increase coordination and integration with early childhood programs to improve timely identification

Work with Medicaid to identify rate of screenings and identify low-resource areas with gaps to be addressed through collectively through program improvement or development

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, 2023, reduce the loss to follow-up and loss to documentation in screening programs

By September 30, 2023, decrease the number of children less than six years of age identified with lead poisoning by 5%

By September 30, 2025, increase the number of children receiving developmental screenings by 3% annually

By September 30, 2025, increase the percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age by 0.5%

By September 30, 2025, increase screening rates in low-resource areas of the state

Strategies

Develop a comprehensive, coordinated and integrated system of services for children

Increase knowledge and awareness among the public, public health professionals, childhood lead prevention workforce members, and other partners about childhood lead poisoning, new threshold blood lead levels, prevention, and intervention through tailored education and outreach

Develop and implement plans to increase coordination and integration with early childhood programs to improve timely identification

Increase identification of children exposed to lead

Work with Medicaid to identify rate of screenings and identify low-resource areas with gaps to be addressed through collectively through program improvement or development

Provide professional development opportunities for health professionals to learn about best practices and state requirements for newborn screening (genetic/metabolic, CCHD, and hearing), lead screening, and developmental screening

Early Intervention

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 receive developmental screening and/or monitoring to support appropriate referrals for EISS, and infants and toddlers with identified disabilities and/or developmental delays receive timely, comprehensive, and family-centered services.

The MSFSEIP is composed of a state office, three regional offices, and nine (9) 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. Additionally, we collaborate with local partners to identify, locate, and evaluate all infants and toddlers with disabilities.

The MSFSEIP State Office provides training, guidance, and oversight to the regional offices and LEIPs to ensure families of children with disabilities and/or developmental delays, from birth through 35 months of age, receive timely, comprehensive, and family-centered services. 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 early intervention 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.

Developmental screening is vital for identifying children who may have delays in physical, adaptive, cognitive, communication, and social-emotional development. By identifying those children who need additional evaluation and diagnosis, resources can be targeted and intervention provided early to reduce the likelihood of developing additional and/or more significant delays. A comprehensive system of developmental screening involving collaborations across early childhood programs, and implementation of data-driven, evidence-based strategies are critical to promoting positive outcomes for children (AMCHP, June 2015).

MSFSEIP is responsible for coordinating a state-wide comprehensive interagency system of 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. It coordinates with providers and families across the state and engages in ongoing collaborative efforts with primary health care providers, early care and education providers, and state and local groups to ensure (1) children receive developmental screening and/or monitoring to ensure appropriate referrals to early intervention, and (2) referred children receive an evaluation for early intervention services.

These infrastructure improvements will ensure the state and local programs have the required system supports to implement and evaluate the use of evidence-based practices. Program standards will enable Program Coordinators to identify program features that support or may be a barrier to implementing evidence-based practices. Program staff may use the Program Standards along with improved program-level data to drive and evaluate quality improvements. Personnel standards aligned with the evidence-based practices to be implemented in Mississippi will enable both preservice preparation programs and in-service professional development providers to identify and

support the development of knowledge and skills required for early intervention professionals to implement these evidence-based practices. Furthermore, the development of an Early Intervention Credential will ensure current and future service providers across disciplines demonstrate the core knowledge and skills required to provide high-quality early intervention services and supports in a home or community setting. Together these infrastructure improvements will assist the state in scaling-up the use of evidence-based practices through improving the MSFSEIP informational and personnel resources.

NOMs, NPMs, SPMs and ESMs

NPM 6: Developmental Screenings
SPM 1: Percent of Children who receive developmental screening
ESM 1: # of Personal contacts with referral sources, presentations made at a MSDH meetings, and exhibitions and/or presentations made at a conference, public event, and/or community meeting.
ESM 2: # of literature or Public Service Announcement distributed to the local media.
ESM 3: # of local health fairs and/or provision of developmental screenings attended by EI service coordinators.

Strategies and Activities (FY October 1, 2020 - September 30, 2021):

Priority: Access to Care (Women, Children, Adolescents and families)

Strategy 1: Develop and distribute resources among MSFSEIP and other early childhood stakeholders regarding early identification of infants/toddlers who may be eligible for MSFSEIP services

In 2020-2021, MSFSEIP Program and Service Coordinators conducted more than 1,200 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 4,148 referrals for infants and toddlers with suspected developmental delay.

Activity 1a: Personal contacts with referral sources, presentations made at a MSDH meetings, exhibitions and/or presentations made at a conference, public event, and/or community meeting, and distribution of literature or Public Service Announcement to local media venues

In 2020-2021, Early Intervention Program and Service Coordinators made personal contacts 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); however, the number of contacts made were significantly decreased due to COVID-19. The Early Intervention Program and Service Coordinators did mail informational resources regarding the MSFSEIP and developmental screenings to traditional partners and provided information in more non-traditional ways, such as leaving at supermarkets to provide information to those who with limited access.

The 2020-2021 Child Find activities and referrals during this reporting period were lower because outreach efforts and the number of infants and toddlers who received developmental screenings were severely impacted by the COVID-19 pandemic. Overall, referrals to MSFSEIP decreased by more than 25% during this period, and the typical referral sources, e.g., pediatricians, childcare facilities, etc., had significant declines in patient contact.

Activity 1b: Participation in a local health fair, back to school events, and community baby showers and/or provision of developmental screening.

In 2020-2021, Early Intervention Service Coordinators also participated in some virtual and drive thru local health fairs and Medicaid/ MSCAN events, including Community Baby Showers, and partnered with local Head Start program conduct developmental screenings for infants, toddlers, and preschool children; however, again, the number of contacts made were significantly decreased due to COVID-19.

Strategy 2: Collaborate with Mississippi Department of Education to develop statewide materials for a Child Find public awareness campaign

Activity 2a: Collaborated with 619 Coordinator (MDE) to develop a resource guide for parents to support transition from Part C – Part B programs.

In 2020-2021 MSFSEIP collaborated with 619 Coordinator (MDE) to develop a resource guide for parents to support transition from Part C to Part B programs. Service Coordinators collaborated with local school district personnel in their regions to develop and/or update plans for communication and data sharing to support transition of children at 36 months of age to school and/or community-based services under IDEA.

Activity 2b: Presented Part C – B early childhood transition guide to MS PTI during virtual meeting ensuring effective/meaningful supports and effective services for children with disabilities and their families.

State level MSDH Early Intervention staff in conjunction with 619 Coordinator, MS Department of Education provided a preview of the First Steps to Next Steps Transition Guide, a manual to guide parents as their children exit Part C Early Intervention at 36 months and the options available. The guide was developed by the Transition Workgroup Committee of the Comprehensive System Personnel Development (CSPD) of the State Interagency Coordinating Council (SICC) for Part B Early Intervention program. The audience consisted of parents, educators, childcare providers, and other stakeholders that serve children in families under IDEA funds. The manual received full board approval from the Mississippi Department of Education in June 2021.

Lead Poisoning Prevention and Healthy Homes

NOMs, NPMs, SPMs and ESMs

SPM 1: Percentage of Medicaid beneficiaries who receive a blood lead screening test at age 12 and 24 months of age.
ESM 1: Number of lead testing conducted among Medicaid-enrolled children at one to two years of age.
ESM 2: Prevalence and incidence of elevated blood lead levels in children less than 72 months of age.
ESM 3: Number of in children identified with EBLLs.
ESM 4: Number of trainings provided to communities, partner organizations, and stakeholders.
ESM 5: The number of children referred to medical, environmental, and social services.

Strategies and Activities (FY October 1, 2020 - September 30, 2021):

Priority: Access to Care (Women, Children, Adolescent, and families)

Objective 1: By September 30, 2022, decrease the number of children less than six years of age identified with lead poisoning

from 251 (9/1/19-9/30/20) by 10%

Strategy 1: Improve data usage that leads to a greater identification of geographic areas and populations at high - risk for lead exposure

Activity 1a: Collaborate with Lead Advisory Committee revising and implementation of plans for surveillance data collection, data quality checks, and data dissemination with a focus on data interoperability.

The program met with the Lead Advisory Committee 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.

Activity 1b: Conduct analysis of surveillance data to identify lead-exposed children, high-risk populations, and geographic areas.

The program developed a draft surveillance snapshot to include 2017-2020 data. This report details the number of children tested, the number identified with elevated blood lead levels, and the percentage of children less than six years of age with confirmed elevated blood lead levels by age and Medicaid status. This data will be used to help the program re-access their strategies for primary and secondary prevention.

Strategy 2: Increase linkage to recommended services for children exposed to lead

Activity 2a: Connect children with elevated blood lead levels to recommended medical, environmental, and social services.

The program works collaboratively with numerous MSDH programs to refer families of children with an elevated lead level for additional services

Activity 2b: Develop alerts in surveillance system to flag and track children with elevated blood lead levels requiring follow up.

The program identified 132 children with confirmed venous blood lead levels ≥5µg/dL who were provided with care coordination services that included telephone counseling, home visits/environmental assessments and referrals, as needed.

Strategy 3: Increase knowledge and awareness among the lay public, public health professionals, childhood lead prevention workforce members, and other partners and stakeholders about childhood lead poisoning and prevention Interventions

Activity 3a: Provide tailored education and outreach to communities, partner organizations, and stakeholders as requested.

Through partnerships, the program was able to provide education and outreach to over 600 individuals and disseminate over 1,700 pieces of educational resources.

Oral Health

The Office of Oral Health is tasked with addressing (1) the Title V MCH Block Grant's priority need of improving oral health and (2) Mississippi's state performance need of limited access to affordable oral health care and insurance. The Office of Oral Health is responsible for the promotion of oral health and prevention and control of oral diseases in the state of Mississippi. Because oral health is vital to overall health, the Office of Oral Health works across agency departments and with stakeholders to create a culture of overall health.

During the year October 1, 2020 to September 30, 2021, the initiatives of the Office of Oral Health were designed to address (1) NPM 13.2 (percent of children, ages 1 through 17, who had a preventive dental visit in the past year; and (2) the state performance measure (increasing the number of trainings provided to nondental providers—medical doctors, nurse practitioners, physician assistants—and staff on oral health assessment and fluoride varnish use in medical settings to decrease early childhood caries in children.

A summary of the evidence-based strategy measures and the results that were achieved are noted in the following table:

Number	Measure	Results
ESM 1	Number of professionals in primary care settings providing oral health care to children and adolescents in the past 12 months	42
ESM 2	Number of dentists trained on Medicaid Fee Schedule updates and coding updates	42 total, 2 of whom were dentists
ESM 3	Number of children aged 1 – 3 who received fluoride varnish application through non-dental providers who participated in the Cavity Free in Mississippi training	1,052 private payers, Monroe County 657 Medicaid payers, Monroe County 40, Lee County (Family Care Medical Clinic)
ESM 4	Number of children aged 1 – 3 referred to a dental home through non-dental providers who participated in Cavity Free in Mississippi training	Unable to identify
ESM 5	Number of Oral Health 101 trainings provided to MSDH non-dental providers	765 WIC participants and their children received Oral Health 101 training as well as oral health kits, which include an age-appropriate toothbrush, toothpaste, and floss. There were also 5 virtual trainings given by our external partner to healthcare workers and community members during this reporting period
ESM 6	Number of children and adolescents who receiving preventive oral health care from oral health professionals in school-based programs in the past 12 months	There is no data for this EMS during this grant reporting period. School-based sealant and screening programs were placed on hold due to COVID-19 and the new policies limiting occupancy. Many of our FQHC dental partners expected to get back into the schools in FY21; however, this was delayed
ESM 7	Number of oral health professionals in school-based programs providing preventive oral health care to children and adolescents in the past 12 months	There is no data for this EMS during this grant reporting period. School-based sealant and screening programs were placed on hold due to COVID-19 and the new policies limiting occupancy. Many of our FQHC dental partners expected to get back into the schools in FY21; however, this was delayed
ESM 12	Number of referrals of children 0-3 years old from MSDH nurses	426
ESM 13	Number of children 0 – 3 years who went to a referred dentist	Information was captured in EPIC system based on EPDST wellness visits. There is an oral health evaluation component. The Office of Oral Health is working to customize reports to find out more regarding specifics of referrals as it relates to linkages to care. At present, this information is unknown

Strategies and Activities: October 1, 2020 to September 30, 2021

Strategy 1: Increase oral health awareness regarding oral disease indicators

The Cavity Free in Mississippi program offers face-to-face training with healthcare providers and their staff on how to perform an oral health evaluation, the benefits of and how to apply fluoride varnish, and caregiver education on good oral hygiene practices. Medical providers and staff also received training on billing/coding for services rendered, fifty.25 gram of 5% sodium fluoride varnish, education pamphlets on fluoride varnish, and a list of dental suppliers and products. During the grant reporting period, Cavity Free in Mississippi trainings and supplies were provided in Yalobusha County at Yalobusha Medical Clinic (1), in Rankin County at Family Health Care Clinic (35), in Harrison County at Children's International (3) and in Forrest County at Lackey Pediatric Clinic (3). A total of 42 medical providers and staff were trained, representing four counties. The Office of Oral Health also incorporated a spreadsheet recording of follow up with non-dental providers in the state. This allows the regional oral health consultants to document which providers they have contacted regardless of their ability to schedule a training. 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 of the oral health assessment and fluoride varnish application in their healthcare system.

With the COVID-19, the presentation was modified to provide these trainings virtually to teams. Upon completion, all participants received a certificate of attendance.
Additionally, medical providers and staff received fifty (50) .25 gram of 5% sodium fluoride varnish, education pamphlet on fluoride varnish, and a list of dental suppliers and products. During the grant reporting period, Cavity Free in Mississippi trainings, at least two hundred (200) .25 grams of 5% sodium fluoride varnish were provided to implement this program.

As part of this training, medical providers and staff received training on billing/coding for services rendered for Medicaid reimbursement as a program implementation incentive. Specifically, it was shared that medical providers who offer this service must use the D0145 (oral health evaluation of children under three years old) and D1206 (topical application of fluoride varnish) which are dental codes. Some states utilize medical codes for this service.

A dental care coordinator was hired in July of 2021. The Office of Oral Health is still working within the barrier around the small number of medical and dental integrated electronic health records that are currently on the market, which will require a substantial investment to the medical providers. Therefore, the Office of Oral Health has created a better internal process to establish follow up procedures with the medical providers and staff members to ensure that the barriers to dental care are addressed, that they are receiving dental referrals, that treatment is received, and a dental home established.

During the grant reporting period, two medical facilities captured the number of children who received fluoride varnish applications from this program. Physicians and Surgeons in Monroe County provided fluoride varnish to 1,052 private payers and 657 Medicaid payers. Family Care Medical Clinic in Lee County provided fluoride varnish to 40.

Strategy 2: Conduct a basic health surveillance of Head Start children

The 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 carries 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. These increased efforts took the form of screenings, education (Head Start and day care staff), and fluoride varnish applications. An MOU was not established with the MS Head Start Association in 2019; therefore, greater efforts were placed on providing these

efforts to children that attended day care facilities.

Once the COVID 19 pandemic is under better control, the Office of Oral Health will continue its efforts to increase the number of centers it will work with across the state. However, the Office of Oral Health has maintained contact with Head Start Centers and day-care centers throughout the state. ROHCs have been distributing hygiene product and education information to local centers and helping to coordinate dental care. The Office of Oral Health have also had several virtual meetings with Head Start Association grantees to keep them abreast of oral health news and help them to better navigate during the COVID 19 pandemic. In light of an open mouth oral health surveillance of head start children, the Office of Oral Health has been in discussions with Head Start Association to provide a non-open mouth surveillance of health start children. During this reporting period, an Oral Health Workgroup was formed with the MS Head Start Association to better discuss the oral health surveillance needs and practicality of reporting for the grantees.

The Office of Oral Health has been unable to move forward with the Basic Screening Surveillance of Head Start students because the screening forms used by the facilities are customized for that given center and many of the grantees do not use the national form. As a result, the Office of Oral Health will not be able to get the information needed when carrying out a non-open mouth surveillance. Additionally, the office did not receive the sample demographic information from each of the centers to further formulate the methodology. Currently, the Office of Oral Health is collaborating with the Head Start Association grantees to adopt the national oral health screening form as the standard form to be used as an enrollment document.

Over the past few months, the Office of Oral Health has collaborated with Head Start Association grantees to create an oral health taskforce composed of Head Start grantee health informatic and IT staff along with community dentists. This taskforce will allow for the discussion of the feasibility and ease of switching to the national dental form while maintaining compliance with other reporting metrics along the electronic record that houses this information. In May 2021, the Head start Association agreed to share the listserv of oral health taskforce members. These individuals coupled with persons from the Office of Oral Health will work to come up with solutions in hopes to carry out the Basic Screening Surveillance of Head start children in the Fall of 2021.The indicators evaluated for preschool (Head Start) children are untreated decay, treated decay and urgency of need for dental care. As the Office of Oral Health did not carry out the Basic Screening Oral Health Surveillance, there is no data to report on.

Oral health supplies and educational materials were donated to children who were learning onsite and for those who were learning virtually.

Strategy 3: Integrate WIC and oral health services

The program hired two new ROHCs in the later part of 2021; however, due to the federally required changes made to WIC's operations, SPIRIT training of new staff has been delayed. The Office of Oral Health has trained the new team members on the collaborative partnership with WIC and working to connect them with chief nutritionist in their perspective coverage areas.

The initial agreement between WIC and the Office of Oral Health was for the SPIRT system to calculate the number of WIC participants that receive oral health education; however, both programs realized that the synchronization of protocol on data input and retrieval from the SPIRIT system was not possible unless an addition to the program is purchased. A different data collection method was established by the oral health director. Oral health consultant collect sign in sheets of the participants that receive oral health education at their respective WIC facilities when visited. These sign in sheets captures the participants name, child/children age (if applicable), pregnancy information

(are you pregnant, are you seeing a dentist, are you breastfeeding), dental home information (have you had a dental visit in the last six months, do you have a dental home) and contact information (may the Office of Oral Health contact you about finding a dentist, phone number or other form of contact). The sign-in sheets are sent to the central office and the participant information is recorded by one of the program's epidemiologists.

With the COVID 19 pandemic, many of the certifications were done virtually and teams worked with nutritionist at various WIC sites to coordinate oral health education inclusion efforts. As such, the nutritionists or clerks have been placing needed information inside the SPIRIT portal.

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 several WIC sites throughout Mississippi, providing oral health kits, finger brushes, training brushes, and brochures in both English and Spanish.

During the summer of 2021, the Office of Oral health hired a dental care coordinator to centralize our care coordination state-wide. The management tools were created using an Excel spreadsheet with a protocol that was shared with all Oral Health Team members. Based on the current protocol, all patients identified and not having a dental home and who are okay with us following up with them are placed on our spreadsheet and contacted to further assist them finding a dental home or other resources. Some patient demographic information is collected and correspondence with said patients is documented.

Strategy 4: Collaborate with faith-based organizations to promote oral health visits in underserved populations

The Office of Oral Health distributed several oral care kits, toothbrushes, boxes of floss, and educational material to several faith-based organizations throughout Mississippi. It also reached out to several faith-based organizations with multiple seminary locations; however, it was unable to establish a relationship to provide this training. The Office of Oral Health is aware that there may be barriers in establishing a robust relationship and are looking for ways to garner greater trust.

During the grant reporting period, several congregational health ministries were contacted to assist them in establishing a dental health component to their current health ministry; however, The Office of Oral Health did not receive much response from many organizations. It was noted that the faith-based organizations had established health ministries that dealt with widely known chronic diseases such as heart disease, diabetes, hypertension, and stroke; yet oral health was not a component. The Office of Oral Health is working to establish a plan in the hopes of creating a better relationship with these organization located within our service areas

During the grant reporting period, no congregational health ministry, parachurch, or charitable organization received training on shared care coordination and patient navigation services. 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.

Strategy 5: Monitor dental care coordination efforts for expectant and post-partum mothers and their children

The Office of Oral Health continues to incorporate integrated templates in EPIC for internal agency use. This process has been slower than anticipated but efforts are continual.

On May 25, 2021, a Zoom call was held with Melanie Williams, the Associate Vice President of Home Visiting Initiatives with Delta Health Alliance. Healthy Start is a program under the home visiting initiative. Our programs

discussed how the Delta Healthy Start Initiative and the Office of Oral Health could better partner. One idea was allowing MSDH ROHCS to provide health education to Delta Healthy Start participants and to provide the Cavity Free Kids training to staff. Currently, this program does a health assessment. Prior to our initial discussion, there was no oral health assessment. Since discussions began, they have included an oral health assessment component of its participants The Office of Oral Health discussed initiating an MOU between the two organizations to share data and further define specific provide services each entity would render. To date, there is no MOU has in place to further define the relationship. The Office of Oral Health are working to renew this partnership in 2022 to gather baseline data on the dental health and level of health literacy to those that participate in this program and to provide education and materials to improve these conditions.

A new oral health consultant was hired in October 2021 for this region, who will work with the dental care coordinator to (1) educate individuals and families about dental health and assist them in setting objectives to improve their oral hygiene through encouragement of tooth decay prevention; (2) collect data to aid dentists in the triage of patients; (3) perform risk assessments; (4) address challenges of social, environmental, and health literacy; (5) coordinate preventative care according to the dentist's guidelines; and (6) assist patients in navigating the healthcare system's challenges. During this grant reporting cycle, these services did not occur due to staffing issues.

During the grant reporting period, two regional oral health consultants provided oral health education and supplies to two foster care facilities: one to Harrison County Elijah's Closet Mission (where 250 adult and 200 youth oral health kits were distributed), and one to the Lauderdale County Foster Grandparent's Group (where 100 youth oral health kits were distributed).

On June 1, 2021, a virtual meeting took place with Kim Jordan, CARES Program Director/Director of Nursing, at Canopy Children's Services and the Office of Oral Health team. Since 1912, Mississippi Children's Home Services, now Canopy Children's Solutions, has placed nearly 7,000 infants and children into permanent, loving homes. Canopy provides adoption home studies, pre- and post-placement solutions, counselling to adoptive parents, specialized adoption training, and interstate compact services. Ms. Jordan was very interested in us creating a partnership to provide education to the children they serve. They currently take the children to get their 6 months dental visits; however, she mentioned that many of them have never been taught the proper procedures on brushing. The Office of Oral Health discussed piloting an oral health education session with a regional an oral health consultant for the children living in their Jackson, MS location; however, with the advent of COVID-19, educational sessions were not scheduled.

Strategy 6: Strengthen collaborative partnership with the Division of Medicaid

The Office of Oral Health continued work with the Division of Medicaid and had meetings with team members who worked directly with the oral health benefits department. In this meeting, the program director was given information on how to get Medicaid codes that do not have a fee associated with them active. Additionally, the program director started attending quarterly meetings with the Division of Medicaid representatives that are held with other Health Services director's and their teams. As part of the Children and Youth with Special Health Care Needs cohorts, oral health referral to dental homes is a central piece. The coding used by dental providers has several codes associated with treating kids with special health care needs. Unfortunately, in the state those codes nor the ones for the application of silver diamine fluoride are not active, do have an associated fee which providers who use them are paid.

The Office of Oral Health's collaborative relationship with the Division of Medicaid will be strengthened by participating in the Advancing Prevention and Reducing Childhood Caries in Medicaid and Chip Affinity Group. This

is a two-year technical assistance opportunity aimed to (1) improve the delivery of fluoride varnish by primary or community care providers, particularly to children under 6 years; and (2) connect beneficiaries with ongoing sources of dental care.
The Office of Oral Health resubmitted the original work request sent to the Division of Medicaid requesting information on the dental codes used in the state. The following information was requested and received from Mississippi Division of Medicaid:

- The total number of children (ages 0-21) by age, Medicaid/CHIP, who were enrolled for at least 90 continuous days for years 2014-2019
- The number of children (ages 0-21) who were screened with evidence of decay (procedure codes D2140-D2799; D2929-D2954; D3310, D3427; D7111-D7230, or D7250)
- The number of children (ages 0-21) who were screened with evidence of decay. Break down by race gender and geography for the years 2014-2019 using codes in 2.
- The number of children (ages 0-21) who received fluoride varnish (D1206) only by a non-dental provider year 2014-2019
- Percent of Medicaid beneficiaries, less than or equal to 20 years of age, who have received a dental visit (D0120-D9999) for years 2018-2019
- Percent of Medicaid beneficiaries, less than or equal to 20 years of age who had their teeth cleaned (D1120) for years 2018 and 2019
- Percent of Medicaid beneficiaries, less than or equal to 20 years of age, who received oral health services (D0120-D9999) by a non-dentist provider
- Percent of Medicaid children ages 6-9 who have received dental sealants (D1351) on permanent molars for years 2018 and 2019
- Percent of Medicaid/CHIP children (ages 0-20) with a dental visit (D0120-D9999) for years 2018 and 2019
- Percent of children ages 1-17 with a dental visit (D0120-D9999) for years 2018-2019

Strategy 7: Build connections and strengthen opportunities with university and allied health schools with dental degree and dental hygiene degree programs

The Office of Oral Health continue 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 persons 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, 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 rotate work in clinics with faculty dentists throughout the state.

In April 2021, the UMMC SOD hired a new dean, Dr. Sreenivas Koka. Dr. Koka is service minded and aspires to assure that students graduating from UMMC SOD recognize their role to serve the community and expressed an interest in increasing dental student public health experiences. In addition to this, Dr. KoKa has shared that they are working to diversify dental school faculty and students more and make sure the school is more inclusive.

As a part of their recruitment efforts, the UMMC SOD visits local colleges and universities to expose students to the field of dentistry. In addition to this, the dental school participates in an annual dental impression's day where students are allowed to come to the dental school for a tour, to do some dental projects and meet dentists and dental students to answer questions about dental school. Due to the COVID 19 pandemic, our program director was not able attend but provided flyers about our DAT scholarship preparatory program to share with students at the dental impression program and on their recruitment visits.

Women, Infants and Children (WIC)

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. In September 2021, there was a total of 76,376 enrolled participants, including 15,974 women, 20,461 infants, and 39,941 children. The WIC food package provides nutritious foods to supplement nutrition requirements from regular meals. WIC participants can choose some or all the following, free of charge: eggs, beans, cheese, baby formula, peanut butter, white and chocolate milks, yogurt, hot and cold cereals, 100% fruit juices, canned tuna or salmon (for breastfeeding mothers), whole wheat bread, pasta, and tortillas, fresh and canned fruits and vegetables, baby food fruits and vegetables, and/ or baby food meats (for breastfed infants).

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. This includes 104 grocery stores, 157 grocery stores with a pharmacy on site, and 12 free-standing pharmacies. Adequate participant access to authorized grocery stores is determined when there is at least one (1) authorized grocery store within a 20-mile driving radius of each WIC clinic in a suburban/urban county, and a 30-mile driving radius of each WIC clinic in a rural county. Adequate participant access to authorized pharmacies is determined when there is at least one (1) authorized pharmacy within a 20-mile driving radius of any WIC clinic. There are currently 45 clinics across 35 counties without an authorized pharmacy within a 20-mile driving radius. 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.

A portion of each state's WIC funds must be spent on breastfeeding promotion and support. WIC is a strong supporter of breastfeeding and has designated that breastfeeding be promoted and supported by the Breastfeeding Program staff and all WIC clinic staff members. The purpose of the WIC Breastfeeding Promotion and Support Program is to promote and support breastfeeding. Breastfeeding promotion focuses on the advantages of breastfeeding on a personal, local, regional, and state level. Breastfeeding support focuses on the interactions with WIC families and communities to enhance the breastfeeding experience. WIC staff provide breastfeeding information and support to all pregnant and breastfeeding women receiving services from the Mississippi WIC Program. 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 MSDH WIC Program provides nutrition education and healthy foods to pregnant and postpartum women, infants, and children up to age 5. According to the Academy of Pediatrics, breastfeeding may lower a child's risk of overweight and obesity. The MSDH WIC Program partners with various community agencies to ensure mothers who may be eligible for services are enrolled to receive nutrition related care. One of these agencies is Head Start, who services children from 0-5 years by aiming to meet the child and family's nutrition and physical activity, educational, mental, and social needs. The Head Start Initiative was chosen because it is a form of outreach that directly impacts WIC participation and enrollment. This program services children from 0-5 years of age by aiming to meet the child and family's nutrition and physical activity, educational, mental, and social needs. Head Start participants are usually eligible to receive WIC. If a parent or guardian chooses, Head Start participants are easily enrolled and benefit from the nutrition education and healthy food WIC provides. The resources that Head Start and WIC provide empower

participants to make lifestyle changes, which improves the health of our state.

According to the MSDH 2019 Infant Mortality Report, of the 37,009 infants born in Mississippi, 312 died. This represents 8.43 infant deaths per 1,000 live births. This number represents a 3.3% decrease from the 2017 rate of 8.72 per 1,000 live births. These data further support our efforts to implement initiatives designed to increase breastfeeding initiation and duration rates in Mississippi. Research shows that breastfeeding is one of many strategies aimed at lowering infant mortality rates. The American Academy of Pediatrics recognizes breastfeeding as a means of decreasing rates of sudden infant death syndrome. The 2020 CDC Breastfeeding Report card shows that, in Mississippi, 70% of infants were ever breastfed and 38.6% were breastfeeding at six months. This is a 6.8% increase in infants ever breastfed and a 3.2% increase for infants breastfed at six months from the 2018 CDC Breastfeeding Report card. The 2011 Surgeon General's Call to Action to Support Breastfeeding identified hospital practices that make it hard to get started with successful breastfeeding, not enough opportunities to communicate with other breastfeeding mothers, lack of up-to-date instruction for healthcare professionals, and lack of accommodation for breastfeeding mothers to express milk at work as obstacles to breastfeeding. This report also recognizes Baby Friendly accreditation and access to breastfeeding professionals as actions the healthcare community can take; and strengthening programs that provide mother-to-mother support and peer counselling as actions the community can take to support breastfeeding families. As of January 2022, Mississippi has 22 baby-friendly designated hospitals with several others on the pathway to designation.

Child Health - Application Year

The following strategies and activities are planned for FY23 to address the identified priorities:

Priority: Increase Access to Timely Appropriate, and Consistent Health and Developmental Screenings

Objective C1: By September 30, 2023, increase the knowledge of health professionals on collecting and submitting newborn screening for genetic/metabolic, critical congenital heart disease (CCHD), and hearing

Objective C2: By September 30, 2025, increase the number of children receiving developmental screenings by 3% annually

Objective C3: By September 30, 2025, increase screening rates in low-resource areas of the state

Objective C4: By September 30, 2025, implement 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 C5: By September 30, 2023, increase the number of infants with confirmed hearing loss who received confirmation of hearing status by 3 months to 67%

Objective C6: By September 30, 2023, reduce the loss to follow-up and loss to documentation in screening programs

Objective C7: By September 30, 2023, decrease the number of children less than six years of age identified with lead poisoning by 5%

Objective C8: By September 30, 2025, increase the percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age by 0.5%

The following are coordinated strategies that address multiple objectives. To eliminate repetitive lists under each objective, they are listed here once, and the related objectives are noted.

Strategy C1.1-C8.1: Develop a comprehensive, coordinated, and integrated system of services for children [link to Objective C1; C2; C3; C4; C5; C6; C7; C8]

- Activity C.a: Develop and maintain an integrated data system 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 C.b: Develop improved functionality and reports in program databases to support a comprehensive, coordinated, and integrated system of services for children and data-driven quality improvement efforts
- Activity C.c: 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 to ensure a comprehensive, coordinated, and integrated system of services for children
- Activity C.d: Develop and implement policies and procedures in child health programs to support a comprehensive, coordinated, and integrated system of services for children
- Activity C.e: 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 C.f: Receive contacts from families and/or contact families to assist them with accessing screenings, evaluations, and referrals to family-centered medical, environmental, developmental, and social services

Strategy C1.2-C8.2: Provide professional development opportunities for health professionals to learn about best practices and state requirements for newborn screening (genetic/metabolic, CCHD, and hearing), lead screening, and developmental screening [link to Objective C1; C2; C3; C4; C5; C6; C7; C8]

- Activity C.g: Assess hospitals to determine gaps with newborn screening and reporting to identify hospitals needing assistance.

- Activity C.h: Invite screening providers to participate in training and education sessions on screening using HealthStream.

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C1.3-C8.3: Contact health care providers to conduct active surveillance to ensure screening, evaluation, and referral data are reported in a timely manner. [link to Objective C1; C2; C3; C4; C5; C6; C7; C8]

- Activity C.f: Receive contacts from families and/or contact families to assist them with accessing screenings, evaluations, and referrals to family-centered medical, environmental, developmental, and social services

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

- Activity C.j: Send letters to families and primary health care providers explaining the need for follow-up

Strategy C1.4-C8.4: Work with Medicaid to identify rate of screenings and identify low-resource areas with gaps to be addressed through collectively through program improvement or development [link to Objective C1; C2; C3; C4; C5; C6; C7; C8]

Strategy C2.5; C3.5; C4.5; C5.5; C6.5; C7.5; C8.5: Develop and implement plans to increase coordination and integration with early childhood programs to improve timely identification [link to Objective C2; C3; C4; C5; C6; C7; C8]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

- Activity C.f: Receive contacts from families and/or contact families to assist them with accessing screenings, evaluations, and referrals to family-centered medical, environmental, developmental, and social services

Strategy C1.5; C3.6; C5.6; C6.6: Improve newborn bloodspot, CCHD, and hearing screening and reporting, including specimen collection procedures among hospital nurseries and laboratory staff [link to Objective C1; C3; C5; C6]

- Activity C.g: Assess hospitals to determine gaps with newborn screening and reporting to identify hospitals needing assistance.

- Activity C.h: Invite screening providers to participate in training and education sessions on screening using

HealthStream.

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C3.7; C6.7; C7.6; C8.6: Increase identification of children exposed to lead [link to Objective C3; C6; C7; C8]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.
- Activity C.f: Receive contacts from families and/or contact families to assist them with accessing screenings, evaluations, and referrals to family-centered medical, environmental, developmental, and social services

Strategy C3.8; C6.8; C7.7; C8.7: Increase knowledge and awareness among the public, public health professionals, childhood lead prevention workforce members, and other partners about childhood lead poisoning, new threshold blood lead levels, prevention, and intervention through tailored education and outreach [link to Objective C3; C6; C7; C8]

- Activity C.h: Invite screening providers to participate in training and education sessions on screening using HealthStream.
- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.
- Activity C.f: Receive contacts from families and/or contact families to assist them with accessing screenings, evaluations, and referrals to family-centered medical, environmental, developmental, and social services

Priority: Improve Access to Family-Centered Care

Objective C9: By September 30, 2025, increase the number of infants and toddlers enrolled into family-centered services in a medical home to 2.15%

Strategy C9.1: Improve hospital and primary care provider family-centered care practices [link to Strategy C11.1; C12.1]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C9.2: Link children exposed to lead to recommended family-centered medical, environmental, developmental, and social services [link to Strategy C10.2; C11.2; C12.2]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Objective C10: By September 30, 2025, increase the percentage of the children who exit early intervention at or near age expectations: (1) in cognitive and language/ communication skills to 52.5% (2) in social emotional development to 64.5% (3) in motor and adaptive skills to 58%

Strategy C10.1: Collaborate with the Mississippi Department of Education to implement a statewide Child Find

public awareness campaign

- Activity C.k: Develop new promotional materials about early intervening services to be distributed via social media, press, and in print
- Activity C.l: Distribute new promotional materials through a variety of approaches (e.g., personal contacts with referral sources; exhibitions and/or presentations at MSDH meetings, community meetings, public events, and/or conferences; and distribution of Public Service Announcement to local media venues)
- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C10.2: Link children exposed to lead to recommended family-centered medical, environmental, developmental, and social services [link to Strategy C9.2; C11.2; C12.2]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C10.3: Develop and distribute resources among early childhood partners and families regarding early identification of infants and toddlers who may be eligible for services [link to Strategy C11.3; C12.3]

- Activity C.k: Develop new promotional materials about early intervening services to be distributed via social media, press, and in print
- Activity C.l: Distribute new promotional materials through a variety of approaches (e.g., personal contacts with referral sources; exhibitions and/or presentations at MSDH meetings, community meetings, public events, and/or conferences; and distribution of Public Service Announcement to local media venues)
- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C10.4: Implement family-centered early intervention practices to improve development outcomes, including school readiness [link to Strategy C11.4; C12.4]

- Activity C.m: Provide professional development to early intervention service providers on an evidence-based model for family engagement in early intervention (i.e., Routines-Based Model for Early Intervention)
- Activity C.n: Implement an evidence-based model for family engagement in early intervention (i.e., Routines-Based Model for Early Intervention) with fidelity

Objective C11: By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5%

Strategy C11.1: Improve hospital and primary care provider family-centered care practices [link to Strategy C9.1; C12.1]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C11.2: Link children exposed to lead to recommended family-centered medical, environmental,

developmental, and social services [link to Strategy C9.2; C10.2; C12.2]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C11.3: Develop and distribute resources among early childhood partners and families regarding early identification of infants and toddlers who may be eligible for services [link to Strategy C10.3; C12.3]

- Activity C.k: Develop new promotional materials about early intervening services to be distributed via social media, press, and in print

- Activity C.l: Distribute new promotional materials through a variety of approaches (e.g., personal contacts with referral sources; exhibitions and/or presentations at MSDH meetings, community meetings, public events, and/or conferences; and distribution of Public Service Announcement to local media venues)

Strategy C11.4: Implement family-centered early intervention practices to improve development outcomes, including school readiness [link to Strategy C10.4; C12.4]

Strategy C11.5: Implement interventions with families to reduce children's exposure to lead and other environmental hazards [link to Strategy C12.5]

Strategy C11.6: Recruit a diverse team of family advisors located in each of the three regions of the state to help and support to families [link to Strategy C12.6]

Strategy C11.7: Expand the EHDI family peer support program with Family Advisors and Deaf/Hard of Hearing Role Models [link to Strategy C12.7]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Objective C12: 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 C12.1: Improve hospital and primary care provider family-centered care practices [link to Strategy C9.1; C11.1]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C12.2: Link children exposed to lead to recommended family-centered medical, environmental, developmental, and social services [link to Strategy C9.2; C10.2; C11.2]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Strategy C12.3: Develop and distribute resources among early childhood partners and families regarding early identification of infants and toddlers who may be eligible for services [link to Strategy C10.3; C11.3]

- Activity C.k: Develop new promotional materials about early intervening services to be distributed via social media, press, and in print

- Activity C.l: Distribute new promotional materials through a variety of approaches (e.g., personal contacts with referral sources; exhibitions and/or presentations at MSDH meetings, community meetings, public events, and/or conferences; and distribution of Public Service Announcement to local media venues)

Strategy C12.4: Implement family-centered early intervention practices to improve development outcomes, including school readiness [link to Strategy C10.4; C11.4]

- Activity C.m: Provide professional development to early intervention service providers on an evidence-based model for family engagement in early intervention (i.e., Routines-Based Model for Early Intervention)

- Activity C.n: Implement an evidence-based model for family engagement in early intervention (i.e., Routines-Based Model for Early Intervention) with fidelity

Strategy C12.5: Implement interventions with families to reduce children's exposure to lead and other environmental hazards [link to Strategy C11.5]

Strategy C12.6: Recruit a diverse team of family advisors located in each of the three regions of the state to help and support to families [link to Strategy C11.6]

Strategy C12.7: Expand the EHDI family peer support program with Family Advisors and Deaf/Hard of Hearing Role Models [link to Strategy C11.7]

- Activity C.i: Provide tailored education and outreach to communities, partner organizations, and stakeholders.

Priority: Improve Oral Health

Objective C13: By September 30, 2023, increase the percent of children with a preventive dental visit by 1%

Strategy C13.1: Promote the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals

- Activity C.o: Increase oral health awareness regarding oral disease indicators [link to Activity W1.1a]

- Activity C.p: Conduct a basic health surveillance of Mississippi's children enrolled in Head Start

- Activity C.q: Coordinate efforts with the WIC program to improve access for WIC recipients (both children and pregnant mothers) to dental care [link to Activity W1.1b]

- Activity C.r: Collaborate with faith-based organization to promote oral health visits in underserved populations [link to Activity W1.1c]

- Activity C.s: Monitor dental care coordination efforts among children 1-17 years

- Activity C.u: Strengthen the collaborative partnership with the Division of Medicaid

- Activity C.v: Continue to build connections and strengthen opportunities with the UMMC SOD and with other schools offering dental hygiene degree programs

Strategy C13.2: Support trainings on use of fluoride varnish in the primary care setting

Priority: Increase Breastfeeding, Healthy Nutrition and Healthy Weight

Objective C14: 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 C14.1: Increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support to reduce childhood obesity [link to Strategy I1.3]

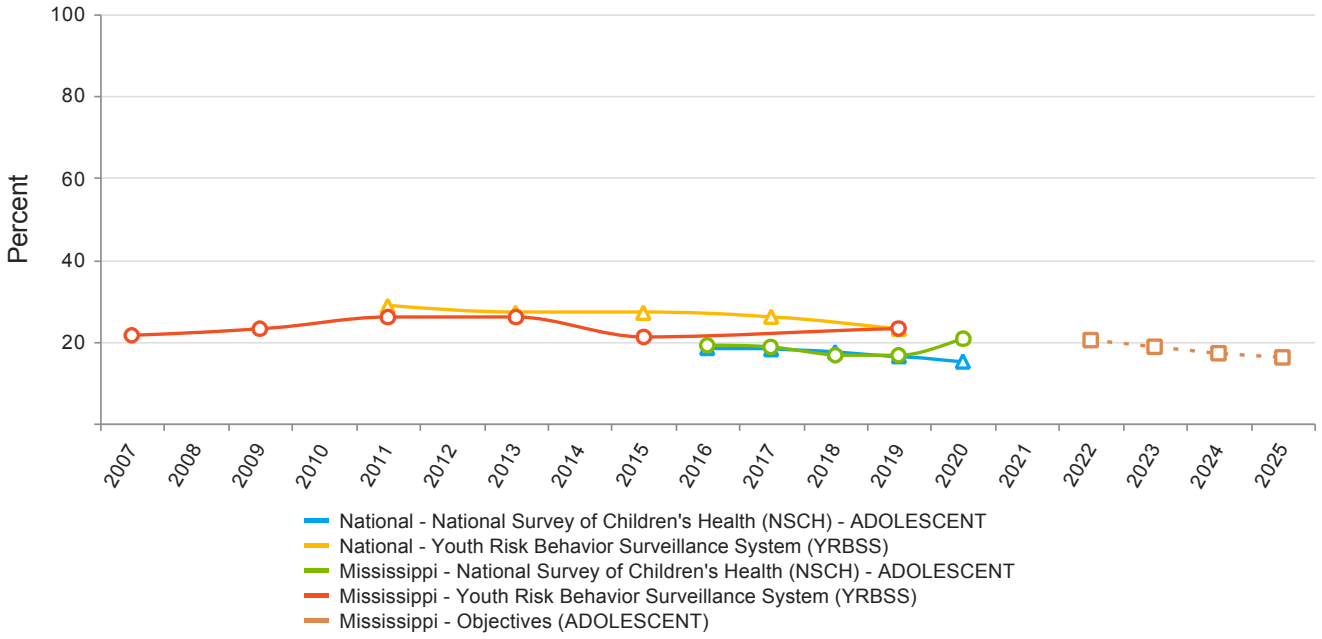
- Activity C14.1a: Maintain and create additional community partnerships as referral sources to the MSDH WIC Program [link to Activity I1.3a]
- Activity C14.1b: Provide breastfeeding education and support to prenatal WIC participants [link to Activity I1.3b]
- Activity C14.1c: Provide WIC participants access to certified lactation consultants [link to Activity I1.3c]

Strategy C14.2: Implement evidence-based practices to decrease obesity in early childhood

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**
Annual Objective		
Annual Indicator	23.4	23.4
Numerator	29,043	29,043
Denominator	123,981	123,981
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2019	2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2020	**2021**
Annual Objective		
Annual Indicator	16.7	20.6
Numerator	38,663	48,356
Denominator	231,717	234,684
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	20.4	18.8	17.2	16.2

Evidence-Based or –Informed Strategy Measures

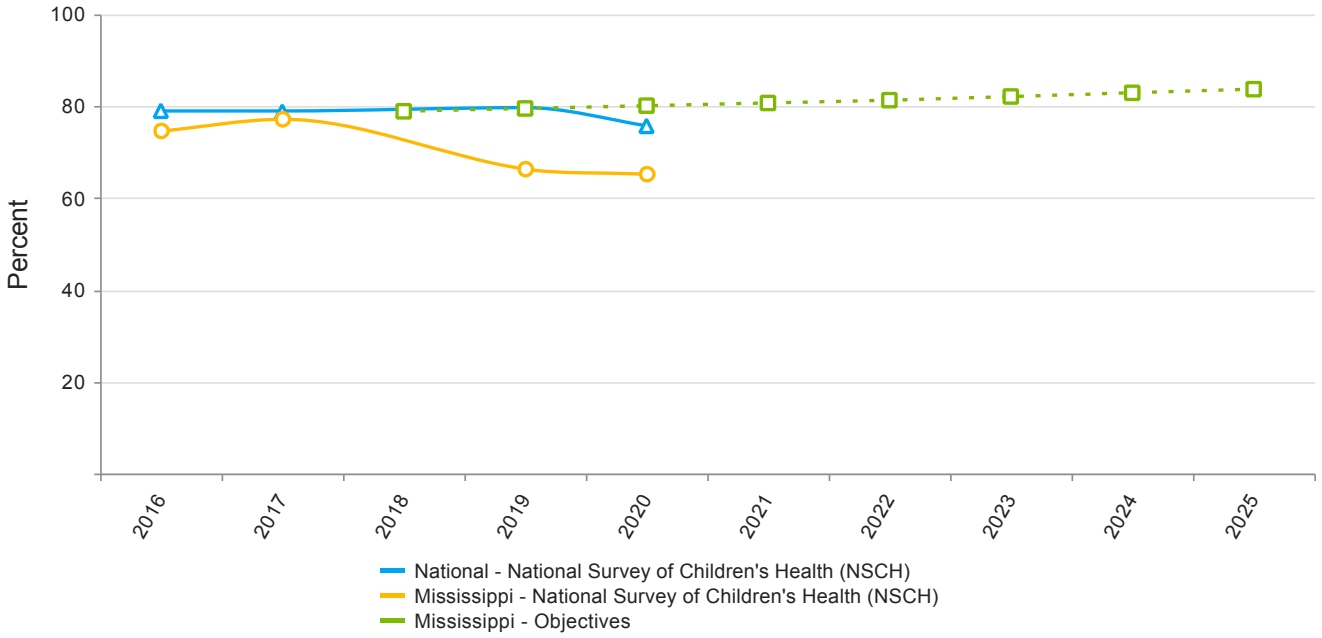
ESM 8.2.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	20.6	
Numerator	48,356	
Denominator	234,684	
Data Source	National Survey of Childrens Health	
Data Source Year	2019-2020	
Provisional or Final ?	Final	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	22.0	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		78.8	79.4	80	80.6
Annual Indicator	74.6	77.0	77.0	66.2	65.1
Numerator	173,066	188,821	188,821	155,497	155,882
Denominator	232,151	245,226	245,226	234,939	239,310
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	81.2	82.0	82.8	83.6

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Number of clinic sites engaged in youth-centered care quality improvement cycles.

Measure Status:	Inactive - Completed				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	3	6	6	7	8
Annual Indicator	5	5	7	7	0
Numerator					
Denominator					
Data Source	MSDH Adolescent Health	MSDH Adolescent Health	MSDH Adolescent Health	MSDH Adolescent Health	MSDH Adolescent Health
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

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		
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, 2023, increase the number of male family planning users by 10%	
By September 30, 2025, increase access and utilization of quality family planning services in MSDH county health departments	
By September 30, 2025, increase HPV vaccination rate among youth 9-13 years and 14-17 years	
Strategies	
Offer adolescent males a range of integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling	
Empower low-income users to make informed decisions about family planning and preventive health services	
Work with internal and external partners, academic institutions, providers and organizations to improve awareness and purpose of HPV vaccination	
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 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

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

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

Priority: Improve the Quality and Uptake of Well-Visits for Adolescents

NPMs, NOMs, SPM, and ESMs:

- NPM 1: Well-woman visit (% of women with a past year preventive medical visit)
- SPM 4: Percent of women ages 15-44 years old that use family planning services
- ESM 1: # of views of the Resource Guide on social media (Facebook, Twitter)
- ESM 2: # of views of Resource Guide on MSDH
- ESM 3: # of views of Resource Guide on Partners' websites
- ESM 4: # of expectant and parenting teens enrolled in PHRM/ISS program

Strategies and Activities (FY October 1, 2020 - September 30, 2021)

Objective 1: 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 1: Increase knowledge and awareness of support for expectant and parenting teens

Activity 1a: Upload all 8 Resource Guides for Expectant and Parenting Youth on MSDH and Teen Health MS (THMS) websites, and any other partners' websites.

All but 7 Resource Guides for Expectant and Parenting Youth have been uploaded to the THMS website. One resource guide is currently being printed and should be available on website by 1/31/22. All 8 Resource Guides will be uploaded to the MSDH website by 1/31/22. MSDH and THMS staffing shortages/changes as long with the effects of the COVID-19 pandemic slowed the production of the Resource Guides for Expectant and Parenting Youth. In the latter part of 2021, MSDH program leadership changed the PHRM/ISS program's name to Healthy Moms/Healthy Babies of MS. This change also includes a revamp of the program including new marketing on the MSDH website.

Activity 1b: Promote Resource Guides for Expectant and Parenting Youth on social media sites such as but not limited to Facebook and Twitter.

This activity has not been started due to delay in printing of the Expectant and Parenting Youth Resource Guides. The promotion of the Resource Guides will be incorporated with the marketing campaign of the new Healthy Moms/Healthy Babies of MS program. The social media campaign should begin by March 31, 2022.

Strategy 2: Provide or link expectant and parenting teens to services that improve educational, health, and social outcomes

Activity 2a: Enroll expectant and parenting teens into the PHRM/ISS program for case management services.

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.

Objective 2: 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 3: Provide health care transition education and self-advocacy training to youth, families, and professionals

Activity 3a: AH and CYSHCN program will organize and host Annual Youth Summit.

In October 2020, the CYSCHN Program collaborated with Adolescent Health, USM-IDS, Fastring Evaluation and Consulting and Delta Community Solutions, LLC to plan Adolescent Health and Wellness sessions during the virtual CYSHCN Family Engagement Summit series. The series consisted of a plenary session for the families and a breakout session for adolescents only. The sessions for adolescents only were more in-depth conversations about the plenary session topic. The Program's youth with special health care needs (YSHCN) advisor selected topics from USM-IDS training modules for adolescents and Health Hack, branded the sessions as "Teen Talk," and subsequently led all the planning meetings. The planning committee developed a promotion plan to ensure that families would participate. As information was disseminated, Adolescent Health developed a flyer and received an offer from Hinds Behavorial Health Services, a community mental health center, to help sponsor the summit series by possibly providing door prizes, logos on material, etc. The first Family Engagement & Adolescent Health Summit Series was held at 10:00 a.m. - 12:00 p.m. on Saturday, February 27, 2021, with minimum participation.

The planning committee considered hosting the series during the evening hours on a weekday but later decided to use social media. Since USM-IDS had a young adult connecting with adolescents on You Tube through "Chit Chat Thursday with Taylor," they agreed to include the CYSHCN Program's YSHCN and expand his video series by offering some of the sessions she selected. Other adolescents may participate in the discussion series also. Scripts will be provided to the adolescents prior to the recording the session for referencing. A subject matter will be onsite to clarify information or summarize the take-away messages. The Program partners will promote the link, measure the views, and attempt to embed a short evaluation or poll. The first session is titled "Mental Health and Social Media" and was recorded on June 17, 2021. This peer-led panel discussion was videotaped. The completion of the final product was delayed due to the pandemic. It is in final stages of production with graphics and sound being added. Once this video is piloted and evaluation measures collected, others in the series can be developed.

Adolescent Health - Application Year

The following strategies and activities are planned for FY23 to address the identified priorities:

Priority: Improve Access to Care

Objective A1: By September 30, 2023, increase the number of male family planning users by 10%.

Strategy A1.1: Offer adolescent males a range of integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling

- Activity A1.1a: Promote integrated health services for adolescent males on social media sites, including but not limited to Facebook and Twitter.
- Activity A1.1b: Identify 1 high school or college in each MSDH District to provide education and referral resources targeted for males about Family Planning services.

Objective A2: By September 30, 2025, increase access and utilization of quality family planning services in MSDH county health departments.

Strategy A2.1: Empower low-income users to make informed decisions about family planning and preventive health services [link to Strategy W3.2]

- Activity A2.1a: Collaborate with HM/HB case managers to provide targeted health education about birth spacing to pregnant and parenting teens.
- Activity A2.1b: Collaborate with HM/HB case managers to provide targeted messaging to encourage pregnant and parenting teens to access family planning services at the health department prior to exiting the program
- Activity A2.1c: Increase training for clinicians on how to effectively communicate with teen parents and patients by partnering with Teen Health MS to train clinicians on youth friendly health care. [link to Strategy W3.1]

Objective A3: By September 30, 2025, increase HPV vaccination rate among youth 9-13 years and 14-17 years.

Strategy A3.1: Work with internal and external partners, academic institutions, providers, and organizations to improve awareness and purpose of HPV vaccination.

- Activity A3.1a: Identify 1 high school or college in each MSDH District to provide education and referral resources about the importance of HPV vaccination.

Priority: Increase Breastfeeding, Healthy Nutrition and Healthy Weight

Objective A4: By September 30, 2025, increase the percent of adolescents, ages 12-17 years who are physically active at least 60 minutes per day

Strategy A4.1: Develop partnerships and work with internal and external partners and schools to complete the School Health Index (SHI) Self-Assessment and Planning Guide

- Activity A4.1a: Identify a School Health Champion at 1 high school or college in each MSDH District.

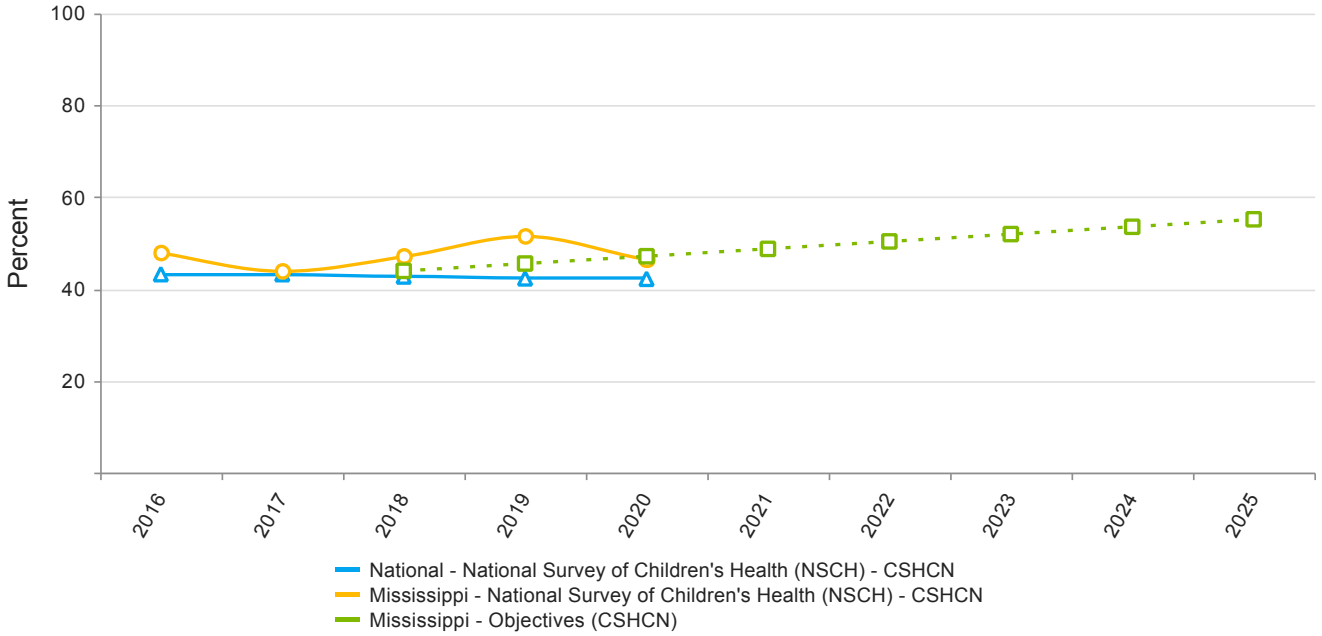
- Activity A4.1b: Partner with the School Health Champion at 1 high school or college in each MSDH District and provide support for conducting or reviewing the School Health Index (SHI) Self-Assessment according to the Planning Guide.

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		43.9	45.5	47.1	48.7
Annual Indicator	47.7	43.8	46.9	51.4	46.2
Numerator	84,259	75,832	78,448	82,086	72,719
Denominator	176,703	173,259	167,120	159,664	157,506
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.3	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					
	2017	2018	2019	2020	2021
Annual Objective	10	15	48	50	52
Annual Indicator	46	46	100	100	0
Numerator					
Denominator					
Data Source	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program
Data Source Year	2018	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	54.0	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		
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		
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		
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		
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, 2023, increase the percentage of CYSHCN who receive care coordination services by 10%	
By September 30, 2023, increase the percentage of Parent Consultants, a parent of a child with special health care needs who can help parents and caregivers navigate a comprehensive system of care, hired by systems participating in the Cares 2 Initiative to 85%	
Strategies	
Maintain Cross Systems of Care Coordination with partners and CYSHCN and families.	
Implement standardized population-based strategies to improve care coordination services and quality reporting.	
Provide education to young adults on healthcare coverage options and coverage literacy	
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, 2023, increase the percentage of participating CYSHCN Cares 2 healthcare systems with policies to transition youths with special health care needs to an adult provider from to 90%

Strategies

Maintain cross systems of care coordination with partners and CYSHCN and families

Establish and implement protocols/policies for transitioning youths with special health care needs to adult care and adulthood

Between October 2020 and September 2021, the MSDH Regional Care Coordinators (RCC) continued linking families and caregivers to resources and services, educating families, and providing long-term care and follow-up with families via phone encounters. During this time, the MSDH CYSHCN Program transitioned to the new agency EHR system, i.e., EPIC. As data were transferred into EPIC, the program personnel cleaned the data of duplications and CYSHCN who aged out of the program. As of March 30, 2021, EPIC data shows that there were 1,020 eligible children enrolled in the CYSHCN Program for receiving care coordination services.

NPMs, NOMs, SPM, and ESMs:

- NPM 11: Percent of children with and without special healthcare needs who have a medical home
- NPM 12: Percent of children with and without special health care needs who received services necessary to make transition to adult health care.

Evidence-based/informed Strategy Measures (FY Oct. 1, 2020 – Sept. 30, 2021)

The CYSHCN Program successfully achieved targets for ESM 1, 2, 3, and 5; however, targets were not met for ESM 4 or 6.

Measure	Target	Result
ESM 1: % of CYSHCN receiving care in a medical home	51.8%	96.8%
ESM 2: % of CYSHCN receiving care in a family-centered, comprehensive, and coordinated system	80%	79.7%
ESM 3 % of patients 12-21 years who talked to the healthcare team about the special health care needs as he or she becomes an adult	50%	81.1% (N=301 of 371)
ESM 4 Percent of patients 12-21 years whose healthcare team encouraged them to become more independent in managing their special health care need	50%	37.7% (N=140 of 371)
ESM 5 Percent of patients ages 0-21 with special health care needs receiving care in a dental home	50%	51.1%
ESM 6 Percent of patients ages 0-21 with special healthcare needs referred for annual dental visit	80%	28.8%

In addition, approximately 77.4% CYSHCN received developmental monitoring and screening; however, this was less than the target set at 80%.

Strategies and Activities (FY October 1, 2020 - September 30, 2021)

Objective 1: By September 30, 2021, increase the number of external partnerships by 10% (i.e., from 19 to 21).

Strategy 1: Maintain cross systems of Care Coordination with partners and CYSHCN and families.

Activity 1a: Assess and determine if meetings will be held live or virtually and evaluate the effectiveness of the selected platform amid COVID-19.

All trainings and meetings were virtual to prevent the spread of COVID-19 among participants. CYSHCN families, partners, providers, and staff were faced with numerous challenges. The health and safety of all individuals is a priority that the CYSHCN Program is committed to so at this time in-person trainings and events were moved to virtual platforms.

Activity 1b: Retain the CYSHCN Leadership Team/Parent Consultant Advisory Council (PCAC) comprised of but not limited to parents and caregivers of CYSHCN, youths with special needs service providers, healthcare providers, agency staff, and other advocates to continue increasing awareness and developing the curriculum/resources.

The CYSHCN Leadership Team met in December 2020 to discuss the status of the CYSHCN Cares 2 healthcare systems and approved the CYSHCN Cares 2 Learning Session agenda for Transformation Cohorts I & II. The systems were adjusting to meet patients' needs although appointments declined significantly. This was apparent as the evaluator discussed gaps in data in its reports. The workgroups reported on the status of their projects. Two of the four workgroups met consistently. Products included a plan to recruit new members, training for Parent Consultants as peer support to families, and a resource template for Parent Consultants and Care Coordinators to document resources in real time.

Activity 1c: Collaborate with other MSDH Health Services Programs to maximize the use of resources, services, partners, families, and children reached.

All members (internal and external) were given an opportunity to share information about their programs or entities. As a result, the University of Southern Mississippi (USM) Institute for Disability Studies formed a partnership with Adolescent Health. The following links were made available to all members.

- Map of CYSHCN Cares 2 Healthcare Systems
- Families as Allies Resources
- Subscribe to the Ally
- ECHO Initiative
- CHAMP for healthcare providers: pediatric mental health education and consultations: CHAMP Provider Video – YouTube

The CYSHCN Program remained committed to its partnership with the Office of Oral Health. In December 2020, the Program strengthened its partnership with Adolescent Health. The CYSHCN Program, YSHCN and Adolescent Health Director collaborated with Fastring Evaluations, LLC, USM Institute for Disability Studies, and Delta Community Solutions, LLC to initiate plans for the Family Engagement and Adolescent Health Summit. Genetics Services, Early Interventions/EHDI, and the Lead Prevention and Health Homes Programs are developing an integrated workplan.

Activity 1d: Promote covidhomebound.com to ensure that age appropriate CYSHCN who are bedridden will have an opportunity to receive the COVID-19 vaccination.

The CYSHCN Program Director expanded the Program's partnerships by serving on the Mississippi Emergency

Healthcare Coalition (MEHC). The purpose of this expansion is to ensure that emerging needs for CYSHCN, their families and Caregivers are considered during the COVID response. The Program began informing partners about the COVID Homebound email address, COVIDHomebound@msdh.ms.gov. This is a service for homebound persons who need assistance with receiving the COVID-19 vaccination.

Objective 2: By September 30, 2023, increase the percentage of CYSHCN who receive care coordination services by 10% (i.e., from 24,936 to 27,430).

Strategy 2: Implement standardized population-based strategies to improve care coordination services and quality reporting.

Activity 2a: Evaluate the performance of the eight CYSHCN Cares 2 healthcare systems and determine their level of engagement and capacity to participate.

The eight CYSCHN Cares 2 healthcare systems participated in ongoing evaluation. See results in the following sections.

Activity 2b: Recruit up to six additional healthcare systems providing coordinated comprehensive support to CYSHCN to participate in the learning collaborative as Transformation Cohorts I & II and Cohort III. Healthcare systems will provide a roster of a multidisciplinary team which includes a CYSHCN parent consultant and care coordinator.

As of 10/01/2020, there were six systems of care participating in the CYSHCN Cares 2 Learning Collaborative. One system of care from Cohort 1 and one system from Cohort 2 are not participating any longer due to competing priorities. Thus, six systems continued and were evaluated through the reporting period of 10/01/20 – 9/30/21. The six remaining healthcare systems graduated and were merged to form as Transformation Cohorts I & II.

The CYSHCN Program advertised its third Request for Applications for the CYSHCN Cares 2 Initiative, a care coordination learning collaborative, on July 2, 2020. The purpose of this initiative was to optimize the quality of life for CYSHCN by aligning medical/dental homes and community support services. The period for Cohort III spanned from September 14, 2020, through June 30, 2021. Applications were due on September 1, 2020. Two systems of care were awarded through this competitive application: Mississippi Center for Advanced Medicine (MCAM), and Yalobusha Medical Clinic.

Activity 2c: Collect patient demographics to monitor health disparities and inequities among the targeted population and plan interventions for implementation. CYSHCN Cares 2 healthcare systems and specialty providers provide demographics data.

Throughout the U.S., the national average of children and youth with special health care needs is 18.2% of all children and youth. In Mississippi, this same number is 23.5%. Moreover, more than 40% of Mississippi's CYSHCN population levies at or below 200% of the national poverty level.

During the reporting year, the program served close to 26,000 CYSHCN (see table below). More than half of the CYSHCN population self-reports their race as Black or African American; approximately 25,000 have insurance and, of those, slightly more than 16,000 are insured through Medicaid.

Demographics of Mississippi CYSHCN Served, 10/1/2020 - 9/30/2021	
Demographic	Total
Total CYSHCN Served	25,832
Race	
African American or Black	14,422
American Indian or Alaska Native	211
Asian	148
White	9,998
Native Hawaiian or Other Pacific Islander	19
Other race or multiple races	1,034
Gender	
Female	12,542
Male	13,290
Total with Insurance	25,227
Medicaid	16,129
CHIP	2,118
Medicare	1
Private	6,979
Uninsured	342

Activity 2d: Conduct a needs assessment with healthcare systems for care coordination and continuing care coordination engagement (Child Medical Home Index) Medical Home Index Assessment.

Medical Home Index Assessment: Each healthcare organization was asked to submit a Medical Home Index Assessment that collects information on 10 indicators derived from the Center for Medical Home Improvement's (CMHI) original Medical Home Index (MHI). The Medical Home Index is a brief representation of the more complete measurement tool. It scores a practice on a continuum of care across there levels: Level 1 is good, responsive pediatric primary care. Level 2 is pro-active pediatric primary care (in addition to Level 1). Level 3 illustrates pediatric primary care at the most comprehensive levels (Levels 1 and 2). Each clinic responded to each of the ten indicators and scored their organization as Level 1, Level 2 partial, Level 2 complete, Level 3 partial, or Level 3 complete. The following table shows the progression of systems of care in Cohort 1 from baseline, 6-month, and one year follow-up.

Results from Medical Home Index Assessment Cohort 1 Baseline (n=4)					
Item	Level 1 N (%)	Level 2 Partial N (%)	Level 2 Complete N (%)	Level 3 Partial N (%)	Level 3 Complete N (%)
#1 Family Feedback		3 (75%)	1 (25%)		
#2 Cultural Competence		2 (50%)	2 (50%)		
#3 Identification of Children in the Practice with SHCN		1 (25%)		3 (75%)	
#4 Care Continuity		4 (100%)			
#5 Cooperative Management between Primary Care Provider and Specialist		2 (50%)	1 (25%)	1 (25%)	
#6 Supporting the Transition to Adulthood		4 (100%)			
#7 Care Coordination / Role Definition		3 (75%)		1 (25%)	
#8 Assessment of Needs / Plans of Care		4 (100%)			
#9 Community Assessment of Needs for CYSHCN	1 (25%)	1 (25%)	1 (25%)	1 (25%)	
#10 Quality Standards (Structures)	1 (25%)	2 (50%)	1 (25%)		
Total	2 (5%)	26 (65%)	6 (15%)	6 (15%)	0 (0%)

Results from Medical Home Index Assessment Cohort 1 Six Month Follow-Up (n=4)					
Item	Level 1 N (%)	Level 2 Partial N (%)	Level 2 Complete N (%)	Level 3 Partial N (%)	Level 3 Complete N (%)
#1 Family Feedback		3 (75%)	1 (25%)		
#2 Cultural Competence		2 (50%)	2 (50%)		
#3 Identification of Children in the Practice with SHCN		1 (25%)	2 (50%)	1 (25%)	
#4 Care Continuity		2 (50%)	1 (25%)	1 (25%)	
#5 Cooperative Management between Primary Care Provider and Specialist		2 (50%)		1 (25%)	1 (25%)
#6 Supporting the Transition to Adulthood		4 (100%)			
#7 Care Coordination / Role Definition		2 (50%)		1 (25%)	1 (25%)
#8 Assessment of Needs / Plans of Care		3 (75%)			1 (25%)
#9 Community Assessment of Needs for CYSHCN	1 (25%)	1 (25%)	1 (25%)	1 (25%)	
#10 Quality Standards (Structures)		2 (50%)	2 (50%)		
Total	1 (2.5%)	22 (55%)	9 (22.5%)	5 (12.5%)	3 (7.5%)

Analysis of Cohort 1 data indicates that Aaron E. Henry Community Health Services Center, Inc. made improvements in one category, as did Coastal Family Health Center. Family Health Center in Laurel made improvements in five categories, and Mallory Community Health Center made improvements in six categories.

Results from Medical Home Index Assessment Cohort 1 One-Year Follow-Up by System of Care (n=3)			
Item	Aaron E. Henry	Coastal Family Health	Family Health Center
#1 Family Feedback	2 Partial	3 Complete	2 Partial
#2 Cultural Competence	3 Partial	2 Complete	3 Partial
#3 Identification of Children in the Practice with SHCN	3 Partial	2 Complete	2 Partial
#4 Care Continuity	2 Partial	2 Partial	2 Partial
#5 Cooperative Management between Primary Care Provider and Specialist	3 Complete	2 Complete	2 Partial
#6 Supporting the Transition to Adulthood	2 Partial	2 Partial	3 Partial
#7 Care Coordination / Role Definition	2 Complete	2 Complete	3 Complete
#8 Assessment of Needs / Plans of Care	2 Partial	3 Partial	3 Partial
#9 Community Assessment of Needs for CYSHCN	2 Partial	2 Complete	3 Partial
#10 Quality Standards (Structures)	2 Partial	2 Complete	2 Partial

Results from Medical Home Index Assessment Cohort 1 One-Year Follow-Up (n=3)					
Item	Level 1 N (%)	Level 2 Partial N (%)	Level 2 Complete N (%)	Level 3 Partial N (%)	Level 3 Complete N (%)
#1 Family Feedback		2 (66.7%)			1 (33.3%)
#2 Cultural Competence			1 (33.3%)	2 (66.7%)	
#3 Identification of Children in the Practice with SHCN		1 (33.3%)	1 (33.3%)	1 (33.3%)	
#4 Care Continuity		3 (100%)			
#5 Cooperative Management between Primary Care Provider and Specialist		1 (33.3%)	1 (33.3%)		1 (33.3%)
#6 Supporting the Transition to Adulthood		2 (66.7%)		1 (33.3%)	
#7 Care Coordination / Role Definition			2 (66.7%)		1 (33.3%)
#8 Assessment of Needs / Plans of Care		1 (33.3%)		2 (66.7%)	
#9 Community Assessment of Needs for CYSHCN		1 (33.3%)	1 (33.3%)	1 (33.3%)	
#10 Quality Standards (Structures)		2 (66.7%)	1 (33.3%)		
Total	0 (0%)	13 (43.3%)	7 (23.3%)	7 (23.3%)	3 (10%)

Mallory Community Health Center is no longer participating in the Cares 2 Initiative. Analysis of Cohort 1 data at the one-year participation mark indicates that Aaron E. Henry Community Health Services Center, Inc. made improvements in four areas, Coastal Family Health Center improved in 7 areas, and Family Health Center in Laurel made improvements in 4 categories when compared to data at the 6-month follow up. Progress can be seen across systems as the percentage reporting in level 1 and level 2 partial are decreasing, and percentages reporting in level 2C and higher are increasing.

Results from Medical Home Index Assessment Cohort 2 Baseline (n=4)				
Item	Central MS Health Services	GA Carmichael	SeMRHI	Urgent Care*
#1 Family Feedback	2 Partial	2 Partial	2 Partial	2 Partial
#2 Cultural Competence	2 Partial	3 Partial	2 Complete	2 Partial
#3 Identification of Children in the Practice with SHCN	2 Partial	2 Partial	1	2 Complete
#4 Care Continuity	3 Partial	2 Partial	2 Partial	2 Partial
#5 Cooperative Management between Primary Care Provider and Specialist	3 Partial	2 Partial	3 Complete	3 Complete
#6 Supporting the Transition to Adulthood	3 Partial	2 Partial	2 Partial	2 Partial
#7 Care Coordination / Role Definition	2 Partial	2 Partial	2 Partial	2 Partial
#8 Assessment of Needs / Plans of Care	3 Partial	2 Partial	2 Partial	3 Partial
#9 Community Assessment of Needs for CYSHCN	3 Partial	2 Partial	2 Partial	3 Partial
#10 Quality Standards (Structures)	2 Partial	1	2 Partial	2 Complete

Results from Medical Home Index Assessment Cohort 2 Baseline (n=4)					
Item	Level 1 N (%)	Level 2 Partial N (%)	Level 2 Complete N (%)	Level 3 Partial N (%)	Level 3 Complete N (%)
#1 Family Feedback		4 (100%)			
#2 Cultural Competence		2 (50%)	1 (25%)	1 (25%)	
#3 Identification of Children in the Practice with SHCN	1 (25%)	2 (50%)	1 (25%)		
#4 Care Continuity		3(75%)	1 (25%)		
#5 Cooperative Management between Primary Care Provider and Specialist		1 (25%)		1 (25%)	2 (50%)
#6 Supporting the Transition to Adulthood		3 (75%)		1 (25%)	
#7 Care Coordination / Role Definition		4 (100%)			
#8 Assessment of Needs / Plans of Care		2 (50%)		2 (50%)	
#9 Community Assessment of Needs for CYSHCN		1 (25%)	1 (25%)	2 (50%)	
#10 Quality Standards (Structures)	1 (25%)	2 (50%)	1 (25%)		
Total:	2 (5%)	24 (60%)	5 (12.5%)	7 (17.5%)	2 (5%)

Results from Medical Home Index Assessment Cohort 2 6-month Evaluation (n=3)*			
Item	Central MS Health Services	GA Carmichael	SeMRHI
#1 Family Feedback	2 Complete	2 Partial	2 Partial
#2 Cultural Competence	2 Complete	3 Partial	3 Partial
#3 Identification of Children in the Practice with SHCN	3 Complete	2 Complete	3 Complete
#4 Care Continuity	3 Complete	2 Partial	2 Partial
#5 Cooperative Management between Primary Care Provider and Specialist	2 Complete	2 Complete	3 Complete
#6 Supporting the Transition to Adulthood	3 Partial	2 Complete	3 Partial
#7 Care Coordination / Role Definition	3 Complete	3 Partial	1
#8 Assessment of Needs / Plans of Care	3 Complete	2 Complete	2 Partial
#9 Community Assessment of Needs for CYSHCN	3 Complete	3 Partial	3 Partial
#10 Quality Standards (Structures)	3 Partial	2 Partial	1

*The Urgent Care Facility was no longer participating when the 6-month evaluation was conducted.

Results from Medical Home Index Assessment Cohort 2 Six-month Evaluation (n=3)					
Item	Level 1 N (%)	Level 2 Partial N (%)	Level 2 Complete N (%)	Level 3 Partial N (%)	Level 3 Complete N (%)
#1 Family Feedback		2 (66.7%)	1 (33.3%)		
#2 Cultural Competence			1 (33.3%)	2 (66.7%)	
#3 Identification of Children in the Practice with SHCN			1 (33.3%)		2 (66.7%)
#4 Care Continuity		2 (66.7%)			1 (33.3%)
#5 Cooperative Management between Primary Care Provider and Specialist			2 (66.7%)		1 (33.3%)
#6 Supporting the Transition to Adulthood			1 (33.3%)	2 (66.7%)	
#7 Care Coordination / Role Definition	1 (33.3%)			1 (33.3%)	1 (33.3%)
#8 Assessment of Needs / Plans of Care		1 (33.3%)	1 (33.3%)		1 (33.3%)
#9 Community Assessment of Needs for CYSHCN				2 (66.7%)	1 (33.3%)
#10 Quality Standards (Structures)	1 (33.3%)	1 (33.3%)		1 (33.3%)	
Total:	2 (6.7%)	6 (20%)	7 (23.3%)	8 (26.7%)	7 (23.3%)

From baseline to the six-month evaluation, Central MS Health Services improved in 8 categories, GA Carmichael improved in 5 categories, and SeMRHI improved in 4 categories. In 6 months, level 3 complete has been reached for 23.3% of indicators for Cohort 2 and only 6.7% of indicators at level 1. Urgent Care is no longer participating in the initiative.

Results from Medical Home Index Assessment Cohort 3 Baseline (n=2)		
Item	MCAM	Yalobusha
#1 Family Feedback	2 Partial	1
#2 Cultural Competence	2 Partial	3 Partial
#3 Identification of Children in the Practice with SHCN	1	2 Complete
#4 Care Continuity	2 Partial	2 Partial
#5 Cooperative Management between Primary Care Provider and Specialist	2 Partial	2 Complete
#6 Supporting the Transition to Adulthood	1	2 Partial
#7 Care Coordination / Role Definition	3 Partial	2 Partial
#8 Assessment of Needs / Plans of Care	1	1
#9 Community Assessment of Needs for CYSHCN	1	2 Partial
#10 Quality Standards (Structures)	2 Partial	2 Partial

Results from Medical Home Index Assessment Cohort 3 Baseline (n=2)					
Item	Level 1 N (%)	Level 2 Partial N (%)	Level 2 Complete N (%)	Level 3 Partial N (%)	Level 3 Complete N (%)
#1 Family Feedback	1 (50%)	1 (50%)			
#2 Cultural Competence		1 (50%)		1 (50%)	
#3 Identification of Children in the Practice with SHCN	1 (50%)		1 (50%)		
#4 Care Continuity		2 (100%)			
#5 Cooperative Management between Primary Care Provider and Specialist		1 (50%)	1 (50%)		
#6 Supporting the Transition to Adulthood		1 (50%)	1 (50%)		
#7 Care Coordination / Role Definition		1 (50%)		1 (50%)	
#8 Assessment of Needs / Plans of Care	2 (100%)				
#9 Community Assessment of Needs for CYSHCN	1 (50%)	1 (50%)			
#10 Quality Standards (Structures)		2 (100%)			
Total:	5 (25%)	10 (50%)	3 (15.0)	2 (10%)	

At baseline, neither system of care in Cohort 3 rated any indicators at level 3 complete. One-fourth if the indicators were at level 1.

Results from Medical Home Index Assessment Cohort 3 Six-Month Evaluation (n=2)		
Item	MCAM	Yalobusha
#1 Family Feedback	2 Partial	2 Complete
#2 Cultural Competence	2 Partial	2 Complete
#3 Identification of Children in the Practice with SHCN	3 Partial	3 Complete
#4 Care Continuity	3 Partial	3 Complete
#5 Cooperative Management between Primary Care Provider and Specialist	2 Partial	3 Complete
#6 Supporting the Transition to Adulthood	2 Partial	3 Complete
#7 Care Coordination / Role Definition	3 Partial	3 Complete
#8 Assessment of Needs / Plans of Care	2 Partial	3 Complete
#9 Community Assessment of Needs for CYSHCN	2 Partial	2 Partial
#10 Quality Standards (Structures)	2 Partial	3 Complete

Results from Medical Home Index Assessment Cohort 3 Six-Month Evaluation (n=2)					
Item	Level 1 N (%)	Level 2 Partial N (%)	Level 2 Complete N (%)	Level 3 Partial N (%)	Level 3 Complete N (%)
#1 Family Feedback		1 (50%)	1 (50%)		
#2 Cultural Competence		1 (50%)	1 (50%)		
#3 Identification of Children in the Practice with SHCN				1 (50%)	1 (50%)
#4 Care Continuity				1 (50%)	1 (50%)
#5 Cooperative Management between Primary Care Provider and Specialist		1 (50%)			1 (50%)
#6 Supporting the Transition to Adulthood		1 (50%)			1 (50%)
#7 Care Coordination / Role Definition				1 (50%)	1 (50%)
#8 Assessment of Needs / Plans of Care		1 (50%)			1 (50%)
#9 Community Assessment of Needs for CYSHCN		2 (100%)			
#10 Quality Standards (Structures)		1 (50%)			1 (50%)
Total:		8 (40%)	2 (10%)	3 (15%)	7 (35%)

From baseline to six-months, MCAM improved in 4 categories. and Yalobusha improved in 8 categories. In just 6 months, level 3 complete had been reached for 35% of indicators for Cohort 3 and there were no indicators remaining at level 1.

Activity 2e: Conduct focus groups with Cohort III healthcare systems' multidisciplinary teams to identify challenges or potential barriers in meeting the CYSHCN Cares 2 deliverables.

To check in with health care systems about their experience with the CYSHCN Cares 2 Learning Collaboration Initiative, brief focus groups were conducted with each system of care prior to the first learning collaborative session

to be held on November 4, 2020 – November 5, 2020. The purpose of the focus groups was to identify challenges or potential barriers in meeting the deliverables that were due prior to Learning Session One. Specifically, participant organizations were asked to develop an Aim Statement, hire a Care Coordinator (Social Worker) and a Parent Consultant (parent of a CYSHCN), and identify a Population of Focus (POF) for which a Plan, Do, Study, Act (PDSA) cycle could be implemented.

Due to COVID-19 restrictions, focus groups were conducted virtually with both health care teams. Prior to conducting each focus group, participants were provided brief guidelines regarding the importance of confidentiality and speaking clearly so that information could be transcribed. Additionally, permission to record the session was obtained from each individual.

The following summary provides overarching themes in responses from organizations. The results provide suggestions from the organizations for additional resources that might be beneficial to address gaps in knowledge about best practices for serving the CYSHCN population.

MCAM was represented by Sharon Pennington, MD (Provider Champion), Jordan Robinson JD, MHA (Senior Leader), Jesus Monico, PhD, MPH (Team Leader), LeAnn Howard, LCSW (Care Coordinator), and Megan Ford, LCSW (Care Coordinator). Yalobusha was represented by Cinnamon Foster (Provider Champion and Senior Leader), John Coaten (Parent Consultant), and Martha Jenkins (Care Coordinator). A brief summary of the questions and responses during the focus group sessions follows.

1. Please introduce yourself and talk about your role in the organization. Tell me about what sort of tasks or responsibilities take up the bulk of your workday.

This question served as an opening question to allow participants to get comfortable talking to the facilitator. One system of care was accustomed to utilizing care coordinators in their workflow, whereas the other system discussed the need to establish a workflow which included the positions of care coordinator and parent consultant. Members of both systems of care expressed their excitement about taking part in the CARES 2 Initiative.

2. When you think of CYSHCN what comes to mind?

Answers to this question varied widely. The overall perception was both Cohort 3 clinics were very familiar with working with CYSHCN clients.

One participant said, "*Case management. All these kids have multiple needs, from financial to insurance to equipment. And then just you know that emotional support aspect to just really kind of talking with them and the parents, making sure they understand everything that is, that this encompasses and what all they need to help support them and make it as easy of a transition from clinic to personal life, to working with siblings to the school to the community, and making sure that they feel supported from a holistic perspective.*"

Another participant stated, "*Well, I had never heard of it until this grant, so I didn't even know that CMP was gone. So, I grew up in the using children's medical program because I used to work with the pediatric neurosurgery orthopedics, so I didn't even know CMP was gone. So, this has all been new for me.*"

3. What concerns do you have about providing care or coordinating care for this population?

The answers to this question were similar to the previous question. Both systems seemed very comfortable with providing services to clients with special health care needs.

One participant said, "*This is something that our clinic has been doing I think relatively very well. Since its inception, we, our whole focus is on patients that requires some specialty care and those typically require a lot of care coordination from diabetes management to congenital heart disease to other iris conditions and so we've been doing this. There are some aspects of your program that we have not been focused on as well. For instance, transitioning from pediatric to adulthood and I think part of that is that we have several lifespan programs where we follow these kids past the age of 18 and so there's not really a transition to an adult provider. But that is, I think one focus that we've talked about kind of bringing more light to. We do. I think our endocrinologist does a really great job trying to transition them from pediatric to adulthood in terms of insurance coverage in terms of managing college job at job prospects and things like that but taking that focus to other populations within our clinic will be very important. But as a whole, I mean we've already had social workers on board. We already have a pharmacist on board. We already have kind of a multidisciplinary team approach because, we recognize these patients need more than just a prescription and you're on your way they need help and support in management of their disease throughout there, I think. Megan put it really well as it that disease process is going to be present in every aspect of their life, from their home life, their personal life, their family life, their school life and having them be successful in their disease management is important.*"

One participant said that her concern wasn't specific to CYSHCN but involved staying in contact with the parent/caregiver of the child. She stated, "*Roadblocks or barriers that we face, not just with CYSHCN patients, but with all our patients is that their phone numbers are constantly changing or their address contact. Parents can have one phone number, and then the next week, it would be different. So that's one of the big barriers that we see every time in our monthly reporting.*"

4. As part of the CYSHCN Cares 2 Initiative you have been asked to write an Aim Statement that aligns the strategic goals of your organization around children and youth with special healthcare needs. Where is your team in that process, and are there any barriers that you are experiencing in writing the Aim Statement?

Both systems had completed their AIM statement at the time of the focus group.

5. As part of the CYSHCN Cares 2 Initiative, you have been asked to identify a Population of Focus that you will focus your system improvements on in the beginning of the initiative. Can you describe the process that your team is using to identify their Population of Focus?

Both systems of care had defined their population of focus at the time of the focus groups. One system is focusing on pediatric patients who have cardiology related diagnoses. The other will work with a subset of children ages 0-17 for all patients seen by one provider.

6. As part of the CYSHCN Cares 2 Initiative, we are asking your organization to hire a Care Coordinator. Where is your organization in this process? Do you anticipate any challenges or barriers to integrating a care coordinator into your current organization (policies, workflow, difficulty identifying good candidates, etc.)?

One system already had a Care Coordinator on staff. Their workflow is well-established. The other system has recently hired a Care Coordinator and is in the process of developing a workflow and training the newly hired employee.

7. As part of the CYSHCN Cares 2 Initiative, we are also asking your organization to hire a Parent Consultant who must be the parent of a CYSHCN. Where is your organization in this process? Do you anticipate any challenges or

barriers to integrating a parent consultant into your current organization (policies, workflow, difficulty identifying good candidates, etc.)?

Both systems reported that they had just recently hired a Parent Consultant. Since COVID, much of the work contacting and following up with patients is being done virtually.

When asked about potential concerns, most could not foresee any issues or barriers. There was quite a bit of discussion about workflow and patient navigation, but all the discussions were helpful in that they served to clarify the teams' expectations for the position or resolved questions around differing roles.

8. As part of the CYSHCN Cares 2 Initiative, we are asking you to provide data that reflects whether the CYSHCN that you provide care for have a medical and dental home, a shared plan of care, and plans for transitioning to adult services when appropriate. What challenges or barriers do you anticipate to collecting / providing this data? What assistance do you need from the CYSHCN program to facilitate collecting that information?

One participant stated, "*That's going to require some manual pull because we don't have a place for them to document a plan of care, or emergency plan. I believe we have a data collection [procedure] in place where we've identified which patients are the CYSHCN patients, and we are reporting on them manually.*"

One participant asked about a few options that had changed on the client encounter surveys. She said, "*There were several more options available than there were in November.*" The facilitator explained that there were some clinics that had experienced turnover and staff shortages, and the changes were to enable types of encounters to be recorded for both Care Coordinators and Parent Consultants.

9. Is there anything else you would like to share today that would make the Cares 2 Initiative more beneficial to your organization's ability to work with and coordinate care for the CYSHN population?

One system's participants wanted to discuss reporting requirements for the monthly reports (Care Coordinator and Parent Consultant), and the differences between those reports and the quarterly reports that were submitted through the dashboard. The facilitator was able to answer most of her questions and referred her to Alicia Barnes for further information.

Other overall conclusions: this cohort seems much better prepared than previous cohorts to begin the process of care coordination. They also seem very engaged and excited to take part in the learning collaborative. Both systems had completed all the tasks that were supposed to be completed prior to the first Cohort 3 Learning Session.

Activity 2f: Assess healthcare systems in Cohort III to determine if electronic health records (EHR) will support optimal patient care for CYSHCN, education, and communication via a patient portal.

In October 2020, the CYSHCN Cares 2 Learning Collaborative Consultant, BC3 Technologies LLC, assessed Cohort III participants for electronic health record (EHR) capabilities. BC3T is led by a former Health Information Officer for the Health Disparities Collaborative who has supported Collaborative Learning Sessions and provided direct technical assistance and consultation to all federally qualified health centers, several rural health clinics, and private practices in Mississippi. The Chief Executive Officer (CEO) has demonstrated the experience and expertise in planning, organizing, facilitating, and addressing the challenges that arise in clinical practice that the health care system alone cannot control, including promotion of broad-reaching systems changes that complement health care efforts and the implementation of evidence-based practices and guidelines, such as health information technology (HIT) and team-based care.

In Cohort III, EHR assessments results indicated the following:

- 2/2 = 100% of the organizations have a certified EHR system.
- None of the healthcare organizations in Cohort III are looking to transition to a new EHR in 2021
- 2/2=100% of the healthcare organizations are sending prescriptions electronically.
- 2/2=100% of the healthcare organizations are using their EHR for clinical decision support such as alerts for drug allergies, and drug-drug interactions.
- 2/2=100% of the healthcare organizations are exchanging clinical information electronically with other key providers/ healthcare settings such as hospitals, emergency rooms, or subspecialty clinicians.
- 2/2= 100% of the healthcare organizations engage patients through health IS such as patient portals, kiosk, secure messaging through the EHR or through other technologies.

Cohort III healthcare organizations can report on most of the CYSHCN measures. One of the healthcare systems has been working with BC3T and their EMR vendor to make sure they are able to capture the scheduling for the parent consultant and care coordinator. The second healthcare organization is a specialty clinic, so all the measures do not relate to their current processes. For the measures that relate to their day-to-day interactions with the patients, they can capture those measures. Cohort III has been diligent in getting the foundation, coding, data captures and templates integrated in the clinic workflow and EMR. To date, they are capturing all data measures.

Activity 2g: Conduct Learning Sessions for the entire multidisciplinary teams on evidence-based medicine, clinical decision support, CYSHCN patient and family engagement, shared plans of care, and community-based services and support.

Learning Sessions are one-day meetings during which participating organization teams meet with the CYSHCN Program's faculty/leadership team and collaborate to learn key changes in the topic area, including how to implement them, an approach for accelerating improvement, and a method for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes.

The CYSHCN Cares 2 Cohorts I and II, Transformation Virtual Learning Session 3 was held on October 15, 2020, 9:00AM – 3:15PM via Zoom In order to determine knowledge gained during the session, a pre-test was administered prior to the beginning of the session, and a post-test was administered at the end of the session. There were 16 individuals representing the Cares 2 Systems of Care that completed both the pre-test and post-test survey.

The Learning Session meeting for Cohort 3 was conducted on 11/5/20 from 8:30AM – 4:00PM via Zoom. To determine knowledge gained during the session, a pre-test was administered prior to the beginning of the session, and a post-test was administered at the end of the session. Representatives from all systems of care were present. In total, 23 participants were on the call.

Learning Session 2 for Cohort 3 was conducted on 2/11/21 from 8:30 AM – 4:00 PM via Zoom. Representatives from all systems of care in Cohort 3 were present. In total, 22 participants were on the call. There were 8 individuals representing the Cares 2 Systems of Care that completed both the pre-test and post-test survey.

As of 10/1/2021, all systems of care became part of the transformation cohort moving forward in the initiative. They had their first Learning Session of the year on 1/20/22 where they will present story boards and update their population of focus and, if they are in their second year of transformation, their population of spread. As of the end of the reporting period, there were six systems of care participating in the initiative. The combined population of focus

consists of 902 children and youth with special health care needs. Of those, 811 (90%) are ages birth to 17 years old, 280 (31%) are ages 12-17 years old, and 91 (10%) are ages 18-21 years old. For the required reporting measures, 96.8% of CYSHCN are receiving care in a medical home (Goal: 51.8%, MICH30.2/HP2020); 79.7% of CYSHCN are receiving care in a family-centered, comprehensive, and coordinated system (Goal: 80%, MICH 31.2/HP2020); 51.1% of CYSHCN are receiving care in a dental home (Goal: 50%); and 28.8% of CYSHCN were referred to annual dental visit (Goal: 80%). Among those 12-21 (n=371), 140 (37.7%) had been encouraged by their healthcare team to become more independent in managing their special health care need (Goal: 50%, DH-5). Within that same age range (12-21), 301 (81.1%) had talked to their healthcare team about their special healthcare need (Goal: 50%). Approximately 77.4% received developmental monitoring and screening (Goal: 80%), and 17.2% had a shared plan of care document in their electronic health records (Goal: 80%).

Activity 2h: Launch CYSHCNCares2.net, 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 CYSHCNCares2.net website and portal for Cohort participants was launched in October 2020. Participating health centers use the website to obtain and share resources. They also use the portal to securely share reports on benchmarks of CYSHCN they serve, e.g., how many visits a CYSHCN saw a physician for a reason other than their chronic condition.

Activity 2i: Collect data from CYSHCN Cares 2 healthcare systems on selected measures (MICH, HP2020, and SPM).

A summary of the PDSA cycles for each of the cohorts follows.

Cohort 1. Coastal Family Health has been engaged in several PDSA cycles since beginning the initiative. The following PDSAs were addressed over the last year. In the area of Community Resources and Policies, they conducted a PDSA to update and revise their Comprehensive Community Resource Directory which will focus on resources related to COVID-19 and Social Determinants of Health. They continue to send email blasts with updates to families so they can receive the updated community resource information. In the area of Care Partnership Support and Patient Support, they have added additional resources/referral around dental and behavioral health services. These are currently being made available to community members. In the area of Delivery System Design, the clinic assessed the technology resource needs and the impact of telehealth on services provided to CYSHCN families. Access to technology continues to be a challenge for families and are not participating fully in family engagement activities that have been conducted over Zoom. In the area of Health Care Organization and Accountability, the PC and CC are initiating a PDSA whereby they are exploring alternative locations within the communities where patients reside and can receive services if they don’t feel safe coming to the clinic for an in-person visit. As a result, the PC/CC have seen patient at alternative sites when possible. In the area of Decision Support and Relationships and Agreements, a PDSA involving brokering a relationship with the local MYPAC Care Coordination and Choices Coordinate Care Solutions agencies to facilitate greater access to care for CYSHCN patients in need of behavioral health services. BAAs are under consideration/revision by both agencies. In the area of Clinical Information Systems and Connectivity, the team discussed the development of documents to be integrated within the EHR to capture data on CYSHCN clients to address shared plans of care, emergency plans, and adolescent transition plans. Intake forms, a safety plan, and transition plans have been added to the EHR Document Library for use by the PC/CC.

Family Health Center has been engaged in several PDSA cycles since beginning the initiative. The following PDSAs were addressed over the last year. In the area of Care Partnership Support and Patient Support, they have planned to increase virtual family engagement activities and have met with family members for the first family engagement

event. In the area of Delivery System Design, the clinic planned to better integrate the Transition Readiness Assessment (TRA), the Emergency Plan, and Dental Template into the EHR. Currently, they are continuing to scan the TRA into the EHR. In the area of Clinical Information Systems and Connectivity, the team planned to get clarification around reportable CYSHCN diagnoses and procedural codes. They are in the process of formulating a guide to compare codes in Greenway but are having difficulty coordinating communication between the Senior Leader, IT, and Greenway.

Cohort 2. As of 10/2020, CMSHS was working on two separate PDSAs. One focuses on Delivery System Design and the other on Clinical Information Systems and Connectivity. For the former, they planned to integrate the parent consultant as a user of the consumers' electronic health record system. To achieve this goal, they provided training around the EHRs components and templates, collected documentation of use from the Parent Consultant, and as a result, she now has access to client records being seen in the clinic on the day of service and the day of contact. For the latter, the goal was to be able to generate reports from the EHR for specific ICD-10 codes. To accomplish this goal, team members accessed available reports and utilized the data to contact patients and reach out to clients on their day of service. They are now establishing goals based on the report registries generated. As a result of these two PDSAs, there is now parent consultant access to records for patients on the day of service and at the time of outreach. Documentation can be entered by the parent consultant related to specific measures (dental home, dental issues, dental providers). Referrals are also able to be initiated based upon the clients' needs for specific services.

GA Carmichael had several ongoing PDSAs in various stages of completion. For example, in Community Resources and Policies, they partnered with GACFHC Social Services Department to compile a list of applicable community resources and organizations that are remaining active during the COVID-19 epidemic. The social services department was able to contact many service and resource providers, but due to staff shortages, some could not be contacted. Staff will continue to work to maintain updated information on these resources. In the area of Delivery System Design, the clinic assessed the process of weekly team huddles to identify and recruit eligible clients more effectively with a goal of reaching 5 patients weekly. They found setting a specific day of the week to conduct huddles difficult as the day-to-day schedule fluctuates, and COVID-19 staffing must be the priority. Despite difficulties, they found the huddles beneficial in identifying potential patients for the Cares 2 initiative and discussing strategies to reach them. In the area of Clinical Information Systems and Connectivity, the team planned to meet monthly with IT staff to evaluate the EHR system to determine if the system is equipped to record and retrieve information on transition plans, emergency plans, and shared plans of care. They utilized a test patient environment in the EHR to review modules in the system and determined that templates would need to be added to record the required benchmark data. They are working with IT staff and the EHR vendor to modify the templates.

Cohort 3. Mississippi Center for Advanced Medicine was working on four PDSAs. One PDSA is related to Community Resources and Policies. For this PDSA, the PC and CC created an institutional resource manual so that referral resources could be made easier to access. The second PDSA focuses on Care Partnership Support and Patient Support. This PDSA works in conjunction with the aforementioned PDSA and serves to identify community partners that provide services specific to the CYSHCN population. Information from both PDSAs is compiled on a shared drive so that it is easily accessible by both the PC and the CC. The next PDSA they are implementing has to do with the Delivery System Design of the clinic. They have developed a workflow for identifying patients, introducing them to the program, enrolling interested families, and communicating among members to ensure a positive patient experience. Identified patients are briefly introduced to the initiative by the MD or RN at the conclusion of a clinical visit. Interested families are referred to the CC for in-person or telephone enrollment, with follow-up within a week by PC. Weekly team meetings identify new candidates, discuss enrolled patients, and troubleshoot challenges to system implementation. This has resulted in an efficient workflow process. The next PDSA is focused on the domain of Health Care Organization and Accountability. The system utilized input from MCAM leadership to design,

implement, and evaluate their ongoing program. Once the data is analyzed from the population of focus, the leadership team will meet to determine how to continue to improve their process while keeping the parameters of the initiative in place. As a result of the PSDAs described above, the clinic has adopted the model of service delivery and introduction of the initiative to prospective families. The provider identifies families that qualify as CYSHCN based of the child's cardiac condition. He calls the CC who meets with the family, completes the assessment, identifies, and provides resources, and introduces the PC who will call them later. The PC then calls the parent, introduces self and services, and schedules a time to meet with the child via facetime.

Yalobusha Medical Clinical, LLC worked on three PDSAs. One focuses on Health Care Organization and Accountability, and the other two focus on Clinical Information Systems and Connectivity. For the first PDSA, the clinic developed and now maintains a central referral book dedicated to CYSHCN patients. All staff participate in recording referrals provided to CYSHCN clients in the referral book. Clinic staff are all tasked with reviewing the book so that they are familiar with the patient's progress. All referrals added to the book include the patient's name; date, reason, and place of referral; and follow-up information that provides whether the patient acted on the referral. Next, the clinic is initiating a list of CYSHCN clients starting on 10/1/2020, the launch date of participation in the initiative. Client lists will be generated by the front office staff, nurses, and the nurse practitioner. They will revisit the data generated in 90 days. For the third PDSA, the clinic investigated how to provide coordinated care to the client and improve scheduling so that there is a non-clinic schedule. Some questions they hoped to answer through the PDSA were to determine how to build the non-resource schedules into the EHR for the Parent Consultant and Care Coordinator. They would like to utilize the data generated to improve care. They consulted with Athena, their EHR provider to assist them in the building of the two non-resources schedules for the PC and CC. They then provided training to the PC and CC so that they could schedule patients and enter information into their electronic charts. In accomplishing this, it allowed all clinic staff to determine if a client was being seen by a billable provider, or on the non-resource schedule. All staff are responsible for adding patients to the non-resource schedule for the PC and CC, reviewing schedules for accuracy, and ensuring that information documented in charts is being used correctly and accurately for record keeping. As a result of these three PDSAs, the clinic now maintains a central referral book dedicated to CYSHCN patients, they have a registry that includes all identified CYSHCN clients provided services through the clinic, and they use the EHR to schedule CYSHCN patient visits with the provider, the CC and the PC.

Activity 2j: Identify or customize a Care Coordination Curriculum for Care Coordinators.

A Care Coordination Curriculum was identified. Training on using the curriculum has not yet been implemented.

Objective 3: By September 30, 2023, increase the percentage of participating CYSHCN Cares 2 healthcare systems with policies to transition YSHCN to an adult provider (from 75% to 90%).

Strategy 3: Establish and implement protocols and policies for transitioning youths with special health care needs to adult care and adulthood.

Activity 3a: Conduct an assessment to determine if CYSHCN Cares 2 healthcare systems in Cohort III have a transition policy

Of the two healthcare systems in Cohort III, 50% reported have a transition policy. Mississippi Center for Advanced Medicine, one of the clinics for Cohort III, confirmed that they have a formal transition policy. MCAM is a specialist organization and some of their patients do not transition due to their medical condition. We will continue to work with them on a process for those patients who are able to transition to an adult specialist.

Activity 3b: Provide CYSHCN 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

The Family and Caregivers' Guide (FCG) was made available for order to all UMMC specialty clinical partners and MSDH Regional Care Coordinators. An ordering form was created specifically for obtaining the FCG. A special link was provided to all RCC and UMC partners. Upon completion of the form an email is sent to CYSHCN Program. This process allowed for timely filling of request for the FCG. UMC has ordered 1300 English FCG, 150 Spanish FCG and Zero Vietnamese FCG. MSDH RCC have ordered 1500 English FCG, 100 Spanish FCG, and 65 Vietnamese FCG. To date a total of 2,800 English FCG, 250 Spanish FCG and 65 Vietnamese FCG have been distributed. All care coordinators report having enough guides to utilize with consumers. Guides were provided to new nurse employed in UMC Pediatric Endocrinology for patient engagement. Two county health departments and oral health providers placed request for guides. These orders were filled and shipped.

Activity 3c: Promote preventive health and wellness screenings and other emerging topics of interest among adolescents.

In October 2020, the CYSCHN Program collaborated with Adolescent Health, USM-IDS, Fastring Evaluation and Consulting and Delta Community Solutions, LLC to plan Adolescent Health and Wellness sessions during the virtual CYSHCN Family Engagement Summit series. The series consisted of a plenary session for the families and a breakout session for adolescents only. The sessions for adolescents only were more in-depth conversations about the plenary session topic. The Program's youth with special health care needs (YSHCN) advisor selected topics from USM-IDS training modules for adolescents and Health Hack, branded the sessions as "Teen Talk," and subsequently led all the planning meetings. The planning committee developed a promotion plan to ensure that families would participate. As information was disseminated, Adolescent Health developed a flyer and received an offer from Hinds Behavorial Health Services, a community mental health center, to help sponsor the summit series by possibly providing door prizes, logos on material, etc. The first Family Engagement & Adolescent Health Summit Series was held at 10:00 a.m. - 12:00 p.m. on Saturday, February 27, 2021, with minimum participation.

The planning committee considered hosting the series during the evening hours on a weekday but later decided to use social media. Since USM-IDS had a young adult connecting with adolescents on You Tube through "Chit Chat Thursday with Taylor," they agreed to include the CYSHCN Program's YSHCN and expand his video series by offering some of the sessions she selected. Other adolescents may participate in the discussion series also. Scripts will be provided to the adolescents prior to the recording the session for referencing. A subject matter will be onsite to clarify information or summarize the take-away messages. The Program partners will promote the link, measure the views, and attempt to embed a short evaluation or poll. The first session is titled "Mental Health and Social Media" and was recorded on June 17, 2021. This peer-led panel discussion was videotaped. The completion of the final product was delayed due to the pandemic. It is in final stages of production with graphics and sound being added. Once this video is piloted and evaluation measures collected, others in the series can be developed.

Objective 4: By September 30, 2021, increase the percentage of Parent Consultants (i.e., a parent of a CYSHCN 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 4: Provide education to young adults on healthcare coverage options and coverage literacy.

Activity 4a: Hire Parent Consultant's for CYSHCN Cares 2 Healthcare Systems.

As of September 2021, 7 of the 8 (87.5%) participating healthcare systems had hired a parent consultant.

Activity 4b: Conduct CYSHCN Cares 2 Learning Collaborative & Transformation Cohort Pre-Learning Session 1.

Learning sessions were held. See Activity 2g above.

Activity 4c: Monitor CYSHCN Cares 2 Parent Consultants and Care Coordinators Intakes and Referrals.

The CYSHCN Cares 2 Parent Consultants and Care Coordinators were to document their intakes and referrals and upload the information in the CYSHCNCares2.net secured portal.

Activity 4d: Collaborate with CYSHCN Cares 2 healthcare systems, parent consultants and community partners to conduct regional CYSHCN Families' and Caregivers' Family Engagement Summits.

Regional CYSHCN Families' and Caregivers' Family Engagement Summits were held. See Activity 3c above.

Children with Special Health Care Needs - Application Year

The following strategies and activities are planned for FY23 to address the identified priorities:

Priority: Assure Medical Homes for C/YSHCN

Objective S1: By September 30, 2023, increase the percentage of CYSHCN who receive care coordination services by 10%

Strategy S1.1: Maintain Cross Systems of Care Coordination with partners and CYSHCN and families [link to Strategy S2.1; S3.1]

- Activity S1.1a: Provide education and information that connects families and care givers to various supports and services needed [link to Activity S2.1a; S3.1a]

Strategy S1.2: Implement standardized population-based strategies to improve care coordination services and quality reporting [link to Strategy S2.2]

Strategy S1.3: Provide education to young adults on healthcare coverage options and coverage literacy [link to Strategy S3.3]

- Activity S1.3a: Develop and disseminate a booklet describing Parent Consultants' success stories [link to Strategy S3.3a]

Objective S2: By September 30, 2023, increase the percentage of Parent Consultants, a parent of a child with special health care needs who can help parents and caregivers navigate a comprehensive system of care, hired by systems participating in the Cares 2 Initiative to 85%

Strategy S2.1: Maintain Cross Systems of Care Coordination with partners and CYSHCN and families [link to Strategy S1.1; S3.1]

- Activity S2.1a: Provide education and information that connects families and care givers to various supports and services needed [link to Activity S1.1a; S3.1a]

Strategy S2.2: Implement standardized population-based strategies to improve care coordination services and quality reporting [link to Strategy S1.2]

Objective S3: By September 30, 2023, increase the percentage of participating CYSHCN Cares 2 healthcare systems with policies to transition youths with special health care needs to an adult provider from to 90%

Strategy S3.1: Maintain Cross Systems of Care Coordination with partners and CYSHCN and families [link to Strategy S1.1; S2.1]

- Activity S3.1a: Provide education and information that connects families and care givers to various supports and services needed [link to Activity S1.1a; S2.1a]

Strategy S3.2: Establish and implement protocols/policies for transitioning youths with special health care needs to

adult care and adulthood

- Activity S3.2a: Encourage parents and caregivers to share decision making responsibilities with C/YSHCN and teach advocacy skills [link to Strategy S1.3a]

Strategy S3.3: Provide education to young adults on healthcare coverage options and coverage literacy [link to Strategy S1.3]

- Activity S3.3a: Develop and disseminate a booklet describing Parent Consultants' success stories [link to Strategy S1.3a]

Cross-Cutting/Systems Building

State Performance Measures

SPM 6 - Percentage of pregnant women and new mothers who felt they were treated unfairly while receiving services.

Measure Status:	Inactive - No data available.

Baseline data was not available/provided.

SPM 7 - Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff.

Measure Status:	Inactive - Replaced

Baseline data was not available/provided.

SPM 8 - Strengthen mental, social and emotional health and well-being through partnerships and programs that build capacity and reduce stigma.

Measure Status:	Inactive - Replaced

Baseline data was not available/provided.

SPM 19 - Adolescent suicide rate

Measure Status:			Active
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
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, 2023, partner with a community-based perinatal and postpartum program to provide services to at least 30 women on maternal mental health
By September 30, 2025, reduce the percentage of suicide attempts among high school student by 1%
By September 20, 2023, screen 100 youth with special health care needs, ages 12-21, for mental health concerns
Strategies
Provide Mental Health First Aid training to MSDH health care professionals
Coordinate and partner with community organizations to provide mental health services to perinatal and postpartum women
Support policy and partnerships to promote youth mental or behavioral health in schools and community
Promote mental health awareness amongst CYSHCN families and improve access to resources

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, 2023, continue collaboration with the Office of Policy Evaluation, Health Equity, and Government Relations to educate providers on promoting a culturally and linguistically appropriate healthcare setting.

By September 30, 2023, develop and implement MCH Workforce Development policies regarding professional development for the MSDH Title V and Health Service program staff and subgrant partners to include topics of implicit bias, discrimination, diversity, inclusion, and racial equity

By September 30, 2023, collaborate with national leaders to identify 3 professional development offerings on implicit bias, diversity, inclusion, and racial equity

By September 30, 2023, establish partnerships or collaborations with at least 10 new MSDH program areas, providers, or external organizations and businesses to improve equitable access to services and care

By September 30, 2023, address birth equity in all MSPQC Quality Improvement Initiatives, AIM initiatives, and the Maternal Mortality Reviews

By September 30, 2023, develop and implement plans to communicate with health care professionals, service providers, and families to address diversity and inclusion in the EHDI system

Strategies

Explore resources for translating program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information.

Ensure MCH workforce and subgrant partners receive training on implicit bias, discrimination, and racism

Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and sub-recipient staff

Identify opportunities for partnerships and collaboration with internal and external partners, providers, organizations, and businesses across the state to improve equitable access to services and care

Use language, images, graphics, and messaging that is both responsive to diversity and health literacy

Support quality improvement and evaluation efforts to improve systems, programs, and outcomes and decrease health inequities

Partner with national organizations to provide training, assessments, and technical assistance in building a strategic plan to address birth equity

Convene a workgroup of stakeholders to develop a diversity plan for EHDI-MS

Explore resources for translating program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information

Cross-Cutting/Systems Builiding - Annual Report

Mississippi did not have any cross-cutting or system building strategies or activities in FY21.

Cross-cutting/system building strategies have since been added to the State Action Plan and will be reported on in subsequent annual reports.

Cross-Cutting/Systems Building - Application Year

The following strategies and activities are planned for FY23 to address the identified priorities:

Priority: Improve Access to Mental Health Services Across MCH Populations

Objective X1: By September 30, 2023, partner with a community-based perinatal and postpartum program to provide services to at least 30 women on maternal mental health

Strategy X1.1: Coordinate and partner with community organizations to provide mental health services to perinatal and postpartum women

Strategy X1.2: Provide Mental Health First Aid training to MSDH health care professionals [link to Strategy X2.2; X3.2]

Objective X2: By September 30, 2025, reduce the percentage of suicide attempts among high school student by 1%

Strategy X2.1: Support policy and partnerships to promote youth mental and behavioral health in schools and community

Strategy X2.2: Provide Mental Health First Aid training to MSDH health care professionals [link to Strategy X1.2; X3.2]

Objective X3: By September 20, 2023, screen 100 youth with special health care needs, ages 12-21, for mental health concerns

Strategy X3.1: Promote mental health awareness amongst CYSHCN families and improve access to resources

Strategy X3.2: Provide Mental Health First Aid training to MSDH health care professionals [link to Strategy X1.2; X2.2]

Objective X4: By September 20, 2025, all Child Health programs, including CYSHCN will develop and implement MCH Workforce Development policies regarding professional development for the MSDH Title V and Health Service program care coordination, service coordination, and case management staff to include topics of infant mental health and supporting families of infants and toddlers to promoting positive social-emotional development

Strategy X4.1: Provide training and reflective supervision to MSDH care coordinators, service coordinators, and case managers to meet the competencies for being endorsed as an Infant Family Specialist (Alliance for the Advancement of Infant Mental Health)

Priority: Ensure Health Equity by Addressing Implicit Bias, Discrimination, and Racism

Objective X5: By September 30, 2023, develop and implement MCH Workforce Development policies regarding professional development for the MSDH Title V and Health Service program staff and subgrant partners to include topics of implicit bias, discrimination, diversity, inclusion, and racial equity

Strategy X5.1: Ensure MCH workforce and subgrant partners receive training on implicit bias, discrimination, and racism

Strategy X5.2: Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and sub-recipient staff

Objective X6: By September 30, 2023, collaborate with national leaders to identify 3 professional development offerings on implicit bias, diversity, inclusion, and racial equity

Strategy X6.1: Identify opportunities for partnerships and collaboration with internal and external partners, providers, organizations, and businesses across the state to improve equitable access to services and care [link to Strategy X7.1]

Objective X7: By September 30, 2023, establish partnerships or collaborations with at least 10 new MSDH program areas, providers, or external organizations and businesses to improve equitable access to services and care

Strategy X7.1: Identify opportunities for partnerships and collaboration with internal and external partners, providers, organizations, and businesses across the state to improve equitable access to services and care [link to Strategy X6.1]

Objective X8: By September 30, 2023, address birth equity in all MSPQC Quality Improvement Initiatives, AIM initiatives, and the Maternal Mortality Reviews

Strategy X8.1: Support quality improvement and evaluation efforts to improve systems, programs, and outcomes and decrease health inequities

Strategy X8.2: Partner with national organizations to provide training, assessments, and technical assistance in building a strategic plan to address birth equity

Objective X9: By September 30, 2023, develop and implement plans to communicate with health care professionals, service providers, and families to address diversity and inclusion in the EHDI system

Strategy X9.1: Convene a workgroup of stakeholders to develop a diversity plan for EHDIMS

Strategy X9.2: Explore resources for translating program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information [link to Strategy X10.1]

Strategy X9.3: Use language, images, graphics, and messaging that is both responsive to diversity and health literacy [link to Strategy X10.2]

Objective X10: By September 30, 2023, continue collaboration with the Office of Policy Evaluation, Health Equity, and Government Relations to educate providers on promoting a culturally and linguistically appropriate healthcare setting.

Strategy X10.1: Explore resources for translating program materials to Spanish, Vietnamese, and any other language needed to allow for improved accessibility of information [link to Strategy X9.2]

Strategy X10.2: Use language, images, graphics, and messaging that is both responsive to diversity and health literacy [link to Strategy X9.3]

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. Through these approaches, the MCH Title V program is aiming to improve two-communication between programs and the populations that they serve, establish an environment within the agency and outside the agency to support family-centered care that will allow our programs to provide resources and services to families that are both beneficial and relevant to their needs.

As an MCH/Title V program we routinely encourage and welcome the voice of families into our program in all capacities. The MCH/Title V Program acknowledges that in order to provide family-friendly services and care, family voices must be a part of the conversation. Families and consumers are given the opportunity to provide feedback to the MCH/Title V programs.

One of the many opportunities available to the public to provide input is through participation in the advisory committees. The Office of Health Services offers several committees, including MCH Advisory Board (focuses on all MCH/CYSHCN programs), CYSHCN's Parent Consultant Advisory Council (PCAC), Lead Poisoning Prevention and Healthy Homes Advisory Committee, Early Intervention State Interagency Coordinating Council (SICC), Early Hearing Detection and Intervention Advisory Committee (EHDI-AC), and Genetics Advisory Council (GAC).

The MCH Engagement Coordinator worked with MCH Advisory Board to acquire feedback to discuss existing and emerging issues associated with MCH/Title V programmatic efforts, accomplishments, and next steps of existing/upcoming projects. Although, COVID hampered the advisory boards to meet in person and as frequently as initially planned, the Engagement Coordinator ensured they stayed informed of the MCH/Title V strategic plan to ensure that all programs are making efforts to address needs of the consumers.

Contact information for the MCH/Title V Director, MCH/Title V CYSHCN Director, and MCH/Epidemiologist will continue to be provided on the MSDH website, ensuring ongoing availability.

Links to the MSDH Facebook and Twitter accounts are located on the MSDH website; MCH inquiries received through social media are forwarded to MSDH Health Services. Feedback is used to inform Mississippi’s ongoing needs assessment as well as current program policy and objectives. Input is solicited from agency partners throughout the year. MSDH Office of Health Services met with the MPHCA, DHA, UMMC, Healthy Start, and the PRAMS, March of Dimes Advisory Board, to receive input on the state's needs assessment and the MCH Block Grant. Public input also continues to be solicited through key parent and family support groups who are affiliated with programs funded by the grant.

Soon, the MSDH MCH Program plans to develop a full TVBG communications strategy and steering committee. The communications strategy will allow the agency to align its current public input and program efforts. These efforts will allow the MCH Program to develop and implement a comprehensive communications plan to increase the visibility, outreach, and use of maternal and child health programs by grantees, MCH professionals and the broader community. The plan will also allow the MCH Program to communicate performance measure and impact assessment findings.

III.G. Technical Assistance

Previously, the Mississippi MCH Title V program sought technical assistance to build capacity for Family Engagement. Consultant Karen Trierweiler worked with Mississippi Title V staff and stakeholders in the development of meeting and training content to enhance the state capacity to engage families across all MCH population domains. The result was to simplify and finalize the state's family and consumer engagement policy and to strengthen state capacity to engage families. An in-person Title V 101 training for the state staff was held in late 2020. This two-day meeting focused on Title V 101 for all staff along with a training on the new family and consumer engagement policy to assist staff in implementing the policy in their MCH work.

In the coming year, Mississippi MCH Title V Program will apply for technical assistance related to the five-year ongoing needs assessment process and activities. The program would like to address and identify significant activities beyond monitoring and surveillance efforts to support the current state indicators and priorities. It is highly anticipated that the MCH Title V Program will also require technical assistance related to professional development, strategic planning, and program alignment.

As she did last year, Mrs. Trierweiler will provide a 1-2 day in-person, peer-to-peer, capacity-building session to support and strengthen the knowledge and skills of the Title V Senior Leadership team. The overall goal will be to provide the foundation for Mississippi to enhance its Title V infrastructure as the state continues to implement its five-year action plan.

Areas for strengthening capacity include the following:

Assessing the MSDH's staffing, structure, and training needs
MSDH is struggling on breaking down the silos within MCH programs. Technical assistance on how to put into place a lean, efficient, and effective structure and staffing plan would be helpful. In addition, developing a plan to train staff on population based and infrastructure-building approaches for MCH populations also is needed. Many of the staff do not have MCH backgrounds. Understanding MCH, population health, how to implement a cohesive Title V Program and ensuring that MSDH has an eye to "the Health Department of the Future" is needed.

Incorporating health equity into all Title V Domains

Using data from the Needs Assessment. MSDH could use technical assistance to develop better program goals and objectives that are more focused, organized and not siloed.

Developing communication strategies with Senior Leadership.
MSDH could benefit from technical assistance on techniques and mentoring on how to communicate and work with the MSDH senior leadership team.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MCH - MSDH-DOM IAAs.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MS Public Health Map_Districts 2022.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FINAL - MSDH-HS Organizational Chart.pdf

VII. Appendix

+

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Mississippi

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,272,183	
A. Preventive and Primary Care for Children	$ 2,781,655	(30%)
B. Children with Special Health Care Needs	$ 2,781,655	(30%)
C. Title V Administrative Costs	$ 927,218	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,490,528	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 731,224	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,095,262	
5. OTHER FUNDS (Item 18e of SF-424)	$ 3,871,552	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,256,100	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 6,954,138	
A. Your State's FY 1989 Maintenance of Effort Amount $ 6,576,655		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 16,226,321	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 113,758,690	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 129,985,011	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 3,314,750
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) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 300,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 4,417,559
Department of Health and Human Services (DHHS) > 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)	$ 92,664,998
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 736,470
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,989,913
Department of Justice > Other > Comprehensive Opioid Abuse Site Program (COSSAP)	$ 6,000,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive Opioid Overdose Reduction Program (CORP)	$ 800,000

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,228,087 (FY 21 Federal Award: $ 9,153,409)		$ 9,153,279	
A. Preventive and Primary Care for Children	$ 2,768,428	(30%)	$ 2,779,687	(30.3%)
B. Children with Special Health Care Needs	$ 2,768,428	(30%)	$ 2,754,651	(30%)
C. Title V Administrative Costs	$ 922,808	(10%)	$ 832,116	(9.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,459,664		$ 6,366,454	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,921,066		$ 119,623	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 549,527	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 3,171,965	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 273,030		$ 3,079,950	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 7,194,096		$ 6,921,065	
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)	$ 16,422,183		$ 16,074,344	
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)	$ 4,300,000		$ 583,281	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 20,722,183		$ 16,657,625	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,300,000	$ 583,281

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Total request for federal fund (estimated based on FY22 Award) Award: B0445225 (7/22/22) Project: CDFA: 93.994 - Maternal and Child Health Services Budget Period: 10/01/2021-09/30/2023 Project Period: 10/01/2021-09/30/2023	
2.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Based on GF01 Funds (General Administration) in FY23 budget	
3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Based on 25% of 003S Funds (Local) in FY23 budget	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Based on 100% of 007S Funds (Newborn Screening Fees) in FY23 budget	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Based on 25% of 08PS Funds (Perinatal Risk Management) in FY23 budget	
6.	**Field Name:**	**1.FEDERAL ALLOCATION**

	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Total of expended federal funds for A51L/B51L/C51L Award: B0440143 (7/20/22) Project: CDFA: 93.994 - Maternal and Child Health Services Budget Period: 10/01/2020-09/30/2022 Project Period: 10/01/2020-09/30/2022	
7.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: From B51L expenditure report pulled 8/10/22	
8.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: From C51L expenditure report pulled 8/10/22	
9.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: From expenditure report pulled 8/10/22	
10.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: GF01 funds (General Administration) expended for children, CYSHCN, and women	
11.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: 003S funds (Local) expended for children, CYSHCN, and women	

12.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: 007S (NBS Fees) expended for children and CYSHCN	
13.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: 08PS funds (Perinatal Risk) and 08ES funds (EI-Infants & Toddlers) expended for children, CYSHCN, and women	
14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Award Number: 1 NU58DP007129-01-00 (05/26/22) Project: CDFA 93.898 - Breast, Cervical, and Other Cancer Control Program Budget Period: 06/30/2022 - 06/29/2027 Project Period: 06/30/2022 - 06/29/2027	
15.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Award Number: 5 NU58DP006696-04-00 (06/30/22) Project: CDFA 93.478 - Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees Budget Period: 09/30/2022 - 09/29/2023 Project Period: 09/30/2019 - 09/29/2024	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

	Field Note: Award Number: 5 NUE2EH001427-02-00 (06/23/22) Project: CDFA 93.197 - Childhood Lead Poisoning Prevention Projects_State and Local Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children Budget Period: 09/30/2022 - 09/29/2023 Project Period: 09/30/2021 - 09/29/2026	
17.	**Field Name:**	**Other Federal Funds, US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Award Number H181A220034 Project: CDFA 84.181A - Infants & Toddlers/Families (Part C) Budget Period 07/01/2022 - 09/30/2023 (09/30/2024) Federal Funding Period 07/01/2022 - 09/30/2023 (09/30/2024)	
18.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Award Number: 5 H61MC00052-22-00 (05/16/2022) Project: CDFA 93.251 - Universal Newborn Hearing Screening and Intervention Budget Period: 04/01/2022 - 03/31/2023 Project Period: 04/01/2020 - 03/31/2024	
19.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: GAD NUMBER: 5MS700704 (07/01/22) Project: CDFA 10.557 - Women Infants & Children (Admin & Food) Grant Period: 10/01/2021 - 09/30/2022	
20.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

	Field Note: GAD NUMBER: 5MS700707 (04/07/22) Project: CDFA 10.557 - Women Infants & Children (Breastfdng Peer Couns) Grant Period: 10/01/2021 - 09/30/2023	
21.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: NO COST EXTENSION Award Number: 4 FPHPA006475-03-07 (03/25/22) Project: CDFA 93.217 - The Title X Family Planning Services Budget Period: 04/01/2021 - 03/31/2023 Project Period: 04/01/2019 - 03/31/2023	
22.	**Field Name:**	**Other Federal Funds, Department of Justice > Other > Comprehensive Opioid Abuse Site Program (COSSAP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Award Number: 2020-AR-BX-0040 Project: CDFA 16.838 - Comprehensive Opioid Abuse Site-Based Program Budget Period: 10/01/2020 - 09/30/2023 Project Period: 10/01/2020 - 09/30/2023	
23.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive Opioid Overdose Reduction Program (CORP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Award Number: 1 H79TI084545-01 (09/07/2021) Project: CDFA 93.243 - Comprehensive Opioid-overdose Reduction Program (CORP) Budget Period: 09/30/2021 - 09/29/2022 Project Period: 09/30/2021 - 09/29/2025	

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 2,781,655	$ 2,786,825
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 2,781,655	$ 2,779,687
4. CSHCN	$ 2,781,655	$ 2,754,651
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 8,344,965	$ 8,321,163

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 1,401,213	$ 1,158,945
2. Infants < 1 year	$ 4,110,906	$ 3,793,750
3. Children 1 through 21 Years	$ 662,480	$ 521,259
4. CSHCN	$ 779,539	$ 1,447,111
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 6,954,138	$ 6,921,065
Federal State MCH Block Grant Partnership Total	$ 15,299,103	$ 15,242,228

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 4,648,229	$ 4,008,411
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,555,989	$ 1,048,988
B. Preventive and Primary Care Services for Children	$ 1,490,318	$ 1,831,292
C. Services for CSHCN	$ 1,601,922	$ 1,128,131
2. Enabling Services	$ 2,172,622	$ 1,361,026
3. Public Health Services and Systems	$ 2,451,332	$ 3,783,842
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		$ 281,125
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 58,080
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 15,645
Other		
Nurse Services		$ 3,653,561
Direct Services Line 4 Expended Total		$ 4,008,411
Federal Total	$ 9,272,183	$ 9,153,279

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 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	$ 1,232,865	$ 2,939,411
3. Public Health Services and Systems	$ 5,721,273	$ 3,981,654
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	$ 6,954,138	$ 6,921,065

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Mississippi

Total Births by Occurrence: 35,149 **Data Source Year: 2021**

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	33,943 (96.6%)	99	60	60 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	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 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	

2. Other Newborn Screening Tests

None

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:

None

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 2021

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	794	62.0	0.0	37.0	0.0	1.0
2. Infants < 1 Year of Age	1,649	62.0	0.0	37.0	0.0	1.0
3. Children 1 through 21 Years of Age	11,452	45.0	0.0	46.0	9.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	7,983	61.0	0.0	33.0	6.0	0.0
4. Others	14,242	44.0	0.0	12.2	41.7	2.1
Total	28,137					

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	35,473	Yes	35,473	67.9	24,086	794
2. Infants < 1 Year of Age	34,479	Yes	34,479	96.6	33,307	1,649
3. Children 1 through 21 Years of Age	817,979	Yes	817,979	14.3	116,971	11,452
3a. Children with Special Health Care Needs 0 through 21 years of age^	192,015	Yes	192,015	4.2	8,065	7,983
4. Others	2,113,388	Yes	2,113,388	2.8	59,175	14,242

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**
	Field Note: The number of deduplicated pregnant women enrolled in Healthy Moms/Healthy Babies reported in EPIC.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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 heath department clinic visit 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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	Field Note: This number comes from the number of males and females 21 years of age and older who had at least one county heath department clinic visit for STI/HIV testing, who had a clinical breast exam or cervical cancer screening, families reached with safe sleep information, webinar participants (topics including parenting, intimate partner violence, and human trafficking), and participants in Title X family planning services.	

Data Alerts:

1.	Children with Special Health Care Needs 0 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Mississippi

Annual Report Year 2021

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	35,514	17,974	14,812	1,774	226	353	70	305	0
Title V Served	35,149	17,847	14,594	1,756	225	353	70	304	0
Eligible for Title XIX	20,963	7,902	11,667	261	206	133	21	0	773
2. Total Infants in State	35,149	17,847	14,594	1,756	225	353	70	304	0
Title V Served	35,149	17,847	14,594	1,756	225	353	70	304	0
Eligible for Title XIX	24,678	8,953	13,483	2	180	164	20	0	1,876

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Data from vital statistics	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2021**
	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:	**2021**
	Column Name:	**Total**
	Field Note: data from the Mississippi Division of Medicaid	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Data from vital statistics	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2021**
	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:	**2021**
	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	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 721-7222	(800) 721-7222
2. State MCH Toll-Free "Hotline" Name	Women's Health Hotline	Women's Health Hotline
3. Name of Contact Person for State MCH "Hotline"	Mary Missy Fisher	Mary Missy Fisher
4. Contact Person's Telephone Number	(601) 576-7856	(601) 576-7856
5. Number of Calls Received on the State MCH "Hotline"		520

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names	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 Reporting, Tobacco Quitline, V	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 Reporting, Tobacco Quitline, V
2. Number of Calls on Other Toll-Free "Hotlines"		130,000
3. State Title V Program Website Address	https://msdh.ms.gov/page/31,0,299,360.html	https://msdh.ms.gov/page/31,0,299,360.html
4. Number of Hits to the State Title V Program Website		338
5. State Title V Social Media Websites		
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 as 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	Health Services Director
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 or Youth Leader (Optional)	
Name	Natasha James
Title	Parent Consultant
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

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Mississippi

Application Year 2023

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.

This ESM goes to a cross-cutting SPM and is being replaced.

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
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
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
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**
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**
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
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
2020/Q3-2021/Q2	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 %			
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
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
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
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
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**
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**
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
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
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
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**
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**
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
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
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
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
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
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
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
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
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
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 <50 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
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
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**
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
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
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
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
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
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
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
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
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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				78.5	79.7
Annual Indicator			74.2	75.4	77.5
Numerator			389,320	390,297	403,215
Denominator			524,486	517,720	520,497
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	80.9	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	67.8	69.8	71.9	74	76.2
Annual Indicator	57.5	63.2	63.4	70.0	68.0
Numerator	19,614	22,091	22,722	22,777	21,999
Denominator	34,098	34,981	35,813	32,539	32,351
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	78.5	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	12.1	12.8	13.4	14.1	14.8
Annual Indicator	11.1	13.0	16.0	18.1	16.4
Numerator	3,657	4,455	5,507	5,651	5,200
Denominator	32,945	34,243	34,464	31,217	31,729
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	15.4	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	65.7	66.8	67.5	68.2	68.9
Annual Indicator	56.1	56.1	72.2	69.4	64.3
Numerator	21,733	21,733	23,861	22,384	20,451
Denominator	38,760	38,760	33,042	32,256	31,790
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2009	2009	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	65.7	66.8	67.5	68.2	68.9
Annual Indicator	62	63.6	72.2		
Numerator	21,089	21,016	23,861		
Denominator	34,025	33,023	33,042		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	69.6	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**
Annual Objective	64.9	66.2	67.5
Annual Indicator	28.8	34.4	32.7
Numerator	9,167	10,964	10,154
Denominator	31,841	31,829	31,010
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			64.9	66.2	67.5
Annual Indicator	62	63.6	28.8		
Numerator	21,089	21,016	9,167		
Denominator	34,025	33,023	31,841		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	68.9	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**
Annual Objective	45.6	47.9	50.3
Annual Indicator	42.3	41.3	42.4
Numerator	13,523	12,948	13,078
Denominator	31,973	31,323	30,870
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			45.6	47.9	50.3
Annual Indicator	39.4	43.4	42.3		
Numerator	13,941	15,145	13,523		
Denominator	35,407	34,882	31,973		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	52.8	55.4	58.2	61.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 45.6% of mothers reporting that their baby does not usually sleep with blankets. 90.5 % of mothers reporting that their baby does not usually sleep with toys, cushions, and pillows. 77.5% of mothers reporting that their baby does not usually sleep with crib bumper pads.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		20.9	19.5	20.5	23.5
Annual Indicator	17.2	18.6	23.7	28.0	31.5
Numerator	11,967	13,102	16,993	19,663	25,115
Denominator	69,709	70,253	71,794	70,109	79,686
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	24.3	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**
Annual Objective		
Annual Indicator	23.4	23.4
Numerator	29,043	29,043
Denominator	123,981	123,981
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2019	2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2020	**2021**
Annual Objective		
Annual Indicator	16.7	20.6
Numerator	38,663	48,356
Denominator	231,717	234,684
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	20.4	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		78.8	79.4	80	80.6
Annual Indicator	74.6	77.0	77.0	66.2	65.1
Numerator	173,066	188,821	188,821	155,497	155,882
Denominator	232,151	245,226	245,226	234,939	239,310
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	81.2	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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		43.9	45.5	47.1	48.7
Annual Indicator	47.7	43.8	46.9	51.4	46.2
Numerator	84,259	75,832	78,448	82,086	72,719
Denominator	176,703	173,259	167,120	159,664	157,506
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.3	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			35.9	37.7	39.6
Annual Indicator	21.2	21.2	35.4	31.6	32.1
Numerator	7,953	7,953	12,028	10,696	10,493
Denominator	37,556	37,556	33,953	33,881	32,729
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2008	2008	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			35.9	37.7	39.6
Annual Indicator	31.3	34.2	35.4		
Numerator	10,967	11,784	12,028		
Denominator	34,995	34,483	33,953		
Data Source	MS PRAMS	MS PRAMS	MS PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
2022	**2023**	**2024**	**2025**	
Annual Objective	41.6	43.7	45.9	47.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	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?"	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			80.6	81.4	82.2
Annual Indicator	78.2	79.1	77.8	77.1	75.0
Numerator	536,054	544,787	525,080	500,754	484,100
Denominator	685,414	689,107	675,079	649,719	645,270
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
2022	**2023**	**2024**	**2025**	
Annual Objective	83.0	83.8	84.6	85.4

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Mississippi

SPM 1 - Percentage of women who smoke in the last three months of pregnancy

Measure Status:	Inactive - Replaced				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	10.1	9.6	9.1	8.7	8.2
Annual Indicator	14.7	10.4	11.4	10	9.8
Numerator	5,092	3,521	3,842	3,381	3,197
Denominator	34,646	33,787	33,605	33,797	32,569
Data Source	Mississippi PRAMS	Mississippi PRAMS	Mississippi PRAMS	Mississippi PRAMS	Mississippi PRAMS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Reduce Maternal Mortality Rates and Disparities by promoting best practices in clinical care and strengthening the Maternal Mortality Review Committee (MMRC) efforts.

Measure Status:	Inactive - Replaced

Baseline data was not available/provided.

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Replacing with new SPMs. Data for this inactive measure had inappropriate numerator and denominator.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Replacing with new SPMs. Data for this inactive measure had inappropriate numerator and denominator.	

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
Annual Objective		
Annual Indicator		3.8
Numerator		5,554
Denominator		144,844
Data Source		Medicaid and Lead Poisoning Prevention Program
Data Source Year		2021
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.9	4.0	4.1	4.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
data for 2020 was not available at the time of application

SPM 4 - Percent of women ages 15-44 years old that use family planning services

Measure Status:	Inactive - Replaced	
State Provided Data		
	2020	**2021**
Annual Objective		
Annual Indicator	3.1	2.8
Numerator	18,237	16,237
Denominator	581,196	581,196
Data Source	MS Title X data and March of Dimes	MS Title X data and March of Dimes
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Percent of Women ages 40-64 yrs. old screened for cervical cancer.

Measure Status:	**Inactive - Women/Maternal Health Domain Team selected a new performance measure to align with activities.**

Baseline data was not available/provided.

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data not available	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data not available	

SPM 6 - Percentage of pregnant women and new mothers who felt they were treated unfairly while receiving services.

Measure Status:	Inactive - No data available.

Baseline data was not available/provided.

Field Level Notes for Form 10 SPMs:

None

SPM 7 - Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff.

Measure Status:	Inactive - Replaced

Baseline data was not available/provided.

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Replacing SPM 7 with a new SPM that is measurable.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Replacing SPM 7 with a new SPM that is measurable.	

SPM 8 - Strengthen mental, social and emotional health and well-being through partnerships and programs that build capacity and reduce stigma.

Measure Status:	Inactive - Replaced

Baseline data was not available/provided.

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Replacing SPM 8 with a new SPM that is measurable.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Replacing SPM 8 with a new SPM that is measurable.	

SPM 9 - Dried blood spot specimens received by labs within 48 hours of collection.

Measure Status:	Inactive - Replaced	
State Provided Data		
	2020	**2021**
Annual Objective		
Annual Indicator		3,567
Numerator		
Denominator		
Data Source		Bureau of Genetics
Data Source Year		2021
Provisional or Final ?		Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: No data provided	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Bureau of Genetics reported 3567 of 33,677 specimens were received within 48 hours of collection.	

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

Measure Status:	Active

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
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		
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
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 EHDI and began using MSDH's EPIC system to capture EHDI information. The EPIC system for EHDI went live in July 2021. Data for the first half of 2021 are in the process of entry. These data are preliminary.

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit

Measure Status:			Active
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	341.0	375.0	413.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: MSDH EPSDT encounter summary for children ages 9-30 months between 7/1/2020 and 6/30/2021	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: increase annually by 10%	
3.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: increase annually by 10%	
4.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: increase annually by 10%	

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
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
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		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	84.0	84.5	85.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Mississippi BRFSS data are not yet available for 2021. The data reported are a 2-year prevalence estimate (2018-2019). Data on payer are not captured every year in BRFSS.

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
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	17.2	18.2	19.2

Field Level Notes for Form 10 SPMs:

None

SPM 19 - Adolescent suicide rate

Measure Status:	Active

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

SPM 20 - Number of MCH programs that have developed a written plan to address health equity

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	3.0	6.0	9.0

Field Level Notes for Form 10 SPMs:

None

SPM 21 - Percent of children with and without special healthcare needs who have a medical home

Measure Status:	Active

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.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Mississippi

ESM 1.1 - Number of community group and activities program attends and partners with

Measure Status:	**Inactive - Completed**				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			50	55	60
Annual Indicator			0	100	100
Numerator					
Denominator					
Data Source			0	PHRM/ISS Outreach Marketing Activities sheet	PHRM/ISS Outreach Marketing Activities sheet
Data Source Year			0	2020	2021
Provisional or Final ?			Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
This data was reported by the PHRM/ISS Outreach Marketing Activities sheet by the Outreach coordinator.

ESM 1.2 - Number of engaged users viewing social media messages delivered by MSDH social sites promoting women's preventive health services

Measure Status:	Inactive - Completed				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			90,202	92,006	93,846
Annual Indicator			0	97,440	30,000
Numerator					
Denominator					
Data Source			MSDH Office of Communications	MSDH Office of Communications	MSDH Office of Communications
Data Source Year			2019	2020	2021
Provisional or Final ?			Provisional	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
due to the COVID-19 pandemic, tracking of non-COVID related messaging was reduced; the best estimate is that the number of messages decreased by 2/3

ESM 1.3 - Number of social media message months promoting women's preventive health services

Measure Status:	Inactive - Completed				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			9	10	11
Annual Indicator			0	7	7
Numerator					
Denominator					
Data Source			MSDH Womens Health Office	MSDH Womens Health Office	MSDH Womens Health Office
Data Source Year			2019	2020	2020
Provisional or Final ?			Provisional	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The social media posts stopped March 2020 due to heavy focus on COVID-19 notifications and state response plan.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The social media posts stopped March 2020 due to heavy focus on COVID-19 notifications and state response plan. Social media posts started again in 2021, but the precise number of message months is not known. Estimated based on 2020 data.	

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.

Measure Status:	Inactive - Replaced

Baseline data was not available/provided.

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: In 2020, due to the COVID-19 pandemic, this ESM remained in the developmental stages. No data available.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: In 2021, due to the COVID-19 pandemic, this ESM remained in the developmental stages. No data available.	

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

Annual Objectives			
	2023	2024	2025
Annual Objective	705.0	776.0	853.0

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).

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					
	2017	2018	2019	2020	2021
Annual Objective	2	3	4	5	6
Annual Indicator	2	11	18	21	22
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.0	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.	

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	20,000	25,000	20,200	20,450	20,700
Annual Indicator	25,000	20,000	10,000	14,880	9,560
Numerator					
Denominator					
Data Source	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program	MSDH Infant Health Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	21,000.0	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.	

ESM 6.1 - The number of participants who received training about Bright Futures Guidelines for Infants, Children, and Adolescents.

Measure Status:	Inactive - Completed			
State Provided Data				
	2018	**2019**	**2020**	**2021**
Annual Objective			415	457
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Office of Child and Adolescent Health	Office of Child and Adolescent Health
Data Source Year			2020	2021
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 6.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring

Measure Status:	Active

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
Annual Objective		
Annual Indicator	20.6	
Numerator	48,356	
Denominator	234,684	
Data Source	National Survey of Childrens Health	
Data Source Year	2019-2020	
Provisional or Final ?	Final	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	22.0	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.	

ESM 10.1 - Number of clinic sites engaged in youth-centered care quality improvement cycles.

Measure Status:	Inactive - Completed				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	3	6	6	7	8
Annual Indicator	5	5	7	7	0
Numerator					
Denominator					
Data Source	MSDH Adolescent Health	MSDH Adolescent Health	MSDH Adolescent Health	MSDH Adolescent Health	MSDH Adolescent Health
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The data refers to the MSDH Office of Child and Adolescent Health's activities to improve care for youth through partnerships with other entities rather than the direct activities of the program.

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		
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.

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	10	15	48	50	52
Annual Indicator	46	46	100	100	0
Numerator					
Denominator					
Data Source	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program	MSDH CYSHCN Program
Data Source Year	2018	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	54.0	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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			600	650	700
Annual Indicator			409	347	0
Numerator					
Denominator					
Data Source			MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	750.0	800.0	850.0	900.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data captured from WIC program and Baby Cafes

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

Measure Status:	Inactive - The state has transitioned to eWIC which has resulted in changes to how oral health education is being distributed.

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			20	25	30
Annual Indicator			19	19	12
Numerator					
Denominator					
Data Source			Regional Oral Health Consultant monthly activity l	Regional Oral Health Consultant monthly activity l	Regional Oral Health Consultant monthly activity l
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Inactive - This ESM was added previously with collaboration with the Prenatal High Risk Management Program which no longer operates in the same way.

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			100	150	200
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			MSDH Office of Oral Health	MSDH Office of Oral Health	MSDH Office of Oral Health
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
No data available to report as this program was not carried about across all programs. We are currently working to incorporate a way to capture this data with PRAMS data.

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			1,000	2,000	3,000
Annual Indicator			0	903	0
Numerator					
Denominator					
Data Source			Office of Oral Health	Office of Oral Health	Office of Oral Health
Data Source Year			2019	2020	2021
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	4,000.0	5,000.0	5,500.0	6,000.0

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.	

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					
	2017	2018	2019	2020	2021
Annual Objective			1,000	2,000	3,000
Annual Indicator			0	976	424
Numerator					
Denominator					
Data Source			EPIC	EPIC	EPIC
Data Source Year			2019	2020	2021
Provisional or Final ?			Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	4,000.0	5,000.0	5,500.0	6,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Information was captured in EPIC EHR system based on EPDST wellness visits. There is an oral health evaluation component. We are working to customize reports to find out more regarding specifics of referrals.

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			60	65	70
Annual Indicator			10	2	8
Numerator					
Denominator					
Data Source			Office of Oral Health	Office of Oral Health	Office of Oral Health
Data Source Year			2019	2020	2021
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	75.0	80.0	85.0	90.0

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.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Mississippi

SPM 1 - Percentage of women who smoke in the last three months of pregnancy
Population Domain(s) – Women/Maternal Health

Measure Status:	Inactive - Replaced
Goal:	Reduce smoking among pregnant women
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women reporting smoking in the last three months of pregnancy **Denominator:** Number of women delivering babies during the reporting period
Data Sources and Data Issues:	Birth certificate: U.S. Standard Certificate of Life Birth (revised 11/2003); Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Further, secondhand smoke (SHS) is a mixture of mainstream smoke (exhaled by smoker) and the more toxic side stream smoke (from lit end of nicotine product) which is classified as a “known human carcinogen” by the US Environmental Protection Agency, the US National Toxicology Program, and the International Agency for Research on Cancer. Adverse effects of parental smoking on children have been a clinical and public health concern for decades and were documented in the 1986 U.S. Surgeon General Report. The only way to fully protect non-smokers from indoor exposure to SHS is to prevent all smoking in the space; separating smokers from non-smokers, cleaning the air, and ventilating buildings do not eliminate exposure. Unfortunately, millions (more than 60%) of children are exposed to SHS in their homes. These children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections leading to 7,500 to 15,000 hospitalizations annually in children under 18 months; and sudden infant death syndrome (SIDS). Higher intensity medical services are also required by children of parents who smoke including an increased need for intensive care unit services when admitted for flu, longer hospital stays; and more frequent use of breathing tubes during admissions.

SPM 2 - Reduce Maternal Mortality Rates and Disparities by promoting best practices in clinical care and strengthening the Maternal Mortality Review Committee (MMRC) efforts.
Population Domain(s) – Women/Maternal Health

Measure Status:	Inactive - Replaced
Goal:	To reduce the number of maternal deaths by increasing the proportion of birthing hospitals that implement the AIM Patient Safety Bundles.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of birthing hospitals implementing the Obstetric Hemorrhage AIM Bundle **Denominator:** Number of birthing hospitals for year of reporting (number may fluctuate)
Healthy People 2030 Objective:	Reduce maternal deaths — MICH-04. Baseline: 17.4 maternal deaths per 100,000 live births occurred in 2018 Target: 15.7 maternal deaths per 100,000 live births
Data Sources and Data Issues:	AIM data portal/ Mississippi Hospital Discharge Data
Significance:	Preventing maternal mortality is essential to improving the health of women in the state. Most maternal deaths are preventable, as the health-care solutions to prevent or manage complications are well known. All women need access to high quality care in pregnancy, and during and after childbirth. Maternal health and newborn health are closely linked. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death for the mother as well as for the baby.

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:	**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 **Denominator:** Number of Mississippi children on Medicaid aged 12 and 24 months
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:	Lead is a potent and pervasive neurotoxicant. Elevated blood lead levels (EBBLs) can result in decreased IQ, academic failure, and behavioral problems in children. There are approximately half a million U.S. children ages 1-5 with blood lead levels above five micrograms per deciliter, the reference level at which CDC recommends public health actions be initiated. No safe blood lead level in children has been identified. Because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized. By school age, children with a history of lead exposure can exhibit poor attention and impulse control, with lower intelligence and academic performance. A blood lead test is the only reliable way to identify a lead-poisoned child. Medicaid has required testing of enrolled children since 1989. Many states do not enforce the Medicaid requirement for children to be tested for lead poisoning. Medicaid-enrolled children are three times more likely to have elevated blood lead levels (EBLLs) than those non-enrolled children, according to national studies.

SPM 4 - Percent of women ages 15-44 years old that use family planning services
Population Domain(s) – Women/Maternal Health

Measure Status:	Inactive - Replaced
Goal:	To be able to function as a gap filling services to offer full family planning services to women 15-44 years old in the state of Mississippi.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of unduplicated family planning method users **Denominator:** Number of female population in MS between 15-44 years old
Healthy People 2030 Objective:	Increase the proportion of women at risk for unintended pregnancy who use effective birth control — FP-10 Reduce the proportion of pregnancies conceived within 18 months of a previous birth — FP-02
Data Sources and Data Issues:	Family planning program database.
Significance:	Family planning services prevent unplanned pregnancies which are more likely than planned pregnancies to occur in young teens, women > 35 years of age, and to women who have had a previous baby without sufficient time to recover (i.e. <1 year between births). Babies from unplanned pregnancies are more likely to be born into poverty, premature, malnourished, and have developmental disabilities. Good coverage of women with family planning services indicates that the medical system is protecting mothers and children from preventable problems.

SPM 5 - Percent of Women ages 40-64 yrs. old screened for cervical cancer.
Population Domain(s) – Women/Maternal Health

Measure Status:	Inactive - Women/Maternal Health Domain Team selected a new performance measure to align with activities.
Goal:	To increase the number of women 40-64 yrs old who have cervical cancer screening.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women, age 40-64 yrs old, who had cervical cancer screening in the calendar year **Denominator:** Number of women, age 40-64 yrs old
Healthy People 2030 Objective:	Increase the proportion of females who get screened for cervical cancer — C-09
Data Sources and Data Issues:	MSDH BCCP Program Cervical Cancer Screening Database
Significance:	Cervical cancer is the most common type of cancer for female population. Since the Pap test was introduced, women are both less likely to get cervical cancer and less likely to die from it. But in recent years, the number of women getting screened for cervical cancer has actually decreased — and some groups are less likely than others to get screened. Strategies to increase cervical cancer screening rates include interventions that target both patients and providers.

SPM 6 - Percentage of pregnant women and new mothers who felt they were treated unfairly while receiving services.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - No data available.
Goal:	Reduce the percentage of pregnant women and new mothers who have ever experienced discrimination while receiving health or medical care.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of women who responded to the MS PRAMS survey and felt they were treated unfairly while receiving services.</td></tr><tr><td>**Denominator:**</td><td>Total number of women who responded to the MS PRAMS survey</td></tr></table>
Healthy People 2030 Objective:	Reduce the proportion of people who can't get medical care when they need it — AHS-04 Increase the proportion of adults whose health care provider checked their understanding — HC/HIT-01 Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted — HC/HIT-03
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System
Significance:	Key findings in the Needs Assessment point to persistent health disparities by race/ethnicity and immigrant, and socio-economic status. In addition, they emphasize the need to address social determinants of health such as housing, education, violence and discrimination/implicit bias as these were among the top factors community members identified as the biggest unmet needs of MS women, children and families, as well as things needed to live their fullest lives.

SPM 7 - Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - Replaced
Goal:	Eliminate drivers of structural and institutional racism.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** 0 **Denominator:**
Healthy People 2030 Objective:	One of Healthy People 2030's 5 overarching goals is specifically related to SDOH: "Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all." In line with this goal, Healthy People 2030 features many objectives related to SDOH. These objectives highlight the importance of "upstream" factors — usually unrelated to health care delivery — in improving health and reducing health disparities.
Data Sources and Data Issues:	MSDH Programs
Significance:	The 10 Essential Public Health Services (EPHS) provide a framework for public health to protect and promote the health of all people in all communities.. For the past 25 years, the EPHS have served as a well-recognized framework for carrying out the mission of public health. The 2020 revised version places equity firmly at its core, actively promoting policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.

SPM 8 - Strengthen mental, social and emotional health and well-being through partnerships and programs that build capacity and reduce stigma.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - Replaced
Goal:	Promote mental health across MCH populations
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of engaged partners working on mental, social and emotional health. **Denominator:**
Healthy People 2030 Objective:	Increase the proportion of children with mental health problems who get treatment — MHMD-03 Increase the proportion of people with substance use and mental health disorders who get treatment for both — MHMD-07 Increase the proportion of homeless adults with mental health problems who get mental health services — MHMD-R01
Data Sources and Data Issues:	MCH Internal Records
Significance:	Mental illness contributes a substantial burden of disease worldwide. Globally, approximately 450 million persons suffer from mental disorders, and one fourth of the world's population will develop a mental or behavioral disorder at some point during their lives. In the United States, approximately 22% of the U.S. adult population has one or more diagnosable mental disorders in a given year. The estimated lifetime prevalence for mental disorders among the U.S. adult population are approximately 29% for anxiety disorders, 25% for impulse-control disorders, 21% for mood disorders, 15% for substance-use disorders, and 46% for any of these disorders. In addition, an estimated one in 10 children in the United States has a mental disorder that causes some level of impairment. The effects of mental illness are evident across the life span, among all ethnic, racial, and cultural groups, and among persons of every socioeconomic level. Moreover, mental illness costs the United States an estimated $150 billion annually, excluding the costs of research. MSDH will work with partners to assess the resources and gaps in mental health services and the role the agency can fill related to mental health in the MCH population.

SPM 9 - Dried blood spot specimens received by labs within 48 hours of collection.
Population Domain(s) – Child Health

Measure Status:	Inactive - Replaced
Goal:	Number of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection **Denominator:**
Healthy People 2030 Objective:	No Healthy People 2030 Objective is provided.
Data Sources and Data Issues:	Genetics Program Data at MSDH
Significance:	To allow for timely diagnosis and treatment, it is important for newborn screening results to be available as quickly as possible. With early identification and therapy, most infants with genetic and metabolic disorders can go on to live normal, healthy lives. The end goal for all conditions screened for is to report by the infant's seventh day of life.

SPM 10 - Percent of severe maternal morbidity events related to hypertension
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	By September 30, 2022, decrease the percentage of severe maternal morbidity events related to hypertension by 0.1% annually
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of severe hypertension events **Denominator:** Number of live births
Data Sources and Data Issues:	Mississippi Hospital Discharge Data Data issues are: Hospital Discharge data are typically delayed by 18-24 months.
Significance:	Mississippi has a high severe maternal morbidity rates and significant racial disparities.

SPM 11 - Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	By September 30, 2025, decrease the percentage of children, ages 2-5 years, who receive WIC services and have a BMI at or above the 85th percentile
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children, ages 2-5 yrs, receiving WIC services with a BMI at or above the 85th percentile **Denominator:** Number of children, ages 2-5 yrs who received WIC services during the reporting period
Data Sources and Data Issues:	WIC Spirit Database
Significance:	Participation in WIC is low in Mississippi and participating in WIC could improve child's nutrition and health.

SPM 12 - Percent of women who are enrolled in WIC and initiate breastfeeding
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the number of WIC mothers who initiate breastfeeding
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of WIC mothers who initiated breastfeeding **Denominator:** Number of mothers enrolled in WIC
Data Sources and Data Issues:	WIC Spirit Database
Significance:	Breastfeeding is low within the WIC population and breastfeeding can improve newborn health and reduce childhood obesity

SPM 13 - Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age
Population Domain(s) – Child Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the number of infants with confirmed hearing loss who received confirmation of hearing status by 3 months to 67%
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Infants with confirmed hearing loss who received confirmation of hearing status by 3 months **Denominator:** Infants with confirmed hearing loss
Healthy People 2030 Objective:	Increase the proportion of infants who didn't pass their hearing screening who get evaluated for hearing loss by age 3 months — HOSCD-02 (https://health.gov/healthypeople/objectives-and-data/browse-objectives/sensory-or-communication-disorders/increase-proportion-infants-who-didnt-pass-their-hearing-screening-who-get-evaluated-hearing-loss-age-3-months-hoscd-02)
Data Sources and Data Issues:	Program database and EPIC.
Significance:	According to NCHAM, approximately 95% of babies receive a hearing screen shortly after birth as part of universal newborn hearing screening; however, many infants who do not pass the hearing screening become lost to follow-up or documentation before an audiological evaluation can be completed or critical educational and medical intervention can be provided. Children with hearing loss who receive timely early intervention services are often able to develop language skills on par with their hearing peers. Timely access to early intervention is dependent upon timely confirmation of hearing status.

SPM 14 - Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit
Population Domain(s) – Child Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the number of children who receive developmental screening using a parent completed tool by 10% annually
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** All children at 9 months, 18 months and 30 months or when indicated **Denominator:**
Healthy People 2030 Objective:	Increase the proportion of children who receive a developmental screening — MICH-17 (https://health.gov/healthypeople/objectives-and-data/browse-objectives/children/increase-proportion-children-who-receive-developmental-screening-mich-17)
Data Sources and Data Issues:	Medicaid data; EPIC EPSDT visit data
Significance:	Developmental screening is early identification of children at risk for cognitive, motor, communication, or social-emotional delays. These are delays that may interfere with expected growth, learning, and development and may warrant further diagnosis, assessment, and evaluation.

SPM 15 - Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely
Population Domain(s) – Child Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	to increase timely screening and referral of newborns and infants diagnosed with a genetic or metabolic condition
Definition:	**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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of cesarean deliveries among term (37+ weeks), singleton, vertex births to nulliparous women **Denominator:** Number of term (37+ weeks), singleton, vertex births to nulliparous women
Healthy People 2030 Objective:	Identical to Maternal, Infant, and Child Health (MICH) Objective 06: Reduce cesarean births among low-risk women with no prior births (Baseline: 25.9% of low-risk females with no prior births had a cesarean birth in 2018, Target: 23.6%)
Data Sources and Data Issues:	National Vital Statistics System (NVSS)
Significance:	Cesarean delivery can be a life-saving procedure for certain medical indications. However, for most low-risk pregnancies, cesarean delivery poses avoidable maternal risks of morbidity and mortality, including hemorrhage, infection, and blood clots—risks that compound with subsequent cesarean deliveries.1 Much of the temporal increase in cesarean delivery (over 50% in the past decade), and wide variation across states, hospitals, and practitioners, can be attributed to first-birth cesareans. Moreover, cesarean delivery in low-risk first births may be most amenable to intervention through quality improvement efforts. This low-risk cesarean measure, also known as nulliparous term singleton vertex (NTSV) cesarean, is endorsed by the National Quality Forum (#0471) and included within The Joint Commission's National Quality Measures for hospitals (PC-02), and the Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP. An Alliance for Innovation on Maternal Health (AIM) patient safety bundle for Safe Reduction of Primary Cesarean Births was released in 2018.

SPM 17 - Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the percent of women who have an annual preventive medical visit
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women on Medicaid ages 18 through 44, who report visiting a doctor for a routine checkup in the past year **Denominator:** Number of women on Medicaid, ages 18 through 44
Healthy People 2030 Objective:	Related to Access to Health Services (AHS) Objective 08: Increase the proportion of adults who receive appropriate evidence-based clinical preventive services. (Baseline: 8.0% in 2015, Target: 10.9%)
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System (BRFSS)
Significance:	An annual well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The Women's Preventive Services Initiative (WPSI) is a coalition of national health professional organizations and patient advocates led by the American College of Obstetricians and Gynecologists (ACOG) and works to develop, review, and update recommendations for women's healthcare preventive services. WPSI recommends an annual well-woman visit beginning in adolescence and continuing across the lifespan with any health care provider offering preventive well-woman care.

SPM 18 - Percent of children with and without special health care needs who received services necessary to make transitions to adult health care
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of children with special health care needs who have received services necessary for transition to adult health care</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children with special health care needs who have received services necessary for transition to adult health care (12-17 years)</td></tr>
<tr><td>Denominator:</td><td>Total number of children with special health care needs (12-17 years)</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NSCH 2019-2020</td></tr>
<tr><td>Significance:</td><td>CYSHCN are children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. They also require health and related services of a type or amount beyond that required by children generally. According to our National Survey of Children’s Health (NSCH) (PDF), in our country:
(1) About 14 million children under 18 years old (19%) have a special healthcare need,
(2) 25% of homes had one or more children with a special healthcare need,
(3) CYSHCN are more likely to live in poverty, be non-Hispanic Black, and have public insurance than non-CYSHCN.

Mississippi needs to work on a coordinated system of care to support transition.</td></tr>
</table>

SPM 19 - Adolescent suicide rate
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	to reduce the adolescent suicide rate among youth ages 15-19 years
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** number of adolescents aged 15-19 years who died by suicide **Denominator:** number of adolescents aged 15-19 years (per 100,000)
Data Sources and Data Issues:	NVSS Data issues: small numbers and potentially unstable estimates
Significance:	Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. There are many factors that contribute to suicide. The goal of suicide prevention is to reduce factors that increase risk and increase factors that promote resilience. In 2020, an estimated 12.2 million adults seriously thought about suicide, 3.2 million made a plan, and 1.2 million attempted suicide. Suicide rates in 2020 were 30% higher than in 2000. Data for Mississippi indicate that the rate has increased from 5.9 deaths per 100,000 adolescents aged 15-19 years in 2012-2014 to 11.6 deaths per 100,000 adolescents aged 15-19 years in 2017-2019.

SPM 20 - Number of MCH programs that have developed a written plan to address health equity
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	to ensure all MCH programs implement plans to achieve health equity by addressing implicit bias, diversity, discrimination, and racism
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** number of written plans that address health equity **Denominator:**
Data Sources and Data Issues:	program data
Significance:	Mississippi ranks last, or close to last, in almost every leading health outcome. In Mississippi and nationwide, these health disparities are significantly worse for those who have systematically faced obstacles to health due to their socio-economic status, race, ethnicity, religion, sexual orientation, geographic location, and other characteristics historically linked to discrimination or exclusion. The result is a disproportionate burden of disease and illness that is borne by racial and ethnic minority populations and the rural and urban poor. Health disparities not only affect the groups facing health inequities, but limit overall improvements in quality of care, the health status for the broader population, and results in unnecessary costs. The MSDH MCH programs believe that developing written plans on how each program will implement plans to achieve health equity by addressing implicit bias, diversity, discrimination, and racism

SPM 21 - Percent of children with and without special healthcare needs who have a medical home
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	to assure that all children with special healthcare have a medical home
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** children, 0-17 years, with and without special healthcare needs who have a medical home **Denominator:** all children, 0-17 years, in Mississippi with special healthcare needs
Data Sources and Data Issues:	NSCH 2019-2020
Significance:	A medical home is essential to overall mental, emotional and physical health of children. The American Academy of Pediatrics specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective care. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional who is familiar with the child and family and the child's health history. In Mississippi, the C/YSHCN program is working towards developing a comprehensive, coordinated and integrated system of services for children.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Mississippi

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Mississippi

ESM 1.1 - Number of community group and activities program attends and partners with
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Completed
Goal:	Increase the total number of community group and activities program attends and partners with by 10% in the next year.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of community group and activities program attends and partners with **Denominator:**
Data Sources and Data Issues:	Program accountability and report the number community groups and activities including Minutes, sign in sheets, and/or activity logs.
Significance:	Program staff develop and sustain partnerships with community organizations and groups, in order to provide education about MSDH services and improve the health of women. With the Fatherhood Coordinator participating on various organizational advisory boards, there is the potential of broaden the community's knowledge about the population served in the PHRM/ISS, BCCP and other health department programs. The PHRM/ISS program hired a promoter for the PHRM/ISS Telehealth project in the Hinds, Madison, Rankin and Yazoo counties. Her goal was to focus on the medical community and professional organization educating them about the benefits of the PHRM/ISS program and the use of telehealth within PHRM/ISS.

ESM 1.2 - Number of engaged users viewing social media messages delivered by MSDH social sites promoting women's preventive health services
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Completed
Goal:	Increase the number of users viewing the social media message delivered by MSDH social sites promoting women's preventive health services by 1% in the next year.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of engaged users viewing social media messages delivered by MSDH social sites promoting women's preventive health services including Facebook Reaches; Twitter Impressions; Web Page Visitors; Video Views. **Denominator:**
Data Sources and Data Issues:	MSDH Office of Communications
Significance:	The social media strategy is to encourage women to seek preventive health services to meet their health care needs. Preventive health screenings provide benefits to women throughout the life course. From a well woman visit to immunizations, these preventive health care services assist with the identification, treatment and/or prevention of health issues and diseases. The social media messages utilized cover a variety of topics to include some of the following: immunizations, flu shots, hypertension, heart disease, breast cancer, cervical cancer, colorectal cancer, smoking, prenatal care, folic acid, and STD/HIV. Social media will continue to be used in order to increase awareness and education of women regarding the important of such preventive health services.

ESM 1.3 - Number of social media message months promoting women's preventive health services
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Completed
Goal:	To increase the number of social media months with partnerships inside and outside MSDH.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of social media message months promoting women's preventive health services **Denominator:**
Data Sources and Data Issues:	Program accountability and report the number of months
Significance:	The strategy within this ESM is to provide a variety of information regarding preventive health services to meet the health care needs of women within Mississippi using Facebook and Twitter. The goal is to work on providing social media tailored messages to meet the various preventive health services for women.

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

Measure Status:	Inactive - Replaced
Goal:	Eliminate drivers of structural and institutional racism
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** 100 **Denominator:**
Data Sources and Data Issues:	MSDH Program Data
Evidence-based/informed strategy:	n/A
Significance:	The 10 Essential Public Health Services (EPHS) provide a framework for public health to protect and promote the health of all people in all communities.. For the past 25 years, the EPHS have served as a well-recognized framework for carrying out the mission of public health. The 2020 revised version places equity firmly at its core, actively promoting policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>to assist women in quitting smoking during pregnancy</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>Number of 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>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Mississippi Quitline and Baby and Me Tobacco Free data

Data issues: new Quitline provider needs to make a concerted effort to document sex / gender and pregnancy status of both callers AND persons up complete the intake process</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>This ESM measures the number of unduplicated individuals who have completed the intake process for OTC-funded tobacco cessation treatment programs and is associated with NPM 1. All providers should be asking their patients about the use of tobacco and nicotine-containing products and, if using tobacco or nicotine, having a discussion around use and making recommendations around quitting and staying quit.

Data from the Mississippi Quitline provider and the Baby and Me Tobacco Free Program</td></tr>
<tr><td>Significance:</td><td>Data from the Mississippi Quitline provider and the Baby and Me Tobacco Free Program helps us understand how many individuals are accessing and initiating steps in quitting smoking. Along with other PRAMS data, it will allow MSDH to look at provider interactions with pregnant women and discussions / recommendations for quitting.

United States. Tobacco use is the leading cause of preventable illness, disability, and death in the United States. About 34 million adults smoke cigarettes. More than 480,000 deaths each year are due to cigarette smoking, including 41,000 deaths from secondhand smoke. Cigarette smoking can negatively affect fertility, making it harder for women to become pregnant. Cigarette smoking during pregnancy has been linked to an increased risk of low birthweight, premature birth, birth defects, and sudden infant death syndrome (SIDS).

Mississippi. There are a number of documented disparities related to smoking in Mississippi.

Mississippi BRFSS Analytic Findings. Approximately 18% of women aged 18-44 years were current smokers. The percentage of current smokers was significantly lower among Black women (11.3%) compared to white women (24.9%), and was significantly higher among women who have not completed a high school education (41.6%) compared to those with more than a high school education (13.2%).

Mississippi PRAMS Analytic Findings. Almost 22% of women aged 18-44 years reported smoking in the 3 months before pregnancy. In the last 3 months of pregnancy, about 1 in 10</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of births occurring in birthing hospitals designated as Baby Friendly</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of birthing hospitals in the state designated as Baby Friendly</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MSDH Infant Health Program and Baby Friendly USA (https://www.babyfriendlyusa.org/for-parents/baby-friendly-facilities-by-state/)</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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:	**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 6.1 - The number of participants who received training about Bright Futures Guidelines for Infants, Children, and Adolescents.
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:	Inactive - Completed
Goal:	Increase the number of participants who received training about Bright Futures Guidelines for Infants, Children, and Adolescents by 10% in the next year.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** The number of participants who received training about Bright Futures Guidelines for Infants, Children, and Adolescents. **Denominator:**
Data Sources and Data Issues:	MSDH Mississippi First Steps Early Intervention Program (MSFSEIP) 2018
Significance:	Bright Futures Guidelines provide the most up-to-date information on preventive screenings and services by visit for infants, children, and adolescents. The Guidelines provide visit-by-visit anticipatory guidance for health care providers.

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:	**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:	**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 10.1 - Number of clinic sites engaged in youth-centered care quality improvement cycles.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Inactive - Completed
Goal:	Improve the quality of preventive services to adolescents and young adults by increasing the number of clinic sites engaged in youth-centered care quality improvement cycles by 20% in the next year.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of clinics actively engaged in youth-centered care quality improvement initiatives. **Denominator:**
Data Sources and Data Issues:	MSDH Adolescent Health Program documents (CoIIN reports).
Significance:	According to the AAP, health behaviors and lifestyle habits that are formed in adolescence often continue into adulthood. Therefore, adolescence is a key period for engaging the adolescent's active participation in a variety of health-promoting and risk-reducing behaviors, such as healthy eating, daily physical activity, and avoiding substance use, and for supporting family connectedness and promoting healthy sexuality. This engagement can happen during an annual well visit that includes high quality youth-centered practices.

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:	**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:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care **Denominator:**
Data Sources and Data Issues:	MSDH Children's Medical Program
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. We are planning to work with two (2) community based clinics utilizing the medical home model as pilot sites for referring and providing care coordination to children and adolescents enrolled in CMP.

ESM 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
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:	**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:	Office of Oral Health/PHRM/FQHC partners During this reporting period, we collaborated with twelve (12) WIC sites. Educational material and oral health supplies were provided to WIC participants in the following county locations: Jackson, Hinds, Lincoln, Simpson, Copiah, Rankin, Wilkinson, Warren, Lowndes, Noxubee, Oktibbeha, and Winston.
Significance:	Oral Health promotion and oral disease prevention in parents and children; referral to dental home

ESM 13.1.2 - Number of WIC sites where oral health education is given to program participants by ROHCs
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

<table>
<tr><td>Measure Status:</td><td>Inactive - The state has transitioned to eWIC which has resulted in changes to how oral health education is being distributed.</td></tr>
<tr><td>Goal:</td><td>Increase the number of places where oral health education is given by Office of Oral Health staff (ROHCs) by 25% in the next year.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of WIC sites where oral health education is given to program participants by ROHCs</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>WIC/Office of Oral Health
765 WIC participants and their children received Oral Health 101 training as well as oral health kits which include an age-appropriate toothbrush and toothpaste, and floss. There were also 5 virtual trainings given by our external partner to healthcare workers and community members during this reporting period. (November 2020-September 2021). An estimated 12 WIC sites were engaged.

November 2020

Jackson County Breastfeeding Class (5 attendees)

Jackson County Molina Mom & Baby drive through baby shower (250 oral health kits donated)</td></tr>
<tr><td>Significance:</td><td>Prevention of oral disease and referral to dental home.</td></tr>
</table>

ESM 13.1.3 - Number of pregnant women who saw the dentist post referral
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

<table>
<tr><td>Measure Status:</td><td>Inactive - This ESM was added previously with collaboration with the Prenatal High Risk Management Program which no longer operates in the same way.</td></tr>
<tr><td>Goal:</td><td>Increase the number of pregnant women who saw the dentist post referral by 50% in the next year to increase their awareness regarding the safety of dental treatment while pregnant.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of pregnant women who saw the dentist post referral</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Office of Oral Health/PHRM/FQHC partners
No data to report.

This ESM was added previously with collaboration with the Prenatal High Risk Management Program, which is no longer operated in the same way.

During the summer of 2021, the Office of Oral health hired a dental care coordinator to centralize our care coordination state-wide. The management tools were created using an Excel Spreadsheet with a protocol that was shared with all Oral Health Team members. Based on the current protocol, all patients identified not having a dental home and who are okay with us following up with them are placed on our spreadsheet and contacted to further assist them finding a dental home or other resources. Some patient demographic information is collected and correspondence with said patients is documented. We have worked with our Family Planning team and EPIC on ways to capture this information in the EPIC electronic Health Record and hopeful future reports will enable us to do so better.</td></tr>
<tr><td>Significance:</td><td>Promotion of oral health and oral disease prevention</td></tr>
</table>

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:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of children 0-3 years old who actually went to referred dentist **Denominator:**
Data Sources and Data Issues:	Office of Oral Health/MSDH Nurses-Epic system - At this time, we are unable to identify how many children were referred to a dental home that participated in the EPSDT screenings from those nurses that provided the fluoride varnish treatment. We are currently working on a centralized system where the Office of Oral Health will be able to get this information from our other team partners to follow up on. We are waiting on some inclusions into EPIC. We do know that Physicians and Surgeons in Monroe County provided fluoride varnish to 1,052 private payers and 657 Medicaid payers and Family Care Medical Clinic in Lee County provided fluoride varnish to 40.
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:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** # of referrals to dentists of children 0-3 by MSDH nurses **Denominator:**
Data Sources and Data Issues:	Office of Oral Health/MSDH Nurses-Epic system According to Epic oral health screening summary, 424 EPDST visits occurred with this age group As apart of this measure, all patients who did not receive an oral health fluoride treatment should be refereed to a dental home. As such, we anticipate all 424 were referred
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:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of training completed by medical providers on use of fluoride varnish in primary care setting **Denominator:**
Data Sources and Data Issues:	Office of Oral Health During the grant reporting period, Cavity Free in Mississippi trainings and supplies were provided in Yalobusha County at Yalobusha Medical Clinic (1), in Rankin County at Family Health Care Clinic (35), in Harrison County at Children's International (3) in Forrest County at Lackey Pediatric Clinic (3); Milestones Pediatric Clinic; Family Health Center; Waynesboro Family Medicine; and Women's Health Services.
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 2021

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	1		
2) Vital Records Death	Yes	Yes	Quarterly	1	Yes	
3) Medicaid	Yes	No	Quarterly	3	Yes	
4) WIC	Yes	Yes	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Less Often than Annually	18	No	
8) PRAMS or PRAMS-like	Yes	Yes	Less Often than Annually	18	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) BRFSS	Yes	Yes	Less Often than Annually	12	No	
10) YRBSS	Yes	Yes	Less Often than Annually	24	No	
11) NSCH	Yes	Yes	Less Often than Annually	21	No	
12) EPIC	Yes	Yes	Daily	0	No	
13) HHLPSS	Yes	Yes	Daily	0	Yes	
14) Catalyst	Yes	Yes	Daily	0	No	

Form Notes for Form 12:

Added four optional data sources

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) HHLPSS**
	Field Note: this is the state's Lead Poisoning Prevention database
Data Source Name:	**14) Catalyst**
	Field Note: this is the database for the breast and cervical cancer prevention program