



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

**State Narrative for  
Missouri**

**Application for 2009  
Annual Report for 2007**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.  
***An attachment is included in this section.***

### **B. Face Sheet**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. Assurances and Certifications**

By signing the Application Face Sheet (Standard Form 424) the Director of the Division of Administration of the Department of Health and Senior Services (DHSS) assures compliance with certifications and assurances for non-construction programs, debarment and suspension, drug-free workplace, lobbying, Program Fraud Civil Remedies Act (PFCRA), and environmental tobacco smoke. The SF424 is submitted electronically through the HRSA EHB/TVIS Web-based system. A copy of the signed SF424 and certifications and assurances may be obtained from Division of Community and Public Health, MO DHSS, P.O. Box 570, 930 Wildwood Drive, Jefferson City, MO 65102-0570.

No Maternal and Child Health (MCH) population groups targeted to receive MCH Block Grant supported services are denied services based upon their ability to pay. DHSS's policy is firmly committed to compliance and enforcement of all federal and state regulations that forbid discrimination in delivery of services to clients and patients served by the DHSS programs. (EEO/AA, Nondiscrimination; Executive Order 11246; Governor's Executive Order 94-03)

The DHSS professional and special services agreement with providers of services to MCH populations states the provider shall not require or request payment for authorized services from clients covered by this agreement. (MO DHSS Participation Agreement for Professional and Special Services Provider, MO 580-1302 (04-06))

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***The updated MO DHSS Participation Agreement for Professional and Special Services Provider, is now MO 580-1302 (10-06).***

*//2009//*

The Single Audit (Single Audit Act of 1996) may be located at the Federal Audit Clearinghouse (<http://harvester.census.gov/sac/>). The MO State Auditor's audit to meet this requirement may be found at <http://auditor.mo.gov/auditreports/default.htm>.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

### **E. Public Input**

Public input was an essential element in the development of this application. The process for obtaining public comments included placing the Proposed Use of Funds document on the Department's Web site ([www.dhss.mo.gov](http://www.dhss.mo.gov)) and electronic notification of location of Proposed

Use of Funds sent to key stakeholders including Family Partners, DHSS management and all 114 local public health agencies (LPHAs). An article was placed in weekly electronic newsletter "Friday Facts" prepared by Center for Local Public Health Services (CLPHS) (<http://www.dhss.mo.gov/fridayfacts/>).

Responses were received from individuals and maternal and child health stakeholders throughout the state. Injury prevention was the primary concern. These were reviewed and incorporated into the plan where appropriate.

In addition to the 11 responses received, the DHSS Web site with the Proposed Use of Funds had a total of 107 hits, internally and externally.

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***The process for obtaining public comments and processing inquiries continued as in previous years.***

***Ads were placed in the St. Louis, Kansas City, Springfield, Columbia, and Cape Girardeau newspapers to notify public of the document on the Web and contact to request hard copies. The DHSS Web site with the Proposed Use of Funds had a total of 206 hits, 45 internally (includes LPHAs) and externally (161).***

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## II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

### C. Needs Assessment Summary

Since 2005 when state general revenue reached fiscal bottom for MCH services, DHSS/Division of Community and Public Health (DCPH) supported its MCH programs within budgetary plateau. However, DHSS's Office of Epidemiology issued State of Missouri's Health Report identifying 10 key population health indicators for comparison of Missouri's overall health status with the nation. Some mirrored priority health need areas identified in 2005 MCH need assessment. Among indicators where Missouri fared worse than the nation were these indicators of growing concern to Missouri Title V agency:

- Infant Mortality (disparities in birth outcomes)
- Obesity
- Smoking (tobacco use)

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Lack of access to primary care delivery networks (overriding MCH priority need identified in 2005) for large segments of MCH population in Missouri continues in 2007 with absence of pediatric dentists in rural areas of critical concern.

DCPH efforts to raise public awareness of disparities in birth outcomes has during last 12 months included:

- Outreach campaign promoting subjects of Safe Sleep and Folic Acid in St. Louis Area.
- State Infant Mortality Collaborative Conference including MCH coalitions, Healthy Start Agencies, DCPH Home Visiting Programs and Office of Minority Health. Participants were provided with orientation to Pregnancy Risk Assessment Monitoring System, overview of infant mortality surveillance and trends and introduction to "Infant Mortality ToolKit."
- Incorporation of selected results from Focus Groups on Infant Care (conducted by University of Missouri - Columbia [UMC] in 2005) into practice of home visiting, breastfeeding and folic acid initiatives supported by DHSS.
- In depth article on Efforts to Reduce Infant Mortality in Missouri was accepted by AMCHP and presented at March 2007 AMCHP conference.

"Burden reports" for Tobacco Use in Missouri: The Human and Economic Toll and for Preventing Obesity and Other Chronic Disease were distributed statewide by DHSS.

Major health reforms also known as Missouri HealthNet were initiated in Missouri in 2007 through enactment of Senate Bill 577 with key features hoped to increase access to essential health services for MCH populations:

- Incentives to doctors and patients to reduce overall costs
- Participant choice among 3 "health improvement plans"
- Availability of "Health Care Advocates"
- Focus on preventive care over more costly emergency care
- Transparency
- Consumer choice

--Health Care Technology Fund  
//2008//

*/2009/*

**Missouri Title V agency recognizes large segments of MCH population still lack access to primary care delivery networks (overriding MCH priority need identified in 2005) with absence of pediatric dentists in rural areas of critical concern. University of Missouri-Kansas City (UMKC) Institute for Human Development recently completed surveys and related analysis of primary care recruitment and retention activities. Data and findings generated reinforce impression there is no central statewide institutional momentum driving recruitment and retention of primary care practitioners. Summarized recommendations from UMKC study:**

**-Greater recruitment of future students from rural areas**

**-Rotation of primary medical school residents in rural areas**

**-Increase reimbursement for health care providers and facilities in rural areas**

**-Provide more scholarships and loan repayment for health care professional students who will serve underserved areas**

**-Greater state advocacy for continuation of J-1 Visa Program that targets rural areas**

**-Greater state advocacy for changing admissions criteria and requirements for entry into schools of health care professions**

**May 2008, OMH in collaborative agreement with MFH released STATE OF MISSOURI HEALTH DISPARITIES REPORT: PROMOTING HEALTH EQUITY & REDUCING HEALTH DISPARITIES IN MISSOURI; disparities were found in (see this section's attachment):**

**--INFANT MORTALITY RATES**

**--LOW BIRTH WEIGHT INFANTS BORN**

**--ASSAULTS AND HOMICIDES**

**--DIABETES**

**--OBESITY**

**--OVERWEIGHT MOTHERS**

**--ASTHMA**

**In conjunction with this, OMH sponsored focus groups on interests of American Indian, Hispanic, Bosnian, Vietnamese, African and African American minority groups in Missouri. Results revealed perceived barriers to health care access, unaffordable health care, lower levels of quality care (often linked to cultural competency) and increase risk/exposure to serious health conditions among minority groups represented (childhood obesity, HIV/AIDS; cardiac or heart disease; diabetes; stroke; physical inactivity, etc.). See this section's attachment.**

**Report concluded with series of standards issued as guidelines health care organizations can follow to lessen occurrence of health disparities in Missouri.**

**DHSS Director met in March 2008 with Missouri federal legislators at Association of State and Territorial Health Organizations (ASTHO) meeting. Senators and congressional representatives were provided "snapshot" of State of Missourians' Health which profiled 5 key health indicators impacting overall health status of Missourians. Profiles were developed for each Missouri congressional district:**

- Tobacco Use in Missouri\***
- Obesity in Missouri\***
- Infant Mortality Disparities in Missouri\***
- Heart Disease in Missouri**
- Diabetes in Missouri**

**Three of the key indicators reflect current Title V MCH priority need areas; condition of diabetes is emerging as MCH priority need area in 2010 Title V needs assessment. Congressional district health profiles presented as part of "ASTHO Snapshot" will be updated for 2010 MCH Five Year Needs Assessment.**

**Missouri provided data in 2007 to AMCHP for A Report of the AMCHP/CDC State Infant Mortality Collaborative: Investigating Troubling Trends with Missouri's recent infant mortality experience summarized:**

**"Missouri's Infant Mortality Rate (IMR) has been persistently higher than the national rate though slightly declining or stagnant through the 1990s. In 2002 it jumped 15 percent to 8.5; up from 7.4 the previous year. African American infants have consistently fared worse than other resident infants. In 2002, for example, the African American IMR was 17.1, roughly double the state IMR and more than double the state IMR and more than double the rate for white infants."**

**Missouri is working with its HRSA (MCHB) contacts to identify qualified consultants to provide technical assistance on how to reposition Title V resources and other resources to better combat infant mortality disparities. Missouri intends to take full advantage of HRSA Title V technical assistance for this purpose.**

**Updated matrix included with 2005 Needs Assessment is attached.**

**//2009//**

**An attachment is included in this section.**

### III. State Overview

#### A. Overview

##### A.1. DEMOGRAPHIC PROFILE

Selected demographic information from U.S. Census Bureau for Missouri can be located under Section II, Needs Assessment under B. Five Year Needs Assessment, 3.1. MCH Demographic Overview. It compares Missouri's population with the United States in regard to age, race/ethnic distribution and educational attainment. Also 3.2. Benchmark Analysis compares maternal and child health related indicators among states similar to Missouri.

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For the entire 2005 Needs Assessment, go to:

<https://perfddata.hrsa.gov/mchb/mchreports/documents/NeedsAssessments/2006/MO-NeedsAssessment.pdff>.

Section II of this 2007 application/2005 report has an attachment with an update to the matrix of the comparison of the performance measures, health systems capacity indicators and state priorities that was included in the Needs Assessment.

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Based upon "Growth in the Heartland: Challenges and Opportunities for Missouri" by the Center on Urban and Metropolitan Policy at the Brookings Institution report copyrighted 2002, Missouri grew in the 1990s but significant growth has stalled since 2000. The state's population decentralized with the population and job gains moving beyond metropolitan areas. With the decentralization came the increase in the capital and operation costs for roads, sewer and water infrastructure, schools and police and fire services; a serious water quality problem in the Ozark lakes due to septic seepage; damage to Ozark lakes and landscapes which threaten a \$1.6 billion tourist industry; high-capacity roads in need of building and maintenance; and isolation of low income and minority Missourians from opportunity as middle-class residents and employment move out to suburban/rural areas.

"Growth in the Heartland" concluded that while Missouri had enjoyed enviable growth in the nineties and many new residential communities had sprouted up during that decade, a slowing economy in the new century raises many questions concerning how best to support the needs of communities that are increasingly dispersed geographically. Missouri's metropolitan areas are all experiencing the "open country" shift of their core populations shrinking as growing numbers of residents leave the central city and even older suburban areas for newer residential developments away from urban congestion.

/2009/

***Previous demographic trends in Missouri have continued and accelerated in the early part of this century. Missouri's metropolitan areas are all experiencing the "open country" shift of their core populations shrinking as growing numbers of residents leave the central city and older suburban areas for new residential developments away from urban congestion. With this demographic shift, job gains for Missouri have also move beyond Missouri's older metropolitan areas. The current population of Missouri is 85.4 percent white and 11.5 percent African American. Nationally, the population is 80.4 percent white and 12.8 percent African American. People of Hispanic origin make up 2.6 percent of Missouri's population. Between 1996 and 2006, Missouri's population grew by 7.6%. Of all racial and ethnic groups, Hispanics had the fastest growth rate at 94.4%. During this period of time the Hispanic population more than doubled in 56 of the counties in Missouri.***

***The Office of Management and Budget (OMB) is now following a new classification system for defining metropolitan population centers versus "non core areas in any given state.***

***Under this new system, a category of "micropolitan" area has emerged. Such areas are considered to be growing population centers of 10,000 to 49,999 and surrounding counties that are linked through commuting ties. These micropolitan counties are becoming "rural trade centers and are increasingly important to the overall economic vitality of non-urban Missouri. " Studies conducted by the Institute for Public Policy have also concluded "the cost of living in many non core areas may not be as high as the more urbanized metropolitan counties." From 2000 to 2005, the population growth that Missouri experienced in the 1990s has slowed considerably. During this time period, Missouri lost population in 37 counties with many of those counties being in the Northern rural sections of the state. Only eight Missouri counties had population gains of 10 percent or more during this time period, 7 metro and 1 micropolitan county. The largest population gains during this time period were in the Springfield area and the St. Louis area. In 2005, there were 18 Missouri counties where persons 65 and older accounted for 20 percent or more of the total population. "These 18 counties (all non-metro) may be aging due to out migration of younger populations, likely in the northern part of the state, or due to the in-migration of older, retirement aged populations, likely in areas surrounding the Lake of the Ozarks and Branson.***

***A more focused analysis of demographic trends and shifts within MCH population groups is now underway; the results of which will be reported in the 2010 Five Year MCH Needs Analysis.***  
***//2009//***

Missouri is the 17th largest state in the nation based on the 2000 Census. In the year 2000, Missouri's population was 5,595,211; by 2003, the total population of Missouri was 5,704,484. Of the total Missouri population in 2000, it was estimated that 84.9% of persons living in Missouri were white; 11.2% were African American and 3.9% were of other racial groups. It was estimated that in 2003 there were 130,928 Hispanics living in Missouri, an increase of 9.3% over 2000 census numbers; the total percentage of whites living in Missouri increased slightly by 1.2% during this time period; and the percentage of African-Americans within the total population had increased by 3.6% from the 2000 census. In 2000, the percentage of the population who were Asian/Pacific Islander increased 55.1% since 1990 from 41,758 to 64,773 in 2000. By 2000, American Indian/Alaskan Native population grew 24% from 1990 to just under 5.6 million in 2000.

***//2007/*** All population estimates are from DHSS Population Missouri Information for Community Assessment (MICA) (<http://www.dhss.mo.gov/PopulationMICA/>). In the year 2004, Missouri's total population was 5,754,618. Of the Missouri population in 2004, it was estimated that 86.1% of persons living in Missouri were white, 11.8% were African-American and 2.0% were of other racial groups. In 2004 there were an estimated 148,201 Hispanics living in Missouri (2.6% of all Missouri residents), an increase of 25.0% over 2000 numbers. The number of whites living in Missouri increased by 2.4% during this time period and the number of African-Americans increased by 4.7% from the 2000 Census. The number of Asian/Pacific Islanders in Missouri grew by 16.5% from 72,798 in 2000 to 84,820 in 2004. By 2004, the American Indian/Alaskan Native population stood at 32,296, a growth of 1.9% from 31,697 in 2000.  
***//2007//***

***//2008/***  
All population estimates are from DHSS Population MICA (<http://www.dhss.mo.gov/PopulationMICA/>). Missouri's population estimate for 2005 was 5,800,310. Of the Missouri population in 2005, it was estimated that 86.1% of persons living in Missouri were white, 11.9% were African-American and 2.0% were of other racial groups. In 2005 there were an estimated 155,519 Hispanics living in Missouri (2.7% of all Missouri residents), an increase of 31.1% over 2000 numbers. The number of whites living in Missouri increased by 3.1% during this time period and the number of African-Americans increased by 5.9% from the 2000 Census. The number of Asian/Pacific Islanders in Missouri grew by 21.5% from 72,301 in 2000 to 87,856 in 2005. By 2005, the American Indian/Alaskan Native population stood at 30,639, a

decline of 2.7% from 31,480 in 2000.  
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**All population estimates are from DHSS Population MICA and the CDC (<http://www.dhss.mo.gov/PopulationMICA/> and <http://www.cdc.gov/nchs/about/major/dvs/popbridge/datadoc.htm>).**

**Missouri's population estimate for 2006 was 5,842,713. Of the Missouri population in 2006, it was estimated that 85.9% of persons living in Missouri were white, 11.9% were African-American and 2.2% were of other racial groups. In 2006 there were an estimated 164,194 Hispanics living in Missouri (2.8% of all Missouri residents), an increase of 38.5% over 2000 numbers. The number of whites living in Missouri increased by 3.6% during this time period and the number of African-Americans increased by 7.1% from the 2000 Census. The number of Asian/Pacific Islanders in Missouri grew by 32.6% from 71,869 in 2000 to 95,285 in 2006. By 2006, the American Indian/Alaskan Native population stood at 33,362 an increase of 4.7% from 31,876 in 2000.**

//2009//

In Missouri, the population of women of childbearing age in 2000 was 1,206,615. In 2005, that population is estimated to decrease by slightly more than two percent to 1,181,916. Most of this decrease is in the 35-44 year old age cohort. Between 1998 and 2003, the number of live births among whites increased by 1.9% and the number of births among African-Americans for the same period declined by 3.1%. Between 1998 and 2003, the total number of births in Missouri increased from 75,242 to 76,960. During this period of time, the number of births among mothers eligible for Medicaid increased from 28,847 (38.3% of total births) to 33,436 (43.5% of total births).

/2007/

All population estimates are from DHSS Population MICA (<http://www.dhss.mo.gov/PopulationMICA/>). In Missouri, the population of women of childbearing age (ages 15-44) had increased by only 0.3% to 1,209,678. During the 2000-2004 period, the 15-24 age cohort increased by 5.5% while the 25-44 age cohort decreased by 2.2%. Between 2000 and 2004, the number of live births among whites increased by 1.5% and the number of live births among African-Americans for the same period declined by 1.5%. Between 2000 and 2004 the total number of live births in Missouri increased from 76,329 to 77,709. During this period of time, the number of births among mothers eligible for Medicaid increased from 30,029 (39.3% of total births) to 35,424 (45.6% of total births).

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In Missouri, the population of women of childbearing age (15-44 years) in 2000 was 1,206,448. This population grew by slightly over 0.3% to 1,210,334 in 2005. An increase of 4.1% in the 15-34 age cohort during this period was offset by a decline of 6.1% in the 35-44 year old age cohort of this population. Between 2000 and 2005, the number of live births among whites increased by 2.3% to 64,136 and the number of births among African-Americans for the same period increased by 0.2% to 11,455. Between 2000 and 2005, the total number of births in Missouri increased 2.9% from 76,329 to 78,547. During this period of time, the number of births among mothers eligible for Medicaid increased from 30,029 (39.3% of total births) to 36,775 (46.8% of total births).

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**In Missouri, the population of women of childbearing age (15-44 years) in 2000 was 1,206,448. This population grew by 0.7% to 1,197,935 in 2006. An increase of 3.8% in the 15-34 year age cohort during this period was offset by a decline of 8.3% in the 35-44 year**

**old age cohort of this population. Between 2000 and 2005, the number of live births among whites increased by 5.3% to 65,987 and the number of births among African-Americans for the same period increased by 8.0% to 12,347. Between 2000 and 2006, the total number of births in Missouri increased 6.6% from 76,329 to 81,353. During this period of time, the number of births among mothers eligible for Medicaid increased from 30,029 (39.3% of total births) to 37,985 (46.7% of total births).**

**//2009//**

The size of the under age five group shrank from 11% of the state's total population in 1960 to 6.6% in 2000. Population forecasts predict it will shrink to an estimated 6.3% in 2020, to 382,000 children, fully 84,000 less than in 1960. The 5-13 age group also declined dramatically between 1960 and 2000, falling from 17% to 12.8% of the total population. By 2020, this age group will number an estimated 689,000 or 110,000 less than in 1960 due to an aging population and couples having fewer children. The 15-17 age group is somewhat larger than it was in 1960, numbering an estimated 304,000 persons in 2005. This age group is projected to fall to 292,000 persons in 2020.

/2007/

All population estimates are from DHSS Population MICA (<http://www.dhss.mo.gov/PopulationMICA/>). The size of the cohort under 5 years of age shrank from 10.8% of the State's total population in 1960 to 6.5% in 2004. The 5-13 age group also declined dramatically between 1960 and 2004, falling from 17.1% to 12.2% of the total population. Though the 15-17 age group is larger than it was in 1960, numbering an estimated 245,096 in 2004 (29.4% of the total population), compared to 194,153 in 1960 (4.5% of the total population), it is expected to fall to 292,000 persons in 2020.

//2007//

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All population estimates are from DHSS Population MICA and the Census Bureau (<http://www.dhss.mo.gov/PopulationMICA/>, <http://www.census.gov/hhes/www/poverty/poverty.html> and <http://www.census.gov/hhes/www/hlthins/hlthins.html>). The size of the cohort under 5 years of age decreased from 10.8% of the State's total population in 1960 to 6.7% in 2005, and is projected to fall to less than 6.5% of the total population by 2020. The 5-13 age group also declined dramatically between 1960 and 2005, falling from 17.1% to 12.1% of the total population, and is projected to decline further to 11.9% of the population. Though the 15-17 age group is larger than it was in 1960, numbering an estimated 250,062 in 2005 (4.3% of the total population), compared to 194,153 in 1960 (4.5% of the total population), it is expected to fall to 241,608 persons in 2020 (3.9% of the total population).

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**All population estimates are from DHSS Population MICA and the Census Bureau (<http://www.dhss.mo.gov/PopulationMICA/>, <http://www.census.gov/hhes/www/poverty/poverty.html> and <http://www.census.gov/hhes/www/hlthins/hlthins.html>).**

**The size of the cohort under 5 years of age decreased from 10.8% of the State's total population in 1960 to 6.6% in 2006, and is projected to fall to less than 6.5% of the total population by 2020. The 5-13 age group also declined dramatically between 1960 and 2006, falling from 17.1% to 12.0% of the total population, and is projected to decline further to 11.9% of the population. Though the 15-17 age group is larger than it was in 1960, numbering an estimated 255,175 in 2006 (4.4% of the total population), compared to 194,153 in 1960 (4.5% of the total population), it is expected to fall to 241,608 persons in 2020 (3.9% of the total population).**

**//2009//**

In 2002, the percentage of population below poverty level was 9.9%. In 2002, the percentage of school-age children below poverty level was 15.3%.

/2008/

In 2005, the percentage of population below poverty level was estimated to be 11.6% ( $\pm 2.0\%$ ). In 2005, the percentage of children under 18 years of age below poverty level was 17.7% ( $\pm 4.3\%$ ).

//2008//

/2009/

**In 2006, the percentage of population below poverty level was estimated to be 12.3% ( $\pm 2.0\%$ ). In 2006, the percentage of children under 18 years of age below poverty level was 16.9% ( $\pm 5.0\%$ ).**

//2009//

In 2000, the percent of children under 18 in Missouri that had limited English language proficiency was approximately 0.6% of the total population under age 18. Geographically, children with limited English language proficiency are situated along the I-70 corridor, around Kansas City and St. Louis and in extreme Southwest Missouri.

## A.2. CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Missouri participated in the first National Survey of Children with Special Health Care Needs that was conducted as a module of SLAITS. Based upon this survey, there are an estimated 215,818(15%) children in Missouri that have special health care needs.

Information from SLAITS Summary Tables from the National Survey of Children with Special Health Care Needs, 2001, shows the national average percentage of:

- CSHCN with adequate health insurance coverage was 59.6 while Missouri's was 66.0;
- CSHCN who receive ongoing, comprehensive care within a medical home was 52.6 while Missouri's was 55.7.

In addition, the national percent of CSHCN needing specific health services:

- for prescription medicine was 87.9 while Missouri's was 90.6;
- for Dental Care was 78.2 while Missouri's was 78.8;-for prevention care was 74.4 while Missouri's was 72.0;
- for specialist care was 51.0 while Missouri's was 52.4;
- for eyeglasses/vision care was 35.6 while Missouri's was 37.1; and
- for mental health care was 25.4 while Missouri's was 28.9.

/2009/

**Based on National Survey of Children with Special Health Care Needs (NSCSHCN) 2005-06, there were an estimated 223,070 (16.2%) children in Missouri that have special health care needs. Percentage of CSHCN with health insurance coverage at time of survey was 96.9% in Missouri, similar to the national figure of 96.5%. Among those currently insured, percentage with adequate health insurance coverage was 69% in Missouri, compared with 66.9% nationwide. Percentage of CSHCN who received coordinated, ongoing, comprehensive care within a medical home was 51.8%, slightly higher than nationwide (47.1%).**

**In addition, national percent of CSHCN needing specific health services:**

- for prescription medicine was 86.4 while Missouri's was 87.6;**
- for routine preventive care was 77.9 while Missouri's was 75.8;**
- for preventive dental care was 81.1 while Missouri's was 80.6;**
- for specialist care was 51.8 while Missouri's was 51;**
- for eyeglasses/vision care was 33.3 while Missouri's was 33.2; and**

**-for mental health care was 25 while Missouri's was 25.9.**  
**//2009//**

Like CSHCN services most commonly reported in other states as NEEDED but NOT received, Missouri reported dental care, mental health care and specialist care as needed but not received. The charts and tables with these details are available in 3.3.3. Children with Special Health Care Needs of the Needs Assessment along with more charts and tables.

### A.3. MIGRATION PATTERNS

An assessment of Missouri's migration patterns by CHIME revealed the following findings (see maps in 3.1.4. Migration Patterns of the Needs Assessment):

"Missouri's population increased by 478,138 persons (9.3%) during the 1990-2000 decade .....More than double the growth of the 1980's (200,307). This was the largest increase, both in terms of actual persons and percentage growth, in the past 70 years. However, Missouri was below the national population increase of 13.2% and ranked 30th among all states in terms of percentage increase. Of particular note, was the dramatic change in migration during the 1990-2000 time period. The net migration increase of 258,458 persons was far greater than anything Missouri had experienced in the recent past. Missouri had been at the break-even level of suffered net-migration losses of greater than 100,000 persons every decade going back to the 1930s. The large changes in migration during the decade of the 1990s fueled the doubling of Missouri's population growth rate. As geographical shifts in Missouri's population were analyzed for this assessment, it is clear that the composition of Missouri's population is increasingly more diverse. Minorities drove much of Missouri's population growth in the nineties and early part of the new century. 'Between 1990 and 2000, the proportion of Hispanics and other persons of color in this state grew from 13.1 percent to 16.2 percent to reach a total of 908,737 Missourians.' Missouri's minority residents now account for fully half of this state's population growth over the last decade. The Hispanic population in Missouri nearly doubled during the last decade, as that minority population grew from 61,702 residents in 1990 to 118,592 in 2000. In summary, Missouri's population (including all MCH population groups) increased by relatively large amounts during the past ten years with the rate of growth slowing during the economic recession beginning in 2000. In absolute terms, Missouri had the highest population increase of the past 50 years. In terms of percentage growth, Missouri migration matched the high water marks of the 1950s and 1960s. The difference between the 1950s era growth was that for the former decade, growth was bolstered by high birth rates; for the latter, it was the result of much higher migration totals. At the county level, Missouri had many fewer counties lose population through migration this decade, compared to the 1980s. However...the Kansas City and St. Louis metropolitan areas, the older central segments (Jackson County, St. Louis County and St. Louis City) all suffered losses in terms of net migration, while many of the suburban counties surrounding them had relatively high in-migration rates..."

### A.4. NEEDS ASSESSMENT METHODOLOGY

The State's overall needs assessment methodology included but was not limited to the following methods:

- Review of Missouri state profiles compiled by Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC) and Association for Maternal and Child Health Programs (AMCHP) to ascertain external perspectives of MCH needs in Missouri
- Qualitative primary data generated through 12 focus groups conducted throughout Missouri divided into two cohorts: client (user) group cohort and provider or agency group cohort
- Review of Community Health Technical Assistance, Resources and Training (CHART) survey of local coalition members, state and county profiles (with selected MCH indicators and related priorities) generated by the Center for Health Information Management and Evaluation (CHIME) and local public health priorities formulated by the Center for Local Public Health Services

(CLPHS)

- MCH population group(s) forecasts developed from demographic data drawn from the U.S. Census and from analysis provided by the Missouri State Demographer's Office
- Composite analysis of selected MCH indicators to compare (county by county) the relative MCH health status of women and children living in different geographical regions in Missouri: infant mortality, unintended pregnancies (teenage pregnancies), tobacco use among mothers during pregnancy, STDs among women of childbearing age, abortions, obesity, percentage of MCH population groups with insurance coverage
- Data provided by the Missouri Department of Social Services (DSS), Missouri Department of Mental Health (DMH), Missouri Primary Care Association (MPCA) and other professional associations concerning the infrastructure capacity (in Missouri) to deliver basic health services to MCH population groups
- Nominal group process used by selected MCH stakeholders to suggest possible MCH priorities for Missouri where stakeholders reviewed a draft version of the assessment presented in this application, reflected upon their own experiences and applied the following criteria in delineating MCH priority need areas for Missouri:
  - Criterion 1--Degree to which need can be impacted by known effective interventions
  - Criterion 2--Degree of health-related consequence(s) of not addressing need
  - Criterion 3--Degree of state and national support other than Title V for impacting need
  - Criterion 4--Degree of current demographic disparity regarding need (e.g. race, gender, income, place of residence)
  - Criterion 5--Degree to which other local providers or service consumers identify need as a high MCH priority

The accumulated information and analysis identified the following emerging issues:

- Adequacy of Primary Care
- Reduction of Obesity
- Domestic Abuse (Violence Against Women)
- Use/Abuse of Tobacco Among Youth
- Mental Health Services for MCH Populations
- Early Childhood Development and Education
- Cigarette Smoking (Tobacco Use) Among Pregnant Women
- Adequate Dental Health Network Capacity

#### A.5. MISSOURI MCH PRIORITIES

The priorities for the MCH populations identified by the 2005 Needs Assessment are listed below according to levels of service.

##### A.5.1. MCH Infrastructure

Support Adequate Early Childhood Development and Education in Missouri-Collaborate to coordinate efforts through a leadership role in an interagency coalition for the purpose of better targeting existing resources for early childhood development and education, identifying gaps in service delivery and infrastructure and pursuing necessary resources to address these identified areas.

Improve the Mental Health Status of MCH Populations in Missouri-Collaborate with state and local partners to transition our state mental health service delivery system to a public health model through a variety of avenues, including our leadership role in a multi-agency Comprehensive Children's Mental Health System planning and implementation process; technical assistance to school communities implementing CDC's School Health Index and transition to use of Coordinated School Health model; and a focus on the prevention aspect of mental health and substance abuse issues, particularly in relation to pregnant women, children and adolescents.

Enhance Environmental Supports and Policy Planning/Development for the Prevention of Chronic Disease-Provide technical assistance and support to local, state and regional initiatives to

develop or enhance environmental supports and/or policies aimed at addressing the three primary risk factors for the development of chronic disease: nutrition, physical activity and tobacco use/secondhand smoke. Emphasis will be placed upon environmental supports and policies that focus upon the development of positive lifestyle choices and habits and decrease chronic disease for the next generations.

#### A.5.2. POPULATION-BASED MCH SERVICES

The thrust of the DHSS new strategic plan is to shift the department's operational focus toward prevention and wellness while supporting programs and initiatives that strive to prevent the worsening of conditions. Every priority identified by the five-year Needs Assessment will be viewed from the prevention prospective. Interventions to address the priorities will take into consideration the need to address prevention at the same time.

**Reduce Interpersonal/Domestic Violence Among MCH Populations-**Continue to advocate for primary prevention to reduce interpersonal violence, as well as provide technical assistance and resources to local and regional partners to implement primary prevention planning in their respective areas using evidence-based approaches.

**Prevent and Reduce Smoking Among Adolescents and Women-**Collaborate with statewide partners to reduce the number of women who smoke during pregnancy using evidence-based practice.

**Reduce Obesity Among Children, Adolescents and Women-**Collaborate with statewide partners to achieve healthy weight among an increased percentage of children and adolescents through increased physical activity and healthy eating habits.

**Reduce Disparities in Birth Outcomes-**Collaborate with state and national partners to examine the intransigent causes and correlations to poor birth outcomes to allow focused interventions and initiatives. Implement and evaluate these resultant interventions and initiatives to decrease racial/ethnic, geographical and socioeconomic disparities related to low birth weight, prematurity, prenatal care received and infant mortality.

**Reduce Intentional and Unintentional Injuries among Infants, Children and Adolescents in Missouri-**Collaborate with statewide partners to implement environmental supports and local, regional and state policies to positively impact motor vehicle accidents/deaths among adolescents; suicide attempts/completions among adolescents; and intentional/unintentional injuries among infants and children.

#### A.5.3. DIRECT/ENABLING MCH SERVICES

**Improve Access to Care-**Provide technical assistance and resources in collaboration with other statewide partners to assure adequacy and cultural competency of provider networks which support reproductive health, primary health, oral health and mental health/substance abuse services for women, infants/children, adolescents and special health care need populations, with an emphasis on medical/oral health home.

**Reduce and Prevent Oral Health Conditions Among MCH Populations in Missouri-**Collaborate with statewide partners to identify and address gaps in oral health service delivery system; conduct oral health surveillance to inform the oral health systems enhancement initiatives; support the training and placement of oral health professionals in underserved areas to better meet the oral health needs of MCH populations in Missouri; encourage the integration of oral health preventive services into primary care and school health settings.

## **B. Agency Capacity**

### **B.1. STATE STATUTES**

March 29, 1883, Missouri Legislature established state agency responsible for promotion of health and prevention of disease by creating State Board of Health. Missouri Crippled Children's Service (CCS) became part of Division of Health in 1974. Department of Health (DOH) was created 1985 to supervise and manage all public health functions and programs formerly administered by DOH. Executive Order 01-02 in 2001 transferred Division of Aging to DOH and formed Department of Health and Senior Services (DHSS) allowing one department to focus on prevention and quality of life.

Missouri statutes related to MCH and CSHCN authority are primarily in Chapter 191-Health and Welfare and Chapter 201-Crippled Children of Missouri Revised Statutes (RSMo).

Funding appropriated in 2004 allowed dental hygienists to bill Medicaid/SCHIP for services rendered under expanded scope of practice per RSMo 332.311 allowing duly registered and currently licensed dental hygienist with at least 3 years of experience, practicing in public health setting, to provide Medicaid eligible children: fluoride treatments, teeth cleaning, sealants without supervision of a dentist.

RSMo Section 630 incorporates Senate Bill 1003 (Child Mental Health Reform Act) to create Comprehensive Children's Mental Health Service System to serve children with emotional and behavioral disturbance problems, developmental disabilities and substance abuse problems. By August 28, 2007, and periodically thereafter, Children's Services Commission shall conduct evaluations of implementation, effectiveness of the system, family satisfaction and progress of achieving outcomes.

/2008/

House Bill 579 in 2007 transferred State Emergency Management Agency from Office of the Adjutant General to Department of Public Safety for deployment of any health care professional licensed, registered or certified in Missouri or any other state and volunteers during emergency declared by Governor. Bill grants volunteers immunity from civil damages for their services. DHSS is allowed to recruit, train and accept services of citizen volunteers to dispense medication in public health emergency.

//2008//

/2009/

***In 2007 Missouri Statute 191.317 was amended to approve provision for releasing results of newborn screening tests to child's health care professional. Before, family permission had to be given.***

***RSMO 191.331 was amended to expand financial eligibility guidelines for children through age 18 to receive metabolic formula. Any child under age 5 is financially eligible and those children from age 6 through 18 are eligible at 300% of federal poverty level (FPL). DHSS rules to implement this statutory provision provide sliding scale for family incomes exceeding 300% of FPL so no family pays more than 50% of cost of formula. Provision provides DHSS authority to use, retain and dispose of biological specimens in conjunction with newborn screening tests and public health research.***

//2009//

### **B.2. CAPACITY AND COLLABORATION**

/2007/

August 2005 DHSS made organizational changes for better utilization of resources, viability of services and position to respond to Missouri State Government Review Commission recommendations.

DCPH was created to raise visibility of public health and be more conducive to planning and implementing public health programs and services with common goals.

DCPH is Missouri Title V agency and takes lead responsibility and collaborates with other state agencies, local communities and private organizations in developing, implementing and supporting policies and services to ensure statewide system to provide for pregnant women, mothers, infants, children and CSHCN.

Offices and programs located in DHSS collaborating with other agencies and entities follow. See [www.dhss.mo.gov/AboutDHSS/Directory\\_of\\_Services.pdf](http://www.dhss.mo.gov/AboutDHSS/Directory_of_Services.pdf).

B.2.1. DHSS DEPARTMENT DIRECTOR'S OFFICE is responsible for management its programs and services with assistance of departmental deputy director. Divisions reporting to Director include Information Technology Services Division, Departmental Support Services, Division of Senior and Disability Services, Division of Regulation and Licensure, DCPH, Boards of Senior Services and Health.

B.2.2. INFORMATION TECHNOLOGY SERVICES DIVISION (ITSD) of the State Office of Administration maintains and enhances an integrated Oracle database that houses client and provider data for MCH applications in DHSS. An interface with DSS provides access to Medicaid eligibility information for DHSS clients. Provider payments are made via interface with Missouri's state accounting system.

B.2.3. DIVISION OF REGULATION AND LICENSURE (DRL), Section for Health Standards and Licensure (HSL), supervises health care and child care licensure activities, state emergency medical services (EMS), registration of Missouri handlers of controlled substances and inspection activities for many Medicare certification programs.

Bureau of Child Care (BCC) is responsible for licensing of family and group child care homes and child daycare centers, staff qualifications and quality initiatives (inclusion services, Nurse Consultation, etc.).

Title V Block Grant funds enhance Child Care Resource and Referral (CCR&R) services for families and CSHCN to provide services including referrals of families to child care programs. Referral Specialists collect data (immunizations, diseases, birth defects, developmental issues and insurance status, etc.).

/2008/

BCC was elevated to Section for Child Care Regulation (SCCR) within DRL.

//2008//

/2009/

**Child Care Health Consultation (CCHC) program moved from SCCR to CLPHS in Center for Health Policy Integration (CHPI) of DCPH in August 2007.**

**CCHC is collaborative project of DHSS and local health agencies. It is partially funded by MCH Title V (2007 7.36%; 2008 11.48%, CCHC). Among other duties, CCHC assists families and child care providers in accessing needed health and social service programs to: decrease risk of injury, disease and abuse of children; provide education and consultation for families of children enrolled in child care facility. Consultation, group training and health promotion addressed asthma, CSHCN, nutrition and physical exercise/fitness, health care access, injury prevention and safety, diabetes, second-hand smoke, chronic disease, dental health, mental health, SIDS and ADHD.**

//2009//

B.2.4. DCPH administers programs addressing chronic disease prevention and nutrition services, healthy families and youth, community protection and provides public health practice and administrative support.

*/2009/*

**Centers and offices reporting directly to DCPH are:**

- Center for Emergency Response and Terrorism (CERT)**
- State Public Health Laboratory (SPHL)**
- Office of Performance Management**
- Office of Financial and Budget Services (OFABS)**
- Section for Chronic Disease Prevention and Nutrition Services (CDPNS)**
- Section for Healthy Families and Youth (HFY)**
- Section for Disease Control and Environmental Epidemiology (DCEE)**
- Section of Epidemiology for Public Health Practices (EPHP)**
- Center for Health Policy Integration (CHPI)**

*//2009//*

DHSS changes in July 2007 included:

-CERT joined DCPH as DCPH plays large part in emergency preparedness and response.

-SPHL joined DCPH as it works closely with emergency response staff, Department Situation Room and CERT and many disease control, environmental and genetic aspects in DCPH.

EPHP in September 2007 and CHPI were formed in DCPH.

*/2008/*

B.2.4.1. CERT developed Ready in 3 for easy 3-step way to prepare for emergency; materials including "Planning for Emergencies: Three Steps to be Prepared; A Family Safety Guide":

1. Create plan for you, your family and your business
2. Prepare kit for home, car and work
3. Listen for information about what to do and where to go during actual emergency

B.2.4.2. SPHL serves as support unit to DCPH when performing tests for newborn screening and confirming diagnosis; and works closely with emergency response staff, Department Situation Room and CERT, and many disease control and environmental aspects in DCPH.

B.2.4.3 OFABS, elevated directly under DCPH Director's office, provides leadership and oversight of fiscal management systems; provides fiscal and budgetary expertise for DCPH, ensures process of invoices and contract payments; supports MCH-related contracts and fiscal note preparation; serves as fiscal issues primary contact for DCPH programs and operations; assures fiscal resources contribute to achievement of DCPH's strategic goals.

*//2008//*

B.2.4.4. CDPNS directs statewide programs designed to combat major causes of premature death, illness, disability and medical costs such as heart disease, cancer, stroke, diabetes, asthma and arthritis through: Bureau of Cancer and Chronic Disease Control (CCDC); Bureau of Health Promotion (BHP); Bureau of Community Food and Nutrition Assistance (CFNA) Programs; and Bureau of WIC and Nutrition Services (WICNS).

B.2.4.4.1. CCDC is to reduce impact of chronic disease by promoting screening and early detection of chronic diseases and evidence-based management with focus on arthritis, asthma, heart and stroke, diabetes and cancer.

B.2.4.4.2. BHP oversees programs and initiatives to reduce tobacco use, physical inactivity and unhealthy eating and supports local programs through contracts, training and technical assistance in implementing evidence-based strategies to reduce risk factors.

/2008/

Governor's Council on Physical Fitness and Health strives to promote a healthy Missouri where people are making healthy lifestyle choices. Council oversees Shape Up Missouri/Moving Across America State by State, Show-Me Body Walk and Show-Me State Games, etc.

//2008//

B.2.4.4.3. WICNS's focus is to decrease preventable nutrition-related morbidity and mortality. Programs coordinated by WICNS focus on assuring "nutritionally at-risk" Missourians receive nutritious food supplements through local grocery vendors.

B.2.4.4.4. CFNA is dedicated to enhancing nutritional status of vulnerable Missourians by ensuring nutritious meals and snacks are served and good eating habits are taught to eligible participants (primarily children, pregnant and breastfeeding women not enrolled in Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and disabled adults or those over age 60 who meet income-eligible guidelines).

B.2.4.5. HFY manages Genetics and Healthy Childhood (GHC) and Special Health Care Needs (SHCN). HFY promotes optimal health by providing leadership to public and private sectors in assessing health care needs of families and communities; develops policy, plans systems of care and designs, implements and evaluates programs to meet health care needs of families.

B.2.4.5.1. GHC promotes and protects health and safety of individuals and families based on their unique needs and situations and utilizes multiple programs in GHC to optimize individual's health and environment from pre-pregnancy through adulthood. Programs include Genetic Services, Newborn Blood Spot Screening, Missouri Newborn Hearing Screening (MNHSP), Newborn Health, Breastfeeding, Birth Defects Awareness, Home Visitation, Alternatives to Abortion, Fetal and Infant Mortality Review (FIMR), Pregnancy Associated Mortality Review (PAMR), Adolescent Health, School Health, Injury/Violence Prevention, Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP) and Alcohol, Tobacco and Other Drug Prevention and Awareness (ATODPA).

/2009/

***And Telehealth Medicine; however MOFASRAPP portions expire 9/29/08.***

//2009//

GHC Cultural Competence:

Printed materials purchased in Spanish and, when available, in Vietnamese and Chinese for MOFASRAPP and Missouri Model for Brief Smoking Cessation Training.

MOFASRAPP development included focus groups with racial and ethnic groups of women in 71 targeted counties.

MOFASRAPP flyers and radio advertising depict rural African-American, Hispanic and Caucasian women.

MOFASRAPP utilizes UMC toll-free number for two of its interventions; interpretive services are arranged for callers with limited English proficiency.

/2009/

***MOFASRAPP portion for 3 preceding activities expires 9/29/08.***

//2009//

Missouri Model for Brief Smoking Cessation Training includes cultural counseling suggestions for African-American, American Indian, Asian American and Pacific Islander, Caucasian and

Hispanic female populations.

**/2009/**

**Funding for Missouri Model Training ends 12-31-08.**

**//2009//**

Abstinence and Teen Outreach Program (TOP) contractors are required to report race and age of clients served. Adults and youth delivering programs must represent youth, communities and neighborhoods served.

Council for Adolescent and School Health (CASH) is composed of adolescent and school health experts representing diverse ethnic backgrounds and geographic areas including rural and urban cultures and communities.

Missouri Community-Based Home Visiting (MCBHV) program requires staff "that reflect the ethnic, cultural and social characteristics of the community served". MCBHV in Columbia serves Hispanic population with Hispanic workers who speak English and Spanish.

Building Blocks programs in Kansas City and St. Louis have bilingual home visiting nurses to serve Hispanic population; interpreters go on visits or staff use "Language Line" when clients are of other nationalities.

Home visiting programs' databases collect race and nationality data of all clients served and collaborate with local area programs (Parents as Teachers [PAT], WIC, prenatal case management, HUD, food pantries, etc.) that provide services to high-risk population.

**/2009/**

**Home visiting and domestic violence programs hosted domestic violence seminar July 2007 to educate providers of home visiting and Alternatives to Abortion programs on domestic violence. Program was funded by grant for Healthy and Safe Families through AMCHP and included cultural competency issues dealing with domestic violence victims.**

**GHC hosted Health Literacy workshop in September 2007 for HFY staff and contractors of home visiting and Alternatives to Abortion programs to promote cultural competency and health literacy in choosing educational materials for program promotions.**

**//2009//**

FIMR projects have community members (area physicians, social workers, members of the religious sect, local health departments, etc.) on both Case Review and Community Action Teams.

Newborn Health, Baby Your Baby and Folic Acid initiatives provide educational materials in English and Spanish including 2005 revised Baby Your Baby Keepsake Book.

Missouri Newborn Hearing Screening Program (MNHSP) provides parent informational brochures in English, Spanish, Croatian and Vietnamese. Informational flyers on hearing loss and risk factors for late-onset hearing loss are printed in English and Spanish. Regional Representatives (RRs) utilize Language Link as needed for interpretive services during phone calls to families. RRs have been trained to say, "Please wait while I get a translator," in Spanish. MNHSP program manager participated in cultural competency training for individuals and organizations.

**/2008/**

**MNHSP staff participated in CDC-sponsored teleconference on cultural competency.**

**//2008//**

Missouri Blood Spot Screening Program provides patient information brochures in Spanish,

Bosnian and Vietnamese.

Minority health issues for Genetic Tertiary Centers are foremost concern since genetic diseases often cluster in specific ethnic groups. Availability of foreign language and deaf interpreters, acceptance of Medicaid and Medicare as full payment for services and sensitivity by genetics staff to minority and handicapping health issues promote delivery of genetic services for Missourians who are part of minority groups. During FFY 2006 programs will be aimed toward Hispanic and Mennonite populations.

GHC Programs:

Four genetic tertiary centers (St. Louis Children's Hospital, Cardinal Glennon Hospital for Children, Children's Mercy Hospital and University of Missouri Hospital and Clinics) collaborate with DMH-Division of Mental Retardation and Developmental Disabilities (MR/DD); DSS-Division of Medical Services (DMS) that administers the Medicaid program; DSS-Family Support Division; Department of Elementary and Secondary Education (DESE)-First Steps; DHSS-SHCN and Metabolic Formula Program. Centers also collaborate with national organizations such as Association of Retarded Citizens (Arc) and refer to local parent support groups (fragile X syndrome, Downs Syndrome, etc.).

*/2009/*

***DMS is now MO HealthNet Division (MHD) and is responsible for: administration of services provided in accordance with Title XIX, Public Law 89-97, 1965 amendments to federal Social Security Act, 42 U.S.C. Section 301, and purchase and monitoring health care services for low income and vulnerable citizens.***

***Telehealth Medicine program provides genetic clients in southern Missouri option of being seen in location close to home.***

***Metabolic Formula Program, funded by general revenue, provides assistance to individuals of all ages diagnosed with covered metabolic condition and meet financial eligibility criteria. It works with formula manufacturers, retail pharmacies, MO HealthNet and genetic tertiary centers to assure program participants are covered.***

***Missouri Sickle Cell Anemia Program promotes and provides education, screening, counseling and follow-up services for individuals with sickle cell disease and sickle cell trait.***

*//2009//*

DHSS contracts with 5 resource centers (Children's Mercy Hospital, University of Missouri Hospital, St. Louis Children's Hospital, Barnes Hospital and Truman Medical Center) to ensure availability of comprehensive medical services for individuals and families with sickle cell conditions. Contractors are required to have information and education materials available in variety of culturally competent formats and provide other services, including foreign language translators and interpreters for hearing impaired. DHSS also collaborates with local agencies, provider groups, coalitions and community-based sickle cell organizations that provide supportive services to individuals and families for non-medical needs.

Newborn Blood Spot Screening Program provides early identification and follow-up of PKU, galactosemia, congenital hypothyroidism, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders, fatty acid oxidation disorders and organic acid disorders (cystic fibrosis [CF] and biotinidase to be added early 2007) that suggest presence of disease in affected, but as yet, asymptomatic infants to ensure a repeat newborn screen or confirmatory test has been done. Infants found to be positive are referred to health care system.

*/2008/*

CF will be added in mid 2007; biotinidase in FFY 08.  
//2008//

**/2009/**

**2007 CF was added. Biotinidase deficiency is expected late 2008. When added, Missouri will be screening for all 29 conditions recommended by American College of Medical Genetics and March of Dimes.**

**//2009//**

MNHSP ensures all babies born in Missouri receive hearing screen and appropriate follow-up including audiologic diagnostic testing and referral to Part C services; most are screened prior to hospital discharge.

Folic Acid Program coordinates Missouri Folic Acid Advisory Committee activities to further enhance awareness of folic acid benefits in preventing neural tube defects and other serious birth defects.

**/2009/**

**2008 the Newborn Health program will use funding from March of Dimes, Missouri Chapter, to work with University of Missouri (UM), Sinclair School of Nursing and high schools in central Missouri to educate students in consumer health sciences classes on benefits of taking folic acid. Before, program had been implemented in northwest Missouri by Missouri Western University. DHSS collaborating with UM hopes to replicate the program.**

**//2009//**

Breastfeeding Program promotes and supports breastfeeding to improve health of infants and their mothers and provides technical assistance, training and educational materials to health providers and general public on breastfeeding and nutritional supplementation appropriate for infants.

Home visiting programs provide services to high-risk pregnant women and their infants prenatally through age 2. Registered nurses (RNs) provide health assessments for prenatal and postpartum mothers and their newborns, while RNs and family support workers provide assessment of risk factors associated with child abuse and neglect; education on maternal/infant/child health, nutrition and parenting; parenting and family support; and case management with appropriate referrals. Building Blocks of Missouri program has sites in Kansas City, Southeast Missouri, St. Louis and Springfield regions and uses Nurse Family Partnership model developed by Dr. David Olds. MCBHV utilizes Families at Risk model developed by UMC/Sinclair School of Nursing in collaboration with DHSS and serves families in 13 counties through contracts with LPHAs and community-based organizations.

**/2009/**

**Springfield site was discontinued July 2007; it had been funded for 4 years by a Healthy Communities, Healthy School grant that ended.**

**//2009//**

ATODPA targets prevention and/or reduction of incidence of alcohol, tobacco and other drugs in preconceptional and prenatal periods, impacting health of maternal and child populations. It includes educational outreach with UMC in use of Missouri Model for Brief Smoking Cessation Training and CDC-funded grant titled MOFASRAPP, a collaboration of DHSS, UMC, DMH, St. Louis Arc and Missouri Institute of Mental Health.

**/2008/**

ATODPA continues educational outreach with cessation training and CDC-funded MOFASRAPP.

**//2008//**

*/2009/*

***MOFASRAPP grant expires 9/29/08. GHC is requesting no-cost extension to continue surveillance portion of grant. Depending on available funding and interest of UMC, FAS Clinic may also continue until 9/29/09.***

***Missouri Model training is no longer through UMC contract.***

***Through December 2008, five 60-90 minute Missouri Model for Brief Smoking Cessation Training presentations are being offered to health care providers of different disciplines who work with women of reproductive age.***

*//2009//*

Currently implemented in St. Louis and Kansas City, FIMR analyzes infant and fetal death records to develop recommendations for community change to reduce fetal and infant mortality. Communities then determine and implement interventions based upon recommendations received that may improve outcomes for future families.

In PAMR study, weight gain information was gathered on all women studied and BMI determined. Evaluation of PAMR data may lead to better understanding and ability to develop interventions.

Adolescent Health Program collaborates with DHSS programs, state and community partners. CASH advises DHSS in assessing adolescent health needs and planning effective strategies to reduce health risks and promote healthy youth development. It contracts for adolescent medicine consultation and educational programs for health professionals, school personnel, parents, adolescents, state agencies and community organizations. Contracts with LPHAs and Wyman Center support / to implement best practices for healthy youth development.

Federal State Title V, Section 510 funding supports contracts with school, community and faith-based organizations to implement abstinence education and youth development programs for adolescents and parent-child sexuality education programs.

School Health Program began as joint effort of DHSS, DESE and DSS to promote enrollment in Medicaid and increase utilization of Healthy Children and Youth (HCY, Missouri's federal Early and Periodic Screening, Diagnosis and Treatment [EPSDT] program for persons under 21) for preventive health services. Effort is made to assure adequate nurse-to-student ratio. Technical assistance and consultation are available.

Injury and Violence Prevention Programs develop public policy, coordinate interventions, collaborate with other agencies addressing injury causes, support collection and analysis of injury data and contracts with community agencies for violence against women (VAW) prevention interventions linked to State VAW Plan.

*/2009/*

***March 2008 GHC began toll-free 24/7 Alternatives to Abortion Information and Referral Line to provide information on Alternatives to Abortion providers. Line provides immediate translation into Spanish and connection to language line for other languages.***

*//2009//*

B.2.4.5.2. SHCN develops, promotes and supports community-based systems that enable best possible health and highest level of independence for Missourians with special health needs.

SHCN utilizes combination of state and federal funds to provide services for children and adults with disabilities, chronic illnesses and birth defects. Services include assessment, treatment and service coordination. Activities of SHCN are focused around National Performance Measures and 6 Key Systems Outcomes of Division of Services for Children with Special Health Needs

(DSCSHN), MCHB, HRSA, U.S. Department of Health and Human Services (DHHS).

*/2009/*

**SHCN developed Service Coordination Model,  
<http://www.dhss.mo.gov/SHCNpdfs/SCModel.pdf> )**

*//2009//*

SHCN Cultural Competency:

SHCN contracted with UMKC, Institute for Human Development, to provide professional training to increase cultural-competency of SHCN staff and providers. Hispanic families with CSHCN or other disabilities were identified to assist with training. Institute supplied Spanish translation on several SHCN documents. SHCN continues to monitor changing demographics and address translation of SHCN letters and forms utilized by non-English speaking participants/families.

*/2008/*

UMKC contract was fulfilled. SHCN staff participate in events focused to increase knowledge and awareness of cultural diversity.

*//2008//*

*/2009/*

**Service Coordinators and SHCN staff members participate in activities to increase knowledge and awareness of cultural diversity including American Indian Council Symposium, West Central Multicultural Forum, Ozark Regional Alliance, Cross Cultural Interpreter Training and Vietnamese American Health Fair. SHCN monies fund language line services and interpreters for Service Coordinators to communicate with individuals with limited English.**

*//2009//*

SHCN Programs:

Administrative Case Management (ACM) for HCY and Missouri Medicaid Physical Disabilities Waiver/ACM provide home and community-based services to limited number of individuals 21 and older with serious and complex medical needs.

CSHCN-Hope Program (RSMo, CCS) is administered through SHCN to provide early identification and health services from participants' birth to 21.

Service Coordination provides for participants/families to receive services from individuals located within participant's region through Service Coordinators' (SCs) use of:

- Comprehensive Assessment Tools (CATs, standardized means to assist in identification of participant/family needs; services necessary to transition through all aspects of life)
  - Medical Home [MH])
  - Service Plans developed with participants/families
- to achieve best possible health and highest level of independence for SHCN participants.

Transition Plans completed by SCs with participants/families and team members (health care professionals, school personnel, state or community agencies, etc.) address participants' needs.

*/2008/*

CATs include all 6 key system outcomes identified by MCHB/DSCSHN.

*//2008//*

With external entities, SHCN collaborates to:

- increase organization of community-based service systems;
- link with DMS for participants' current Medicaid status;

and/or contracts for:

- assistive technology for eligible CSHCN from birth to 21;
- State Disability Determination Unit (DDU) to refer children applying for SSI to CSHCN program;
- UMKC, Institute for Human Development, to coordinate statewide, multi-agency efforts for HRSA/MCHB grant for Missouri's Early Childhood Comprehensive System (ECCS) Plan;
- participation in local, regional and state disaster response planning activities to represent SHCN participants' needs.

Family Partnership (FP) Initiative is implemented through contract for statewide activities and provides families of individuals with special needs with opportunity to: offer each other support and information; give SHCN input; increase public and community awareness of special needs issues; and promote state legislation for programs for individuals with special needs and their families.

Collaborative efforts with an LPHA in Southwest Missouri and with Reynolds County Health Center are to improve services for special needs children and increase utilization and understanding by engaging and training key stakeholders in MH concept.

/2008/

LPHA MH contracts have been fulfilled. SHCN continues to distribute MH concept materials.

//2008//

SHCN Adult Head Injury Program facilitates Missouri Head Injury Advisory Council (MHIAC) which makes recommendations for improvement of systems to meet needs of those with traumatic brain injury (TBI) and serves in advisory role to Federal TBI Implementation Grant awarded to DHSS.

SHCN continues to recruit additional providers to improve availability of services to participants; utilizes GIS mapping to identify areas of need for participants and providers; places SHCN provider enrollment forms on Internet; maintains provider enrollment information in the Missouri Health Strategic Architecture and Information Cooperative (MOHSAIC) system for access by SCs.

/2009/

**B.2.4.6. EPHP was created to combine State Epidemiologist, Office of Epidemiology (OOE), Office of Community Health Information (CHI), Bureau of Health Informatics (BHI), and Bureau of Vital Records (BVR).**

**EPHP serves as highest scientific authority on issues related to control and prevention of diseases and health risk behaviors. EPHP houses resources necessary to operate and maintain major public health information systems, state vital statistics, state vital records, community health information, major federal block grants, contracts supporting public health surveillance and medical and public health epidemiology resources necessary to prevent, intervene and control infectious disease and other conditions impacting Missourians' health.**

//2009//

B.2.4.6.1. OFFICE OF EPIDEMIOLOGY (OOE) (a merger of OOE with Grants Development to consolidate resources mutually beneficial) provides epidemiologic leadership, consultation and expertise for DHSS divisions and centers, LPHAs, other stakeholders and partners to enhance health and safety of Missouri citizens; guides public health practices through effective use of public health surveillance; plans and evaluates public health programs; provides epidemiologic and medical consultation; conducts epidemiologic teaching and training; plays leadership role in setting state health policy; and provides grant development and management of MCH and Preventive Health and Health Services block grants and State Systems Development Initiative

grant; designs/supports continuous quality improvement teams to improve outcomes and reduce operational costs, evaluations of community health programs, statewide need/capacity assessments, contracts and memorandums of understanding required for major surveillance systems managed by DHSS.

Some projects OOE plays lead role: State Infant Mortality Collaborative; Perinatal Period of Risk Approach (PPOR) analyses; Missouri Pregnancy Risk Assessment (MoPRA), a Pregnancy Risk Assessment Monitoring System (PRAMS)-like survey and application for PRAMS funding; Fetal Alcohol Syndrome surveillance; autism surveillance; surveillance of TBI among children and adolescents and application for research funding; design and implementation of methodology to determine new state priorities; MCH research agenda for Missouri; investigations of perceived clusters of adverse MCH events; and evaluation of several MCH programs.

*/2009/*

***MoPRA evolved into PRAMS. Toddlers survey is being considered.***

*//2009//*

B.2.4.6.2. CHI is responsible for promoting health information for DCPH and TEL-LINK, (800) 835-5465, DHSS toll-free information and referral telephone line for maternal, child and family health services. Staff serves as integral part of preventive health care programs such as smoking cessation, cancer detection, treatment and management of obesity programs, genetics and child nutrition assistance services.

B.2.4.6.3. BHI is responsible for vital statistics system; maintains various health-related databases; performs linkages between program and vital statistics data; provides program evaluations based on applicable program-vital statistics data; provides Internet access to MCH indicators via Community Data Profile pages and MICA system; collaborates with such entities as DMS [now MO HealthNet] regarding MCH indicators for Medicaid managed-care population; provides support for Missouri Child Fatality Review program; produces health indicators from linked birth-PAS data systems; links Statewide Traffic Accident Records Systems (STARS) motor vehicle crash data to hospital inpatient and emergency room data and death certificate data to study medical and cost outcomes of crashes; and provides data support to private organizations such as March of Dimes.

Vital Statistics system follows National Center for Health Statistics (NCHS) guidelines regarding collection and analysis of race and ethnicity data.

BHI has a diverse staff that includes individuals from foreign countries that speak different languages.

B.2.4.6.4. Bureau of Vital Records fulfills DHSS's statutory responsibility to serve as state archives for vital records; and maintains central registry of births, deaths and fetal deaths and Putative Father Registry; maintains reports of marriages and divorces; conducts trainings to ensure accurate and timely filing of vital records; and provides vital records for use in preparation and publication of vital statistics data for national, state and local levels.

*/2009/*

***B.2.4.7. CHPI was established for increased integration, collaboration among DCPH, DHSS and external partners with focus on policy and legislative issues and rules. CHPI has Center for Local Public Health Services (CLPHS), Office of Minority Health (OMH), Office of Primary Care and Rural Health (OPCRH) and Office on Women's Health (OWH).***

*//2009//*

B.2.4.7.1. CLPHS includes MCH Coordinated Systems and adds value to state public health system by supporting population-based approach to health issues in communities and provides leadership and technical assistance to LPHAs to help develop processes to improve community-

based public health systems.

*/2009/*

***CCHC program moved from SCCR to CLPHS in CHPI August 2007.***

***FFY 2007, 112 of 114 counties were provided free services of health consultation, education and health promotion through CCHC program.***

***2,482 child care facilities impacting 74,484 children received services. Health Issues of Obesity Prevention and Asthma Management in the young child were specifically targeted.***

***Structured education was provided to child care providers and parents on related topics. 1,827 completed education on "Healthy Nutritional Environment"; 1,472 on "Healthy Environment around Physical Activity; 1,917 on Asthma Management in Young Children.***

***FFY 2008 has same targeted issues with additional educational components offered for Obesity Prevention and 1:1 consultation offered on development of individual asthma action plans in child care. 112 of 114 Counties in Missouri are receiving these services.***

*//2009//*

MCH Coordinated Systems distributes federal MCH Services Block Grant funds to LPHAs through its MCH services contract to maintain and improve health status of maternal and child populations by establishing and maintaining integrated multi-tiered service coordination system with capability of adapting to address targeted MCH issues. Each contractor has contractual obligation to utilize evidence-based interventions and address identified MCH risk indicators most disparate from state rates.

In FFY 2005 there were 110 LPHA contracts with community specific interventions with over 265 short-term outcomes to reach Healthy People 2010 objectives.

*/2008/*

In FFY 2006 there were 110 LPHA contracts with over 265 short-term outcomes. Under new contracts in 2007, there are 111 contracts with over 150 short term outcomes to reach Healthy People 2010 objectives while addressing Missouri's MCH priorities. New contracts are allowing selection of fewer outcomes for more money to be focused on selected outcomes.

*//2008//*

*/2009/*

***Under new contracts in 2008, there are 112 contracts with 112 systems building outcomes to reach Healthy People 2010 objectives.***

*//2009//*

B.2.4.7.2. OMH addresses cultural competency; develops and reviews DHSS programs that impact health status of minorities.

*/2009/*

***Initiatives address infant mortality in high risk communities and obesity in children and adults.***

***May 2008 OMH through agreement with MFH released STATE OF MISSOURI HEALTH DISPARITIES REPORT: PROMOTING HEALTH EQUITY & REDUCING HEALTH DISPARITIES IN MISSOURI. It revealed substantial inequities among ethnic/racial and other vulnerable Missouri groups. OMH held focus groups with minorities to reveal barriers. Report ended with guidelines issued to health care organizations to lessen health disparities occurrence. See Needs Assessment section attachment.***

*//2009//*

B.2.4.7.3. OWH, supported by Title V, exists to integrate awareness of culturally competent women's health issues and concerns into planning for DHSS programs and services, coordinate existing activities related to health of girls and women and promote broader, more effective collaboration related to women's health issues. Top priority areas:

- Violence against women
- Healthy lifestyles
- Protection of families from violence

B.2.4.7.4. OPCRH works to ensure access to and availability of primary health care services for all populations. OPCRH Oral Health Program (OHP) provides broad range of core public health services, including preventive and restorative dental care, oral health surveillance, oral health promotion and education, public water fluoridation monitoring and support, technical assistance to communities and oral health research. It serves as resource on oral health issues for other state and federal agencies, dental professionals, community organizations and the public. Initiatives include Elks Mobile Dental Program, Oral Health Preventive Services Program, Fluoride Mouthrinse (FMR) Program, Oral Health Surveillance, Public Water Fluoridation Program and Preventive Dental Services Program.

/2008/

Also Missouri Donated Dental Services (DDS), Portable Dental Equipment, and Missouri Coalition for Oral Health.

//2008//

/2009/

***To enhance educational materials available through OHP, PowerPoint presentations were designed specifically for kindergarten-high school seniors and made available free-of-charge on DHSS Web site in 2007. Presentations can be used by School Nurses, teachers or other healthcare/child care professionals in conjunction with their health curriculum.***

//2009//

Dental Advisory Group helps OHP evaluate oral health environment, assists in evaluation of DHSS oral health programming and provides guidance in future public health interventions to decrease oral disease.

OHP employs cadre of Registered Dental Hygienists in communities to aid in development of oral health interventions and act as liaisons with communities, health professionals and schools on oral health issues.

OHP develops new oral health initiatives and update and enhance current program activities in collaboration with dental consultant from UMKC School of Dentistry.

/2009/

***OHP is collaborating with Dental Advisory Group to develop new Oral Health Plan to enhance ongoing activities and additional initiatives to improve oral health. Another initiative planned is to work further with SHCN, MRDD, Elks Mobile Program, LPHAs and Federally Qualified Health Centers (FQHCs) to develop strategies to improve oral health care access for special health care needs population.***

//2009//

## **C. Organizational Structure**

DHSS has streamlined Division of Community Health's (DCH) operations to more effectively serve women, infants, children and adolescents in Missouri. DCH is responsible for maternal, child and family health; nutritional health; chronic disease prevention and health promotion; and

programs for community health improvement. DCH is also responsible for the preparation of Maternal and Child Health (MCH) Services Block Grant annual plan and application. Director of DCH serves as Director of the state's Title V program, as well as Director of the state's CSHCN program.

/2007/

DCH is now the Division of Community and Public Health (DCPH).

//2007//

Section III. State Overview, B. Agency Capacity, contains more detailed information regarding the sections and programs. The DHSS Web page provides access to the Directory of Services with descriptions for all services of DHSS at [http://www.dhss.mo.gov/AboutDHSS/Directory\\_of\\_Services.pdf](http://www.dhss.mo.gov/AboutDHSS/Directory_of_Services.pdf).

Organizational charts for State Executive Departments, DHSS and DCH [DCPH] are located in the attached file to illustrate the hierarchy of the government and the state agencies and are maintained on file.

Other divisions, centers and offices within DHSS which continue to play vital roles in supporting a comprehensive set of services for targeted Title V populations in Missouri are:

- Division of Senior Services and Regulation, Section for Health Standards and Licensure, Bureau of Child Care
- Division of Environmental Health and Communicable Disease Prevention (EHCDP)
- Department/Program Support Services, Center for Health Information Management and Evaluation (CHIME)
- Office of Epidemiology
- Center for Local Public Health Services (CLPHS)
- Office on Women's Health
- Office of Minority Health
- Senior Services
- Division of Administration Services

/2007/

Due to the reorganization, of the above agencies, only Bureau of Child Care of the new Division of Regulation and Licensure and State Office of Administration's Information Technology Services Division (ITSD) (formerly part of CHIME) remain outside of the Division of Community and Public Health.

CHIME databases and information systems are now located within BHI of PHPAS and the State OA ITSD.

//2007//

/2008/

BCC was elevated to a section within DRL and is now Section for Child Care Regulation (SCCR).

//2008//

/2009/

***DCPH administers programs addressing chronic disease prevention and nutrition services, healthy families and youth, community protection and provides public health practice and administrative support.***

***Centers and offices reporting directly to DCPH are:***

- Center for Emergency Response and Terrorism (CERT)***
- State Public Health Laboratory (SPHL)***
- Office of Performance Management***

- Office of Financial and Budget Services (OFABS)
- Section for Chronic Disease Prevention and Nutrition Services (CDPNS)
- Section for Healthy Families and Youth (HFY)
- Section for Disease Control and Environmental Epidemiology (DCEE)
- Section of Epidemiology for Public Health Practices (EPHP)
- Center for Health Policy Integration (CHPI)

**DHSS changes in July 2007 included:**

**-CERT joined DCPH as DCPH plays large part in emergency preparedness and response.**

**-SPHL joined DCPH as it works closely with emergency response staff, Department Situation Room and CERT and many disease control, environmental and genetic aspects in DCPH.**

**EPHP in September 2007 and CHPI were formed in DCPH. BHI is now located in EPHP.**

**//2009//**

**An attachment is included in this section.**

## **D. Other MCH Capacity**

### **D.1. MATERNAL AND CHILD HEALTH FULL TIME EMPLOYEES (FTEs)**

The number and location of DCH staff with related Title V Block Grant MCH responsibilities are listed in the attached document. This listing includes staff who provide planning, evaluation and data analysis capabilities.

The number of full-time employees is 121.71 as of May 31, 2005. In addition, there are 11.75 staff outside of DCH, located in Office on Women's Health, Office of Information Systems, State Center, Office of Epidemiology and the State Public Laboratory who provide support in the policies for women's health, development and maintenance of the databases, statistical reports, etc. and the performance of such tests as the newborn screening tests.

**//2007/**

The number of full-time employees is 131.08 as of May 31, 2006. In addition, there are 7.5 staff outside of DCPH, located in ITSD and the State Public Laboratory who provide support in the development and maintenance of the databases and the performance of such tests as the newborn screening tests.

**//2007//**

**//2008/**

The number of full-time employees is 123.01 as of May 31, 2007. In addition, there are 7.25 staff outside of DCPH, located in Information Technology Services Division and the State Public Laboratory, who provide support in the development and maintenance of the databases and the performance of such tests as the newborn screening tests.

**//2008//**

**//2009/**

**The number of full-time employees is 130.23 as of June 2008, including the staff of the State Public Laboratory which is now located in DCPH. In addition, there are staff outside of DCPH, located in Information Technology Services Division, who provide support in the development and maintenance of the databases.**

**//2009//**

### **D.2. TITLE V SENIOR LEVEL MANAGEMENT POSITIONS**

Also see attachment to the preceding section, III. State Overview, C. Organizational Structure.

Paula Nickelson, MEd., is the Director of DCH (the agency responsible for maternal, child and

family health; nutritional health; chronic disease prevention and health promotion; and community health improvement programs and for the preparation of the MCH Block Grant annual plan and application). Ms. Nickelson serves as the Director of the Missouri Title V program and as the Director of the state's Children with Special Health Care Needs program. Ms. Nickelson has a distinguished career in the human services and management fields. Her experience in mid-Missouri includes roles as the Chief of the former Bureau of Family Health, Director of Clinical Services for the Rusk Rehabilitation Center and Director of Evaluation and Counseling for Advent Enterprises, Inc.

/2007/

Glenda R. Miller, RN, MPH, BC CHNCS, became Director of DCPH in August 2005; she had previously been Director of the former DHSS Division of Maternal, Child and Family Health. Ms. Miller's diverse background includes serving as: Director of Center for Local Public Health Services where she developed and monitored the Core Public Health Functions contract in 114 counties and evaluated effectiveness and efficiency of the public health system; Education/Training/Social Marketing Coordinator for Burrell Behavioral Health where she developed education and training for System of Care Federal Grant, designed a strategic plan for social marketing and coordinated training and social marketing for multiple agencies in six counties; Project Evaluator, Sinclair School of Nursing for University of Missouri-Columbia; Faculty Instructor for Southwest Missouri State University; Faculty/Instructor for Webster University; Director, Disease Management and Health Risk Assessment for Cox Health Plans; Medicaid Special Programs Manager for Cox Freeman Health Management Services; HIV/AIDS Care Service Coordination (Emergency Appointment) for Missouri Department of Health; Assistant District Administrator for Missouri Department of Health for 21 counties in Southwest Missouri; and Community Health Nurse Consultant for Missouri Department of Health.

//2007//

/2009/

***Due to the additional responsibilities Glenda Miller has accepted including the addition of State Public Health Laboratory to DCPH, July 2007 Melinda Sanders assumed the responsibilities of Title V Director.***

//2009//

Robin Rust, MPA, is the Deputy Division Director for DCH. In December 2002, Ms. Rust came to DHSS as Deputy Division Director for the former Division of Maternal, Child and Family Health. She has a distinguished public service career spanning over 22 years of service with DSS. Her experience as Assistant Deputy Director in the Division of Medical Services for policy on fee for service, strong management skills, extensive knowledge of provider and funding systems within the state and established relationships with many of DCH's external partners are invaluable.

/2007/

Susan Jenkins is the Deputy Director for DCPH in DHSS. Prior to her current Deputy Director position, Ms. Jenkins was Deputy Director of the Division of Environmental Health and Communicable Disease Prevention. She began her career in public health as the Director of the Office of Governmental Policy and Legislation for DHSS that serves as the departmental liaison office with the State Legislature, Congress and their staffs. Previously, Ms. Jenkins was with the Office of Administration for 22 years serving as a senior budget and policy analyst on elementary and secondary and higher education issues before becoming an Assistant Director for State Planning in the Division of Budget and Planning, Office of Administration, and served as co-chair of the Governor's Interagency Planning Council which helped initiate a state integrated strategic planning model throughout the state departments. Ms. Jenkins has a degree in Psychology from the University of Missouri-Columbia.

//2007//

/2008/

Harold Kirbey, BS in Sociology and graduate work at UM-C in Rural Sociology, was appointed

Deputy Director of DCPH, November 1, 2006. Mr. Kirbey has served DHSS since 1987 in the positions of Health Program Representative, Management Analyst Specialist II, Bureau Chief and Chief of Office of Primary Care and Rural Health. His experience with DHSS, the legislature, LPHAs, primary care providers and other public health partners will serve DCPH well.

//2008//

Deborah Goldammer, MA, MPA, is the Section Administrator for the Office of Fiscal Support (OFS) and provides fiscal and budgetary expertise for DCH. OFS processes invoices and contract payments for various sections and programs within the division. Ms. Goldammer has served both the legislative and executive branches of Missouri State Government in various capacities since 1976.

/2007/

Scott Clardy is the Administrator of the Section for Public Health Practice and Administrative Support (PHPAS) in DCPH. Mr. Clardy has over 18 years of experience in public health, including public health laboratory sciences and environmental public health. As the Administrator of PHPAS, Mr. Clardy oversees the Bureau of Fiscal Services that processes invoices and contract payments, BHI, CHI and BVR. Mr. Clardy holds a Bachelor of Science degree in Biochemistry from the University of Missouri-Columbia.

//2007//

/2008/

Jennifer Duncan, CPA, MPA, is the Chief of the Office of Financial and Budget Services (OFABS). OFABS provides fiscal and budgetary expertise for DCPH, analyzing and tracking budgets and ensuring smooth processing of invoices and contract payments for the sections and programs within the division. Mrs. Duncan, a Certified Public Accountant, holds a Masters of Public Administration degree from the University of Missouri-Columbia and a Bachelor of Science Degree with Special Honors in Accounting from Jacksonville State University. Mrs. Duncan is a member of the Association of Governmental Accountants and the Missouri Society of Certified Public Accountants.

//2008//

Melinda Sanders, MS(N), RN, Section Administrator for MCFH in DCH, began her work at DHSS in 1998. Ms. Sanders has 26 years of nursing experience, including 12 years as a Family Nurse Practitioner. While at DHSS, Ms. Sanders worked as a Consultant Community Health Nurse for children with special health care needs and Chief of the former Bureau of Genetics and Disabilities Prevention before becoming Section Administrator. Ms. Sanders holds Bachelor of and Master of Science degrees in Nursing from the University of Missouri-Columbia.

/2007/

Ms. Sanders' title now is Section Administrator for Section for Healthy Families and Youth in DCPH.

//2007//

**/2009/**

***Due to the additional responsibilities Glenda Miller has accepted including the addition of State Public Health Laboratory to DCPH, July 2007 Melinda Sanders, Administrator of Section for Healthy Families and Youth (HFY), assumed the responsibilities of Title V Director. The majority of the programs and activities receiving MCH Title V funding are located in HFY.***

**//2009//**

Sherri Homan, RN, PhD, is the Section Administrator for OSEPHI in DCH. OSEPHI supports DCH in strategic planning; quality improvement initiatives; program evaluations; coordination of specific grants including MCH Title V Block Grant; public information dissemination; initiation and maintenance of surveillance systems, data management and reporting; and epidemiologic

consultations and assistance. Dr. Homan began her work with DHSS in 1986 and has served as Deputy Division Director and as Assistant to the Director for Strategic Planning and Program Evaluation for the former Division of Chronic Disease Prevention and Health Promotion. Dr. Homan received an Associate Degree in Nursing from Missouri Western State College in St. Joseph, Missouri and completed her Bachelor's and Master's of Science in Nursing from the University of Missouri. Dr. Homan is a Family Nurse Practitioner and also completed her doctorate at the University of Missouri in the Department of Education.

/2007/

Dr. Homan now serves in the Office of Epidemiology in DCPH.

Dr. Bao-Ping Zhu, MD, MS (EIS '96) is the State Epidemiologist for Missouri and Chief of Office of Epidemiology (OOE) and oversees unit preparing MCH Title V Block Grant. Immediately prior to his current position, he was a Lead Maternal and Child Health (MCH) Epidemiologist with the Division of Reproductive Health, Centers for Disease Control and Prevention (CDC) during 1998-2003, assigned to the Michigan Department of Community Health (MDCH) as the Chief MCH Epidemiologist. Dr. Zhu's main areas of expertise are in Perinatal and MCH Epidemiology. He has also researched and published in other fields, including the epidemiology of tobacco use and its health consequences, statistical methods in critical care medicine, nutritional epidemiology and epidemiologic theories. He was a co-author of the 1998 Surgeon General's Report on preventing tobacco use among youths. Dr. Zhu earned his MS degree in biostatistics from the University of Massachusetts School of Public Health in 1993 and his MD degree in Preventive Medicine (with concentration in Epidemiology) from the Chinese Academy of Medical Science/Peking Union Medical College in 1990. He was a CDC Epidemic Intelligence Service (EIS) Officer during 1996-1998 and had post-doctoral training in biostatistics and epidemiology at INSERM, France, during 1990-1991.

//2007//

/2009/

***Dr. Sarah Patrick will be joining DHSS as the new State Epidemiologist and administrator of the Section of Epidemiology for Public Health Practices full time in June, 2008, as Dr. Zhu accepted the position of Deputy Resident Advisory for the Field Epidemiology Training Program at the China CDC. Dr. Patrick will be transitioning into the position February-May. Dr. George Turabelidze will continue to serve as interim State Epidemiologist and Dr. Nick Boshard will continue to provide oversight and management for daily operations until June. Dr. Patrick has extensive experience with CDC, Aberdeen Area Indian Health Service, and Michigan Department of Health; and served as a state epidemiologist for South Dakota Department of Health. She is on the faculty of the Department of Family Medicine with University of South Dakota School of Medicine where her teaching responsibilities include epidemiology and biostatistics. She is concluding her work as Director for National Center of Excellence in Women's Health Project for Region VIII.***

//2009//

Nick Boshard, PhD, MPH, is in charge of the Quality Improvement, Planning and Evaluation (QIPE) in OSEPHI. QIPE supports the departmental and interagency planning and evaluation to better achieve healthy outcomes for women, infants, children, adolescents and children with special health care needs through grants development and management (including the Title V Block Grant and the State Systems Development Initiative [SSDI] Grant); program analysis and evaluation; statewide MCH need/capacity assessments; departmental strategic planning; and interagency planning and evaluation. Dr. Boshard has over 20 years of experience in the health field including executive positions with multi-hospital systems, teaching experience with the Graduate Program in Health Services Management (University of Missouri) and public health experience with the Centers for Disease Control (CDC).

/2007/

Dr. Boshard remains in charge of the grants development arm of OOE and supports the development and submission of major DHSS federal block grant applications including MCH Title V Block Grant Application, the Preventive Health and Health Services Block Grant, the State Systems Health Development Initiative Grant and other grant applications that support MCH populations in Missouri. Major program evaluations are conducted within DCPH and statewide assessments of the priority needs of MCH populations and the delivery capacity to meet those needs.

//2007//

MCH epidemiological capacity is enhanced through three full time Public Health Epidemiologists assigned to consult and evaluate MCFH related programs and activities: Pamela K. Xaverius, PhD; Venkata PS Garikapaty, PhD, MPH; and Linda Browning, PhD, MPH, RD.

/2007/

MCH epidemiological capacity is enhanced through a full time Public Health Epidemiologist assigned to consult and evaluate maternal, child and family health related programs and activities: Venkata Garikapaty, PhD, MPH. Other Public Health Epidemiologists in the department devote a significant portion of their time researching MCH related issues: Sherri Homan, RN, PhD; and Bao-Ping Zhu, MS, MD, who is the State Epidemiologist for Missouri.

//2007//

/2009/

**September 2007, Dr. BaoPing Zhu accepted the position of Deputy Resident Advisory for the Field Epidemiology Training Program at the China Centers for Disease Control and Prevention.**

//2009//

#### D. 3. PARENTS OF SPECIAL NEEDS CHILDREN

SHCN has a contract with a LPHA to administer the Family Partnership. Three Family Partners, employed by the LPHA, are paid with SHCN monies. FP members are chosen for their expertise as parents of special needs individuals. FP members participate in making SHCN policies and procedures and provide feedback on SHCN items.

/2009/

**A statewide conference for parents was held in November 2006. Approximately 90 family members participated in this conference for the exchange of information and mutual education and support.**

//2009//

**An attachment is included in this section.**

### **E. State Agency Coordination**

#### E.1. STATE ORGANIZATIONAL RELATIONSHIPS

Organization relationships among state agencies are illustrated in chart attached to Section III. C. Organizational Structure.

DHSS has several agreements or memoranda of understanding with other state agencies to collaborate to serve Title V populations including DSS, DESE, DMH and Department of Natural Resources (DNR).

Special state commission (5 senators and 5 representatives from legislature and several department directors including DHSS Director) was established to assess future of Medicaid in Missouri and options to reform Medicaid.

*/2009/*

**2007 Senate Bill 577, Missouri Health Improvement Act of 2007, includes renaming Missouri Medicaid to MO HealthNet.**

*//2009//*

*/2007/*

January 2006 Governor Blunt created Missouri Healthcare Information Technology task force to recommend better ways state government and private organizations share healthcare information. DHSS Director Julie Eckstein chairs 14-member taskforce, <http://www.dhss.mo.gov/HealthInfoTaskForce/index.html>.

*//2007//*

Comprehensive Children's Mental Health Services Initiative, September 2004, requires state agencies to develop comprehensive children's mental health services system to focus greater public attention on state policy for greater mental health parity with physical medical services, managed care protections for plan members with mental disorders and access to needed medications.

Missouri Title V Agency was leader in establishing blueprint for development of DMH's comprehensive children's mental health system with emphasis on primary prevention.

*/2007/*

Paula Nickelson is DHSS representative on Comprehensive System Management Team (CSMT)

*//2007//*

*/2009/*

**Glenda R. Miller is representative; Melinda Sanders is alternate.**

*//2009//*

DCH Director, Deputy Director and MCFH Administrator collaborate with Healthy Start in Bootheel area, St. Louis and Kansas City and conduct quarterly conference calls. Healthy Start coalitions participated in 5-year Title V needs assessment.

*/2007/*

DCPH Director serves on Kansas City's Board of Directors and is represented on St. Louis Coalition's Board of Directors.

*//2007//*

DHSS actively participates in Missouri Medicaid Managed Care Quality Assessment and Improvement Advisory Committee to advise DMS on measurable population-based quality indicators, health policy that improves health status of Medicaid managed care clients and identification of "best practices" of MCH care.

DCH is sponsoring evaluation of Home Visiting Program with DSS and Children's Trust Fund with focus on effectiveness of different models.

*/2007/*

Evaluation completed and executive summary prepared.

*//2007//*

Collaboration continues with DHSS SHCN Service Coordination staff, other state agencies and local communities to enroll children in SCHIP and Medicaid.

*/2007/*

SHCN information system links with DMS to provide Medicaid status.

//2007//

ACM is provided by agreement SHCN has with DMS. SHCN authorizes medical necessity of in-home nursing services and provides Service Coordination for participants in HCY and Physical Disabilities Waiver (PDW) for participants over 21.

SHCN has agreement with DDU to refer children who apply for SSI to SHCN area offices.

SHCN maintained contract with Department of Labor, Missouri Assistive Technology Project, to provide assistive technology for CSHCN families.

/2008/

Missouri Assistive Technology moved to DESE. SHCN continues contract.

//2008//

**/2009/**

**SHCN continues Missouri Assistive Technology contract for variety of home access improvements, vehicle access and range of assistive technology devices for CSHCN.**

**//2009//**

/2007/

Support Partner Program was eliminated June 2005. SHCN Adult Head Injury Program now facilitates MHIAC.

//2007//

Missouri Brain Injury Association manages family mentoring Support Partner Program.

DMH, DSS, DESE/Division of Vocational Rehabilitation and SHCN are streamlining intake process and service planning. Common HIPAA-compliant release of information form and data elements were agreed upon when electronic solution is available.

OHP began new cooperative effort with DNR to better monitor and intervene with public water systems fluoridated but optimal level of fluoridation not maintained.

/2008/

OHP began updating Missouri's public water systems fluoridation data received from DNR for CDC Water Fluoridation Reporting System (WFRS).

//2008//

**/2009/**

**OHP provided DNR public water systems fluoridation data to CDC WFRS and continues to on annual basis.**

**OHP and CLPHS encourage collaboration with LPHAs on OHP activities to assist communities in taking ownership of their oral health and implement Preventive Services Program (PSP) for children.**

**//2009//**

/2007/

OHP began working with DMH, State Schools for Severely Handicapped (SSSH), Sheltered Workshops, SHCN and Elks Mobile Dental Services to develop oral health networks for dental operatories in MRDD Regional Centers.

//2007//

/2008/

Pilot dental care access survey was conducted in a MRDD Regional Center September-October

2006.  
//2008//

*/2009/*

***OHP, DMH-MRDD and SHCN conducted 2007 state survey to examine oral health needs of SHCN people. See attachment.***

***OHP implemented Oral Health PSP in Elks Mobile Dental Van Program late 2007 and January 2008.***

***OHP works with: DESE's SSSHs to implement Oral Health PSP in 2008; MPCA to encourage more dental sites in FQHC and to present Infant Oral Care Training April 2008; Head Start State Collaboration Office; MO Head Start Association; Central MO Community Action Head Start.***

*//2009//*

GNH [now GHC] coordinates governor-appointed Genetic Disease Advisory Committee that advises DHSS in quality assurance of delivery of services to residents with genetic conditions. It has 5 sub-committees (Newborn Blood Spot Screening, Newborn Hearing Screening, Cystic Fibrosis, Hemophilia and Sickle Cell Anemia) comprised of representatives from treatment centers, providers, physicians and consumers.

Missouri Fetal Alcohol Syndrome Action and Care Team (MOFASACT) was developed to have statewide concentrated focus on FAS for prevention and intervention activities and information shared among committee members including UMC, St. Louis Arc, DMH and DHSS. Federal Substance Abuse and Mental Health Services Administration (SAMHSA) offered consultant services for developing comprehensive plan for FAS prevention in Missouri.

*/2007/*

Also, McCambridge Substance Abuse Treatment Center, PAT, Office of State Courts Administrators, ParentLink, Saint Louis University and MOFASRAPP.

*//2007//*

*/2008/*

MOFASACT members include 2 university medical schools, 2 hospitals, 3 state agencies, a substance abuse treatment center, 2 interested citizens, family advocacy organization and 2 parenting organizations.

*//2008//*

*/2009/*

***DHSS discontinued sponsorship of MOFASACT and co-chair responsibilities September 2007 to allow MOFASACT to participate in legislative advocacy and other issues.***

*//2009//*

MCFH is teaming up with SIDS Resources, Inc., to send messages to reduce risk of SIDS (Back to Sleep campaign). February 2005 SIDS Resources completed project for GNH to educate hospital nursery room nurses on Back to Sleep and is doing short-term project with GNH for Children's Hospitals and remaining general hospitals. December 2003 - April 2005 Safe Sleep Workgroup, chaired by DHSS and SIDS Resources and included child advocates from state and breastfeeding community (La Leche and IBLCE-The International Board of Lactation Consultant Examiners), met to develop Safe Sleep brochure.

*/2007/*

English and Spanish brochure distribution began to promote "safe sleep" for infants and decrease infant asphyxiation due to bed-sharing.

GHC will work with SIDS Resources to promote "safe sleep" conference with American Academy of Pediatrics (AAP) October 2005 recommendations.  
//2007//

/2008/  
Safe sleep brochure was updated with 2005 AAP "Safe sleep" recommendations.  
//2008//

**/2009/  
May 2007 "Safe sleep" conference was held.  
//2009//**

HSF [now HFY] facilitated development of FIMR committees to improve understanding of root causes of infant death and promote evidence-based interventions and solutions. FIMR continues in St. Louis Maternal Child Health Coalition in 3 zip codes targeted by St. Louis Healthy Start. FIMR program started January 2004 in Kansas City through Kansas City Maternal and Child Health Coalition.

/2007/  
FIMR expanded to entire St. Louis City and County region.  
//2007//

/2008/  
FIMR continues in St. Louis City and County. Kansas City programs target same 5 zip codes as Kansas City Healthy Start.  
//2008//

School Health in HSF works with DESE on school health initiatives, guidelines for school health programs, professional development for school nurses, etc.

/2007/  
Collaboration includes DMH, DSS, Department of Agriculture, Missouri Association of School Nurses, Missouri Student Success Network, Missouri Coordinated School Health Coalition and Missouri School Boards' Association. Targeted audiences include school staff and parents.  
//2007//

Adolescent Health in HSF coordinates statewide Council for Adolescent and School Health (CASH).

Adolescent health consultation and education contract with Children's Mercy Hospital for Adolescent Medicine Consultation Services supports services of Adolescent Medicine Consultant, training, technical assistance and ADOLESCENT SHORTS sent to 6500 adolescent health and mental health professionals.

/2007/  
CASH developed Missouri State Framework for Promoting Health of Adolescents to promote importance of addressing health needs of adolescents. 2006 DHSS completed public health assessment tool.

**/2009/  
Based on results of adolescent health system capacity assessment and quality improvement action plan, DHSS Adolescent Health Leadership Team was formed to strengthen capacity and coordination of DHSS programs and services to meet adolescent needs. Team merged with CASH to promote application of guiding principles and State Framework for Promoting Health of Adolescents.  
//2009//**

State coordinator represents DHSS on Governor's Substance Abuse Prevention Initiative Advisory Committee. Adolescent Health Program, Adolescent Medicine Consultants and DSS Chafee Foster Care Program collaborate on adolescent mental health issues training. STD/HIV/AIDS and Teen Pregnancy Prevention Team improves coordination of education and public health partners and develops youth-focused programming.  
//2007//

**/2009/**  
**State adolescent health coordinator represents DHSS on Governor's Substance Abuse Prevention Advisory Committee, Missouri Youth/Adult Alliance, and Missouri Department of Transportation Youth Traffic Safety Committee.**  
**//2009//**

Injury and Violence Prevention Program (IVPP) in HSF coordinates Missouri Injury Control Advisory Committee, a forum for addressing injury issues and providing guidance on injury prevention initiatives and activities. Committee has state, local, public and private agencies and professionals. IVPP worked with Committee to generate baseline data for STATE INJURY PREVENTION REPORT CARD and design report, INJURIES IN MISSOURI: A CALL TO ACTION.

/2008/  
IVPP works with Injury and Violence Prevention Advisory Committee to generate baseline data for report card and second edition of INJURIES IN MISSOURI: A CALL TO ACTION.  
//2008//

IVPP serves as lead agency for Missouri SAFE KIDS Coalition; supports 8 SAFE KIDS coalitions. Coalitions seek to reduce accidents and injuries to children as result of motor vehicle accidents, falls, drownings, bicycle accidents, fires, recreational injuries and poisoning. Block grant funding was used to generate additional contract support for SAFE KIDS coalitions.

/2008/  
IVPP supports 9 SAFE KIDS.  
//2008//

**/2009/**  
**IVPP supports 8 Safe Kids.**  
**//2009//**

/2007/  
SAFE-CARE (Sexual Assault Forensic Examination-Child Abuse Resource and Education) Network, administered by DHSS and supported by a Medical Director and Advisory Council, provides medical evaluations to alleged victims of child maltreatment and training to physicians and nurse practitioners to conduct medical evaluations of alleged victims.

Other stakeholder groups: DESE, Center for Safe Schools at UMKC; Department of Labor and Industrial Relations; Department of Transportation, Division of Highway Safety and Missouri Coalition for Roadway Safety; Department of Public Safety, including Highway Patrol; Iowa; Kansas; Nebraska; SAFE KIDS Coalition and SAFE-CARE.

Folic Acid Program coordinates Missouri Folic Acid Advisory Committee activities (medical professionals and educators, March of Dimes, DESE, public health professionals, etc.) to enhance awareness of benefits of folic acid in preventing neural tube defects and increase consumption of folic acid by women of childbearing age.  
//2007//

/2008/

MCH Coordinated Systems works with DESE, UM, DMH and Heartland Center to promote healthy and resilient communities to address mental wellness in MCH population, a Missouri MCH priorities.

//2008//

## E.2. FQHCs/COMMUNITY HEALTH CENTERS

PRIMO (Primary Care Resource Initiative for Missouri) receives funding from Health Access Incentive Fund (HAIF) and assists in expanding dental services through FQHCs.

FQHCs work closely with DHSS OMH and Senior Services to address access and disparity health issues. DHSS programs refer many individuals to FQHCs for medical and dental care.

/2007/

OPCRH, OMH and CCDC partner with FQHCs to address access and disparity health issues.

//2007//

/2009/

***OHP with PRIMO Partners encourages and supports dental students receiving funding from HAIF and being placed in FQHCs to improve oral health access. Out of 21 FQHCs, 19 deliver dental services in 40 sites; 2 more are building clinics within next year. Since July 2007 12 placements (includes dentists and physicians with 1 additional dentist placement pending) have been made by PRIMO Partner MPCA. OHP works with UMKC School of Dentistry. PRIMO is currently adding funding for pediatric dentist residency (\$10,000 for 1-year residency). PRIMO has changed academic eligibility for dental hygienists students to include associate degree rather than limiting eligibility to bachelor degree.***

//2009//

## E.3. LPHAs

DCPH entered into 109 LPHA contracts with over 250 short-term outcomes to build MCH community-based systems of care through support of public health intervention customized to each community.

/2007/

DCPH entered into 110 LPHAs contracts with 265 short-term outcomes.

//2007//

/2008/

In 2008 DCPH will enter into 112 LPHA contracts with 112 short-term outcomes while addressing Missouri's MCH priorities. New contracts allow selection of fewer outcomes in order for funds to be focused on selected outcomes.

//2008//

/2009/

***In 2008 DCPH has entered into 112 LPHA contracts with 112 system-building outcomes to address Missouri's MCH priorities. Contracts include 3-year plan to address local MCH priority.***

//2009//

/2008/

SHCN maintains contracts with LPHAs to provide service coordination for CSHCN and adult survivors of TBI.

//2008//

*/2009/*

**FFY 2008 DCPH has LPHA contracts to provide CCHC services in 112 of 114 counties. Targeted health issues this contract year:**

**-obesity prevention**

**-asthma management in young children**

*//2009//*

#### E.4. TERTIARY CARE CENTERS

SHCN has approximately 600 provider contracts. Through provider agreements with tertiary care centers, pre-approved specialty and sub-specialty care is provided for CSHCN who otherwise would have no resources for health care services.

*/2007/*

SHCN continues approximately 600 provider contracts.

*//2007//*

*/2008/*

SHCN discontinued contracts with providers who had not submitted claims in past 3 years but maintains approximately 400 provider agreements and continues to attract and enroll new providers.

GHC's 4 university genetic tertiary center contracts to support statewide program and provide evaluation for genetic conditions, genetic screening, counseling, diagnostic evaluation of genetic conditions and outreach along with tracking and follow-up on all abnormal newborn screen results and consultation to health care providers on those disorders screened by Newborn Screening Program.

*//2008//*

#### E.5. UNIVERSITIES

DHSS contracts with Southwest Missouri State University (name becomes Missouri State University August 2005) to provide technical assistance, training and consultation services to birthing hospitals and centers operating universal newborn hearing screening programs.

*/2007/*

MSU contract is in effect for fiscal year 2007.

*//2007//*

UM contract provided for statewide comprehensive Breastfeeding Educator Program presented to audience of physicians, educators, nurses, lactation consultants, etc., for training in basic lactation management skills needed in every WIC clinic and pediatrician office.

*/2007/*

Cystic Fibrosis Outreach Clinics contract with UM Health Care offers services in Cape Girardeau and Springfield areas.

ATODPA has educational outreach with UMC (to continue in 2007) in use of Missouri Model for Brief Smoking Cessation Training and CDC-funded grant MOFASRAPP (continuing through 2007), a collaboration of DHSS, UMC, DMH, St. Louis Arc and Missouri Institute of Mental Health.

*/2009/*

**DHSS is not contracting with UMC through 12/08 for MO Model Training; MOFASRAPP grant expires 9/29/08.**

*//2009//*

SHCN maintained UMKC, Institute for Human Development, contract to increase cultural

competency of SHCN staff and providers.

SHCN contract with UMKC, Institute for Human Development, coordinates statewide multi-agency efforts to achieve ECCS grant outcomes.

//2007//

/2008/

UMKC fulfilled contract to increase cultural competency of SHCN staff.

Cystic Fibrosis Outreach Clinic contract offers services in Springfield areas.

ATODPA educational outreach with UMC contracted with an expert presenter in 2007 in use of Missouri Model for Brief Smoking Cessation Training and CDC-funded grant MOFASRAPP with 2 state agencies, university hospital, behavioral research arm of medical school and family advocacy organization.

//2008//

**/2009/**

**UMC is no longer involved in this contracted activity; grant expires 9/29/08.**

**//2009//**

Missouri Partnership for Enhanced Delivery of Services (MoPEDS), facilitated through Department of Health Psychology in UM School of Health Professions with assistance from SHCN, is developing coordinated system of care for CSHCN in mid-Missouri and encouraging local partnerships with family, health care providers, schools and state agencies.

/2008/

MoPEDS is facilitated through Thompson Center in UMC. SHCN works with UMC Training and Interdisciplinary Partnerships and Services (TIPS) for Kids, Leadership Education in Neurodevelopmental and Related Disabilities (LEND) training program in Missouri.

**/2009/**

**CSHCN Service Coordinators attend LEND training. CSHCN staff provide training for LEND group.**

**//2009//**

DHSS partnered with UM to enroll home visiting clients into Domestic Violence Enhanced Home Visitation-DOVE Project. DOVE is National Institutes of Health (NIH)-funded \$3.5 million research project to test home visitation intervention to reduce domestic violence and improve lives of pregnant and postpartum women and their children.

//2008//

SHCN has contracts with LPHAs and UM-Mount Vernon to provide service coordination for TBI patients over 21.

WIC/Nutrition Services' contract with UM-School Nutrition Education Program provided sequential nutrition education curriculum for pre-K through 12th grade.

/2008/

WIC/Nutrition does not have this contract or project now.

//2008//

#### E.6. EPSDT

Monthly EPSDT (HCY) reports are available to LPHAs electronically on Mobius hosted on State Data Center mainframe. HSF is assisting LPHAs in using reports as related to their MCH

contracts meeting constituents' needs.

/2008/

CLPHS assists LPHAs in using reports.

//2008//

Title V funds support LPHAs for purpose of establishing and maintaining an improved coordinated system capable of addressing targeted MCH issues for entire MCH population.

## E.7. GRANTS AND OTHER COLLABORATIVE RELATIONSHIPS

Early Childhood Comprehensive Systems (ECCS) Grant was awarded to Missouri to assemble group of stakeholders to guide development of State Plan to create early childhood comprehensive system. DHSS is using interagency approach for leadership. DHSS, DESE, DMH, DSS and Head Start State Collaboration Office form steering committee. Larger coalition of stakeholders meets quarterly and includes family members and representatives from Children's Trust Fund; Citizens for Missouri's Children Crider Center; Departments of Corrections, Economic Development, Elementary and Secondary Education, Insurance, Mental Health and Social Services; Family Voices, FIMR Board, Head Start, Heart of America, Metro Council on Early Learning, Missouri Dental Association, MPCA, Parent Link, PAT, Partnership for Children, Project Life, Ozark Center, Southeast Missouri State University, Governor's Office, United Way and UM Hospital and Clinics.

ECCS Plan is structured along natural continuum from child and family through community and state and allows for participants/families to be involved in identification of their needs and decision-making process to meet needs. ECCS plan will be included in state strategic plan.

/2007/

Coalition includes Association for Education of Young Children, Missouri Dental Hygienists Association and Senate and House of Representatives.

SHCN contract with UMKC, Institute for Human Development, coordinates statewide multi-agency efforts to achieve ECCS grant outcomes.

//2007//

/2009/

***ECCS grant was approved by Governor; newly created subcommittee of Children's Services Commission is entitled Early Childhood Coordinating Board. Board is to implement ECCS plan.***

//2009//

/2007/

SHCN obtained Missouri Foundation for Health (MFH) grant to promote MH concept and maintained contracts with Reynolds County Health and Wright County Health Centers to promote education of key stakeholders and assurance of long-range sustainability of MH system.

//2007//

/2008/

MFH grant cycle was completed and LPHA MH contracts were fulfilled. SHCN continues to distribute MH concept materials.

//2008//

Significant achievements occurred due to opportunities provided by Universal Newborn Hearing Screening Grant (continues through March 2006) to ensure diagnosis of congenital hearing loss by 3 months of age and entry into early intervention by 6 months of age. Regional representatives were hired to track infants who missed or failed initial hearing screening to assure linkage to early

intervention services and MH. DHSS finalized agreement with DESE to share aggregate data (First Steps enrollment, intervention services, type of amplification, etc.) on children with confirmed hearing loss. Further collaboration with DESE is proceeding to share specific early intervention information to improve follow-up efforts.

*/2007/*

MNHSP was supported with general revenue funds, HRSA Universal Newborn Hearing Screening and Intervention, CDC Early Hearing Detection and Intervention and MCH Block Grant. Universal Newborn Hearing Screening Grant continues through March 2007; CDC grant until June 30, 2007.

*//2007//*

*/2009/*

***HRSA Universal Newborn Hearing Screening Grant continues through March 2008. CDC grant continues until June 30, 2008. Applications for new grants will be completed for each.***

*//2009//*

DHSS was awarded FAS prevention CDC funding through September 28, 2008. Grant funds support development and implementation of MOFASRAPP. DMH, Missouri Institute of Mental Health, UMC, St. Louis Arc and MPCA are collaborating in project to reduce alcohol-exposed pregnancies, educate health care providers on FAS, establish FAS centers and enhance existing surveillance systems.

*/2009/*

***Grant extension is being requested to continue surveillance and FAS center through 9/29/09.***

*//2009//*

*/2007/*

CDC-funded MOFASRAPP (collaboration of DHSS, DMH, Missouri Institute of Mental Health, UMC and St. Louis Arc) continues through September 28, 2008, to develop and implement integrated systems framework for prevention and surveillance of alcohol-exposed pregnancies and FAS.

*//2007//*

*/2009/*

***This grant portion expires 9-29-08.***

***GHC participates in ongoing activities of Heartland Regional Genetics and Newborn Screening Collaborative (HRGNSC) that included for 2007 distributed copies of prenatal DVD, "Newborn Screening: Protecting Your Baby's Health" which concerns newborn screening for expectant parents. DVD, in English and Spanish, was sent to prenatal clinics, midwifery clinics and birthing centers and assisted in development of family health history materials sent to state genealogy groups.***

***FY 09 HRGNSC will:***

- focus on "Just in Time" primary care provider education project to give web-based information on heritable disorders;***
- develop MH portal that involves information, tools and resources to aid primary care providers in caring for CSHCN and providing MH for their patients.***

***GHC distributed family health history materials through Area Agencies of Aging in conjunction with Grandparents day.***

***FY09 GHC and DMH will promote family health history.***

//2009//

Some other federal funds DCH receives: State Systems Development Initiative (SSDI) Grant; Abstinence Only Education; TBI Grant; Rape Prevention and Sexual Assault Prevention Education Grant; Integrated Comprehensive Women's Health Services Grant; State Oral Health Collaborative Systems Grant; CDC Obesity Grant and HRSA State Planning Grant to study health insurance coverage (9/1/04-8/31/05).

Other funding and collaboration include: Food Stamp Nutrition Education Program; Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases; "Bridging the Gap between Abstinence-Only and Comprehensive Sex Education" conference sponsored by DHSS and DESE with public health and education agencies from Kansas and Iowa; Tobacco Cessation Among Women of Reproductive Age Team; partnership of DHSS and DMH in use of state funds and collaborations with community coalitions to generate local in-kind services and resources for first time focus on FAS conferences; Missouri Folic Acid Advisory Council coordination; Breastfeeding Peer Counseling Program.

/2008/

DHSS and DMH have discontinued use of state funds for FAS conference and community collaborations.

//2008//

/2009/

**"Bridging the Gap between Abstinence-Only and Comprehensive Sex Education" conference changed to "Annual HIV/AIDS/STDs & Human Sexuality Education Conference".**

**OWH received grant from MFH to support Denim Day rape education and awareness initiative, a collaboration between OWH and Injury and Violence Prevention.**

**Other federal funds: Preventive Health and Health Services Block Grant and African-American Infant Mortality Preventive Initiative grant funded by State Partnership Grant Program to Improve Minority Health in DHHS Office of Minority Health.**

//2009//

#### E.8. FAMILY PARTNERSHIP (FP):

SHCN developed contract with LPHA contractor to provide FP services.

SHCN has LPHA focus on FP activities. Face-to-face meetings, monthly conference calls with FP family members and quarterly regional English/Spanish newsletters (uploaded to FP Web site) are means to share resource information and training on specific topics relevant to families with special needs individuals.

FP members participate in decision-making process for SHCN policies and procedures. SHCN fact sheets, brochures and forms are distributed for FP members' feedback.

FP provides outreach activities to encourage participation in FP meetings. SHCN explored and researched interest groups to assist in identification and recruitment of youth participation.

/2007/

FP continues LPHA contract for statewide activities with an increase in participation of face-to-face meetings. Core group of 15 Family Partners review SHCN materials to assure appropriate resources are utilized with families. Family Partners continue to build contacts and professionals network.

//2007//

/2008/

FP continues through LPHA contract. Face-to-face meetings and newsletters continue. SHCN maintains FP Web Site. Family Partners continue to review SHCN materials and conduct outreach activities.

//2008//

/2009/

**Approximately 90 family members participated in November 2006 state conference to exchange information and mutual education and support.**

//2009//

**An attachment is included in this section.**

## F. Health Systems Capacity Indicators

### Introduction

While the majority of the activities listed below are funded in some portion (staffing, supplies, etc.), there may be some which do not receiving funding from the MCH Title V Block Grant but still impact the health systems capacity indicator.

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	39.9	39.3	34.6	36.4	36.4
Numerator	1475	1460	1326	1406	1406
Denominator	369776	371829	383096	386752	386752
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

### Notes - 2007

Source: Missouri Information for Community Assessment (MICA) - Inpatient Hospitalization, and the Bureau of Health Informatics, MO DHSS. 2007 data will be available in December 2008, and 2006 data are used as proxy for 2007.

### Notes - 2006

The data is from the Patient Abstract System. There is a one year lag time in receiving data from the reporting hospitals. Current 2006 data won't be available until Fall, 2007. 2005 estimate used for 2006 denominator until more current numbers available.

The numerators and denominators have been revised to include only MO residents with an ICD-9 Code of 493.0 - 493.9.

### Notes - 2005

The data is from the Patient Abstract System. There is a one year lag time in receiving data from the reporting hospitals. Current 2005 data won't be available until Fall, 2006.

The numerators and denominators have been revised to include only MO residents with an ICD-9 Code of 493.0 - 493.9.

**Narrative:**

--Missouri Asthma Prevention and Control Program (MAPCP) Web site (<http://www.dhss.mo.gov/asthma/RelatedLinks.html>) provides information and links for schools and child care centers regarding controlling asthma symptoms, preventing most acute asthma attacks and maintaining desired activity levels. Links are provided to the 2005 Missouri state asthma plan and the 2005 Missouri School Asthma Manual. Partners include Asthma & Allergy Foundation of America-Greater Kansas City Chapter, Missouri Pharmacy Association, DESE, Missouri Medicaid, Glaxo-Smith Kline, Sinclair School of Nursing, Missouri DNR-Air Pollution Control Program, DSS-FSD, St. Louis City Department of Health, Kansas City Health Department, Missouri School Nurses Association, Missouri Hospital Association, American Lung Association, Missouri School Boards' Association, Kansas City Missouri School District, St. Louis University-School of Public Health, Missouri Primary Care Association, Greater Kansas City Black Nurses Association, Allergy and Asthma Consultants, St. Louis Regional Asthma Consortium and University of Missouri Outreach and Extension.

--"Improving Missouri School Asthma Services" is a collaborative effort of DHSS, Missouri School Boards' Association, Missouri Association of School Nurses and University of Missouri-Columbia to equip local school nurses to support children who have asthma, increase awareness and support among school staff and board members and partner with parents to meet needs of children and reduce disabling effects of poorly controlled asthma.

--School Health Capacity Building-Title V and state funding supports the School Health Services program (a collaborative effort of DHSS, DSS and DESE) in funding special contracts with public schools, public school districts and LPHAs to establish or expand population-based health services for school-age children in defined geographic areas. It focuses on increasing access to primary and preventive health care for school-age children; identifying school-age CSHCN and referring them to a system of care; and providing professional education to school health professionals who work with school-age children who may be overweight, at risk for being overweight, or have diabetes, asthma, or attention deficit hyperactivity disorder (ADHD).

--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines. This service focuses on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and provision of service coordination activities for families. Service coordination is provided through 13 regional contracts and by SHCN staff located in area offices throughout the state.

--Coordination and Systems Development-Title V funds are used to support staff in DCPH to carry out activities related to coordination of state and local agencies in data collection, analysis and data processing.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services to provide technical assistance to identify factors impacting MCH health status.

**/2009/**

***Child Care Health Consultation (CCHC) -- This cooperative program between DHSS and LPHAs provides on-site consultation, education and health promotion services to child care facilities. Appropriate asthma management in young children has been a two-year focus of this program with the intent of decreasing emergency room visits of young children for asthma related complaints. In FFY 2007, 313 hours of group education and 14 hours of on-site consultation were provided to a total of 1,864 child care providers and 53 parents of children in child care.***

**//2009//**

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	90.3	89.2	91.9	92.8	90.8
Numerator	30733	31672	34465	40497	40857
Denominator	34047	35517	37488	43619	44982
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

Source: MO HealthNet Division, Missouri Department of Social Services.

Numerator is the number of Medicaid enrollees (including SCHIP) whose age is less than one year in FFY 2007 who received at least one initial or periodic screen. Denominator is the number of Medicaid enrollees (including SCHIP) whose age is less than one year in FFY 2007.

**Notes - 2006**

Both numerator and denominator obtained from Division of Medical Services. Denominator = total eligibles < 1 year of age who should receive at least one initial or periodic screening in 2006 = 43619. Numerator = total eligibles < 1 year of age who received at least one initial or periodic screening in 2006 = 40,497. Numerator and denominator were then multiplied by the proportion of individuals 0-19 years of age enrolled in Medicaid (0.876, obtained from Form 21, HSI #09A) vs. those enrolled in SCHIP + Medicaid.

**Notes - 2005**

Both numerator and denominator obtained from Division of Medical Services. Denominator = total eligibles < 1 year of age who should receive at least one initial or periodic screening in 2005 = 42,795. Numerator = total eligibles < 1 year of age who received at least one initial or periodic screening in 2004 = 39,344. Numerator and denominator were then multiplied by the proportion of individuals 0-19 years of age enrolled in Medicaid (0.876, obtained from Form 21, HSI #09A) vs. those enrolled in SCHIP + Medicaid.

**Narrative:**

--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines focusing on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and providing service coordination activities for families through 13 regional contracts and by SHCN staff located in area offices throughout the state.

--Home Visiting-Funds are allocated to Missouri Community-Based Home Visiting Program (MCBHV) and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. Home visiting services include referral and case management services. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

--Child Care Initiatives-Funds are used to enhance child care resource and referral (CCR&R) services for families and CSHCN.

--Coordination and Systems Development-Title V funds are used to support staff in DCPH to carry out activities related to coordination of state and local agencies in data collection, analysis and data processing.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	90.3	89.2	91.9	92.8	90.8
Numerator	5003	5336	4879	582	433
Denominator	5543	5984	5307	627	477
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2007**

Source: MO HealthNet Division, Missouri Department of Social Services.

The method to determine denominator and numerator for this measure was revised to reflect more accurate information on SCHIP. The denominator is the number of SCHIP enrollees less than one year of age in FFY 2007. MO HealthNet only tracks total HealthNet (Medicaid including SCHIP) EPSDT numbers for children under one year of age, but does not track SCHIP EPSDT numbers for this age group. Therefore, the numerator is estimated by multiplying the number of Medicaid (including SCHIP) enrollees under one year of age who received at least one initial periodic screen (40,857 in FFY 2007, HSCI #2) by the proportion of SCHIP enrollees under one year of age among the total number of Medicaid (including SCHIP) enrollees under one year of age ( $477 / 44,982 = 0.0106$ , FFY 2007).

2006 denominator and numerator were also changed based on the revised method.

**Notes - 2006**

Both numerator and denominator obtained from Division of Medical Services. Numerator and denominator were obtained by multiplying the proportion of individuals 0-19 years of age enrolled in SCHIP (0.126, obtained from Form 21, HSI #09A) vs. those enrolled in SCHIP + Medicaid.

**Notes - 2005**

Both numerator and denominator obtained from Division of Medical Services. Denominator = total eligibles < 1 year of age who should receive at least one initial or periodic screening in 2005 = 42,795. Numerator = total eligibles < 1 year of age who received at least one initial or periodic screening in 2005 = 39,344. Numerator and denominator were then multiplied by the proportion of individuals 0-19 years of age enrolled in SCHIP (0.124, obtained from Form 21, HSI #09A) vs. those enrolled in SCHIP + Medicaid.

**Narrative:**

--Collaboration continues among DHSS SHCN Service Coordination staff, other state agencies and local communities to identify and help enroll children in Missouri's SCHIP and Medicaid.

--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines focusing on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and providing service coordination activities for families through regional contracts and by SHCN staff located in area offices throughout the state.

--MCH Coordinated Systems Contracts with LPHAs establish and maintain an integrated multi-tiered service coordination system. Funds are disbursed using an outcome-based contract to LPHAs with a contractual obligation to use evidence-based interventions to address identified health risk indicators such as percent of children without health insurance.

**/2009/**

***In 2007, MCH Coordinated Systems contracted with LPHAs to establish and maintain an improved coordinated system within their communities to address periodic screening for children under one year of age. In 2008, contracts with LPHAs have changed the focus to injury prevention, obesity and tobacco prevention. Funds are disbursed using an outcome-based contract to LPHAs with a contractual obligation to use evidence-based interventions to address identified health risk indicators. LPHA contractors may also continue to address periodic screenings.***

**//2009//**

--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. Home visiting services include referral and case management services. In 2005 the program was expanded to the St. Louis City/County region.

--Child Care Initiatives-Funds are used to enhance child care resource and referral (CCR&R) services for families and CSHCN.

**/2009/**

***CCHC program provides consultation and education to child care providers related to the care of children with special health care needs such as asthma, diabetes, seizures, autism and ADHD.***

**//2009//**

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	77.7	78.5	79.2	77.2	75.2
Numerator	59797	61010	62177	62764	61541
Denominator	76960	77709	78547	81353	81879
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

Source: Missouri Information for Community Assessment (MICA) - Births, and the Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

**Notes - 2005**

2005 numbers are current as of May 5, 2006.

The 2001 numerator has been revised.

**Narrative:**

--Baby Your Baby Web site ([www.dhss.mo.gov/babyourbaby](http://www.dhss.mo.gov/babyourbaby)) has information for pregnant women, their families and communities on healthy pregnancies and healthy babies. Topics and links include prenatal care and nutrition, MC+ (Medicaid), WIC, and TEL-LINK that is a toll free information and referral line.

--Campaign ads were developed with the Missouri Broadcaster's Association for messages to promote healthy pregnancy through early and adequate prenatal care. Ads promote the importance of the family history to identify health problems that run in the family which can help doctors better determine the risk of disease among their patients and help motivate them into action to stay healthy.

--The WIC Program provides various assistance including medical referrals to health care providers to address the WIC participants needs.

--MCH Coordinated Systems Contracts with LPHAs --Title V funds support LPHAs for the purpose of establishing and maintaining a system capable of addressing adequate prenatal care. Two performance measures were addressed in jurisdictions where the data was most disparate: Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (11 LPHAs); and Decrease the percent of pregnant women receiving inadequate prenatal care (13 LPHAs).

/2008/

Contracts with LPHAs have been renewed with the focus on the objectives on injury prevention, obesity and tobacco. Local contractors will continue to address the issue of adequate prenatal care with local funds.

//2008//

--Healthy Babies-This initiative provides educational materials through the Web site and printed materials in English and Spanish that promote healthy pregnancies and healthy birth outcomes and encourages early entry into prenatal care. The Web site ([www.dhss.mo.gov/babyourbaby](http://www.dhss.mo.gov/babyourbaby)) will be active through January 2008.

/2009/

***This contract has been renewed through January 2013.***

//2009//

--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

--Genetic Services-Title V partially funds the program's contributions in the reduction of morbidity

and mortality associated with genetic disorder. The genetic disease program maintains a referral network that connects Missourians in need of diagnostic treatment, counseling and specialized health services with appropriate health care providers.

**/2009/**

**General revenue funds support the metabolic formula program to provide for those of any age, including pregnant women, who require formula and who qualify under the financial guidelines.**

**//2009//**

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	80.3	81.8	80.0	79.7	79.2
Numerator	433644	324000	356000	358000	361000
Denominator	540113	396000	445000	449000	456000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2007**

Accurate number of potentially Medicaid-eligible children is not available. Estimates of denominator and numerator are obtained from Current Population Survey Table Creator on the Census Bureau website:

[http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Numerator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid.  
Denominator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid + Number of kids of ages 0-17, below 300% FPL, and not on Medicaid (uninsured).

**Notes - 2006**

Accurate Medicaid eligibility information currently not available. Estimates of denominator and numerator are obtained from Current Population Survey Table Creator on the Census Bureau website:

[http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Numerator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid.  
Denominator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid + Number of kids of ages 0-17, below 300% FPL, and not on Medicaid (uninsured).

**Notes - 2005**

Accurate Medicaid eligibility information currently not available. Estimates of denominator and numerator are obtained from Current Population Survey Table Creator on the Census Bureau

website:

[http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Numerator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid.

Denominator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid + Number of kids of ages 0-17, below 300% FPL, and not on Medicaid (uninsured).

**Narrative:**

--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines focusing on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and providing service coordination activities for families through 13 regional contracts and by SHCN staff located in area offices throughout the state.

--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. Home visiting services include referral and case management services. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

--Outreach and Education-TEL-LINK is partially funded by Title V to support the maintenance and promotion of the state's toll-free telephone referral service. This service offers callers information and direct referrals to health-related services available in local communities and statewide. In January 2005, the TEL-LINK Web site was developed. During this year, a total of 9,984 hits were made to the Web site. Collaboration with other state programs and agencies was developed to promote the program and other health care benefits. Outreach was provided through direct mailings and exhibits at various conferences and health fairs to promote the program and distribute health educational materials to Missourians.

/2008/

In year 2006, promotion of TEL-LINK was provided through direct mailings, distribution of health education materials and exhibits at various conferences and health fairs. The toll free number was utilized in collaboration with other state health programs such as Cancer and Chronic Disease Control. The TEL-LINK Web site continues to serve as another avenue for promoting the program to Missourians. A link to the TEL-LINK Web site was added from the department's home page.

//2008//

/2009/

***In year 2007, promotion of TEL-LINK in collaboration with programs in DCPH provided additional marketing opportunities for individuals to call the toll free number and receive referrals to social services agencies, which provide Medicaid services to children.***

//2009//

--Child Care Initiatives-Title V Block Grant funds are used to enhance Child Care Resource and Referral (CCR&R) services for families and CSHCN. Through this project the CCR&R has qualified inclusion staff in every CCR&R agency to provide statewide-enhanced services listed below:

-Referrals will remain an integral part of services delivered. All eight local agencies will maintain toll-free phone numbers. Families may call and seek referrals to child care programs. Referral Specialists will collect data such as: immunization status of children, health issues including diseases and birth defects, developmental issues and insurance status of children.

-Call-enhanced services with development of a plan of action, in collaboration with the family, to support child care services to a child with special needs.

-Referrals of all families of children with special needs to Missouri's Early Intervention Programs

(First Steps), local Public School District or other appropriate programs or services.

*//2009/*

**The CCHC program provides information to child care providers and parents of children in child care regarding a source of health care coverage, primary care services and specialty care services as requested.**

*//2009//*

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	31.3	34.2	33.7	35.0	38.3
Numerator	40224	42268	43175	45850	47818
Denominator	128715	123636	128262	131054	124885
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

Source: MO HealthNet Division, Missouri Department of Social Services.

Numerator is the number of EPSDT eligible children aged 6-9 years receiving any dental services in FFY 2007. Denominator is the number of children aged 6-9 years eligible for EPSDT in FFY 2007.

**Notes - 2006**

Both numerator and denominator obtained from Department of Social Services, Division of Medical Services. Denominator = eligibles 6-9 years of age who received corrective treatment in 2006 + eligibles 6-9 years of age who received any dental services in 2006 + eligibles 6-9 years of age who received preventive dental services in 2006 + eligibles 6-9 years of age who received dental treatment services in 2006 = 131,054. Numerator = eligibles 6-9 years of age who received any dental services in 2006 (45,850).

**Notes - 2005**

Both numerator and denominator obtained from Division of Medical Services. Denominator = eligibles 6-9 years of age who received corrective treatment in 2005 (19,831) + eligibles 6-9 years of age who received any dental services in 2005 (43,175) + eligibles 6-9 years of age who received preventive dental services in 2004 (39,012) + eligibles 6-9 years of age who received dental treatment services in 2004 (26,244) = 128,262. Numerator = eligibles 6-9 years of age who received any dental services in 2004 (43,175).

**Narrative:**

--Oral Health Program (OHP)-OHP provides preventive and restorative dental services through Elks Mobile Dental Program, Oral Health Preventive Services Program, DDS Program and Fluoride Mouthrinse Program and preventive dental services initiatives. Recipients of Elks Mobile Dental Program services include CSHCN and other vulnerable children. Children in Head Starts, Early Head Start and elementary school are screened, educated, referred and provided fluoride

varnish through Oral Health Preventive Services Program. With Missouri Dental Association, OHP finances DDS which utilizes network of volunteer dentists to provide comprehensive dental care to low-income maternal and child health populations in most need of care, at no charge to patient.

/2008/

Children in Early Childcare Centers are screened, educated, referred and provided fluoride varnish through Oral Health Preventive Services Program. Interactive Missouri maps on DHSS Web site identify fluoridated public water systems and oral health programs/services. Kindergarten-12th Grade Oral Health Education Curriculum is available on DHSS Web site. Other oral health education brochures/pamphlets have been updated.

//2008//

/2009/

***So far in 2007-2008 school year, 15,676 children have participated in the Oral Health PSP ranging from ages of less than 1 year old to 18 years of age.***

***The K-12 Oral Health Education Curriculum is nationally and internationally known and has had exceptional positive reviews.***

***The Web site [www.mohealthysmiles.com](http://www.mohealthysmiles.com) was established in 2007 to provide information to the public on the Oral Health Preventive Services Program. Radio media spots help promote the program as well as promote good oral health care.***

***The Oral Health PSP is enhancing its training process by developing online training modules. This enhancement will make it possible for many additional dental professionals to be trained and be able to volunteer their services to the program.***

***In 2007-2008, Oral Health Intervention Topic Modules were developed and added to MICA on DHSS Web site to assist communities and public health professionals in assessing their public health needs and developing initiatives to address oral health issues in their communities.***

//2009//

--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines focusing on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and providing service coordination activities for families through 13 regional contracts and by SHCN staff located in area offices throughout the state.

--Outreach and Education-TEL-LINK is partially funded by Title V to support the maintenance and promotion of the state's toll-free telephone referral service. This service offers callers information and direct referrals to health-related services available in local communities and statewide.

/2008/

In year 2006, promotion of TEL-LINK was provided through direct mailings, distribution of health education materials and exhibits at various conferences and health fairs. The toll free number was utilized in collaboration with other state health programs such as Cancer and Chronic Disease Control. The TEL-LINK Web page continues to serve as another avenue for promoting the program to Missourians. A link to the TEL-LINK Web site was added from the department's home page.

//2008//

/2009/

***In year 2007, promotion of TEL-LINK in collaboration with programs in DCPH provided additional marketing opportunities for individuals to call the toll free number and receive***

**referrals to resources providing dental services.**

//2009//

--Child Care Initiatives-Title V Block Grant funds are used to enhance CCR&R services for families and CSHCN. CCR&R has qualified inclusion staff in every R&R agency to provide statewide-enhanced services:

- Referrals remain an integral part of services delivered. All 8 local agencies maintain toll-free phone numbers. Families may call and seek referrals to child care programs. Referral Specialists will collect: immunization status of children, health issues including diseases and birth defects, developmental issues and insurance status of children.
- Call-enhanced services with development of plan of action with the family to support child care services to a child with special needs.
- Referrals of all families of children with special needs to Missouri's Early Intervention Programs (First Steps), local Public School District or other appropriate programs or services.

/2008/

Local CCR&R's provide oral health training to child care providers as part of Basic Child Care Orientation Training supported by DHSS and DSS.

//2008//

/2009/

**The CCHC program provides information to child care providers and parents of children in child care regarding a source of health care coverage, primary care services and specialty care services as requested.**

//2009//

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	0.6	75.5	73.6	84.4	81.4
Numerator	85	13653	14308	14434	14421
Denominator	14980	18075	19451	17109	17727
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

Denominator is the number of SSI recipients under 16 years old in Missouri, December, 2007. Source: Social Security Administration, Supplemental Security Record, available at <http://www.hrtw.org/youth/data.html#ssi>

Numerator is the number of Missouri Medicaid recipients <16 years of age who are referred for SSI supported rehabilitative services as of December 31, 2007. Source: Missouri Department of Social Services, Research and Evaluation Unit.

Annual indicator for 2006 was revised based on the denominator the number of SSI recipients under 16 years old in Missouri, December, 2006. Source: Social Security Administration, Supplemental Security Record. The indicator 2005 and earlier was based on the denominator for ages under 18 years. Therefore the percents for 2007 and 2006 are not comparable with those for 2005 and earlier.

**Notes - 2006**

In order to better reflect the number of kids with special health care needs who are receiving rehabilitative services, for 2004 the definition of "State's CSHCN program" was broadened to include numbers of children that are served by Medicaid for SSI supported rehabilitative services. The denominator is the total number of children < 18 years of age in Missouri receiving SSI payments in December, 2005 (provisional 2005 number used). Denominator provided by SSI State Statistics Report for Missouri. The numerator is the total number of children < 16 years of age in Missouri in Medicaid that are referred for SSI supported rehabilitative services in December, 2006. Numerator provided by Missouri Department of Social Services, Research and Evaluation Unit.

**Notes - 2005**

In order to better reflect the number of kids with special health care needs who are receiving rehabilitative services, for 2004 the definition of "State's CSHCN program" was broadened to include numbers of children that are served by Medicaid for SSI supported rehabilitative services. The denominator is the total number of children < 18 years of age in Missouri receiving SSI payments in December, 2005. Denominator provided by SSI State Statistics Report for Missouri. The numerator is the total number of children < 16 years of age in Missouri in Medicaid that are referred for SSI supported rehabilitative services in December, 2005. Numerator provided by Missouri Department of Social Services, Research and Evaluation Unit.

**Narrative:**

--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines. This service focuses on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and provision of service coordination activities for families. Service coordination is provided through 13 regional contracts and by SHCN staff located in area offices throughout the state.

During FY2005, the Injury and Violence Prevention Program partnered with the Special Health Care Needs Unit (SHCN) to assess the safety needs of CSHCN and acquire equipment to increase the safety of those children. SCs in the SHCN Unit documented unmet needs and coordinated the purchase of safety equipment for CSHCN and their families. Items purchased included 166 baby gates, 202 child safety kits, 488 first aid kits, 119 helmets and pads, 52 infant head supports, 321 smoke/carbon monoxide detectors and 207 thermometers.

**Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)***

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	9.1	6.7	7.9

**Narrative:**

--FIMR Development-Funds will continue to be used in supporting and expanding existing FIMR boards/projects in local communities to examine the causes of fetal and infant deaths not examined by the Child Fatality Review Board and to recommend policy, program or systems changes which may reduce the rate of fetal infant mortality.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH) programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention and other issues impacting MCH health status.

**Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births***

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	matching data files	8.6	5.6	7.2

**Narrative:**

--FIMR Development-Funds will continue to be used in supporting and expanding existing FIMR boards/projects in local communities to examine the causes of fetal and infant deaths not examined by the Child Fatality Review Board and to recommend policy, program or systems changes which may reduce the rate of fetal infant mortality.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH) programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention and other issues impacting MCH health status.

An epidemiological investigation was conducted in response to an inquiry regarding a suspected cluster of fetal and infant deaths in the St. Charles County, Missouri, during the 2003 year. This evaluation showed no evidence of an elevated fetal or infant mortality rate, regarding the temporal distribution of rates, the percent contribution of pregnancies with multiples, and potential environmental risks. While there were no statistically significant increases in St. Charles County regarding infant mortality, in 2003, pregnancies with multiples provided a higher contribution to the overall infant mortality rate than the following year (although not significantly different than the state as a whole). The greatly diverse causes of death indicated that a variety of causes and risk factors, rather than a single environmental exposure, contributed to the fetal and infant deaths.

OGE assisted in the identification of and prioritization of MCH-related health problems and health risk behaviors for infants, children, adolescents and women of childbearing age using the Priority MICA, an interactive web-based data system. The priority areas were ranked according to severity and risk for Missouri's population based on death trend, number of deaths, racial disparity for deaths, hospital days of care, number of hospitalizations and emergency department visits, disability burden, amenability to change and community support.

*/2009/*

***In 2008, 41 LPHA contractors are addressing injury prevention among this population through an improved coordinated system and based on interventions that are evidence-***

*based, field tested or validated by expert opinion.  
//2009//*

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	76.5	91.4	84.1

**Narrative:**

--Baby Your Baby Web site ([www.dhss.mo.gov/babyourbaby](http://www.dhss.mo.gov/babyourbaby)) has information for pregnant women, their families and communities on healthy pregnancies and healthy babies. Topics and links include prenatal care and nutrition, MC+ (Medicaid), WIC, and TEL-LINK that is a toll free information and referral line.

--Campaign ads were developed with the Missouri Broadcaster's Association for messages to promote healthy pregnancy through early and adequate prenatal care. Ads promote the importance of the family history to identify health problems that run in the family which can help doctors better determine the risk of disease among their patients and help motivate them into action to stay healthy.

--The WIC Program prescribes and pays for nutritious foods to supplement the diets of pregnant women, new mothers, infants and children up to five years of age, who qualify as "nutritionally at risk," based on a medical and nutrition assessment and state income and federal poverty guidelines. The WIC Program provides various assistance including medical referrals to health care providers to address the WIC participants needs.

--MCH Coordinated Systems Contracts with LPHAs-Title V funds support LPHAs for the purpose of establishing and maintaining a system capable of addressing adequate prenatal care. Two performance measures were addressed in jurisdictions where the data was most disparate:  
-Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (11 LPHAs); and  
-Decrease the percent of pregnant women receiving inadequate prenatal care (13 LPHAs).

*/2009/*

***In 2008 contracts with LPHAs have been renewed with the focus on the objectives on injury prevention, obesity and tobacco. Local contractors may continue to address the issue of adequate prenatal care within their communities.***

*//2009//*

--Healthy Babies-This initiative provides educational materials through the Web site and printed materials in English and Spanish that promote healthy pregnancies and healthy birth outcomes and encourages early entry into prenatal care. The Web site ([www.dhss.mo.gov/babyourbaby](http://www.dhss.mo.gov/babyourbaby)) will be active through January 2008.

/2009/

**This contract has been renewed through January 2013.**

//2009//

--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

--Genetic Services-Title V partially funds the program's contributions in the reduction of morbidity and mortality associated with genetic disorder. The genetic disease program maintains a referral network that connects Missourians in need of diagnostic treatment, counseling and specialized health services with appropriate health care providers.

--FIMR Development-Funds will continue to be used in supporting and expanding existing FIMR boards/projects in local communities to examine the causes of fetal and infant deaths not examined by the Child Fatality Review Board and to recommend policy, program or systems changes which may reduce the rate of fetal infant mortality and possibly encourage prenatal care in first trimester.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH) programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention and other issues impacting MCH health status.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	67.3	82.7	75.2

**Narrative:**

--Baby Your Baby Web site ([www.dhss.mo.gov/babyyourbaby](http://www.dhss.mo.gov/babyyourbaby)) has information for pregnant women, their families and communities on healthy pregnancies and healthy babies. Topics and links include prenatal care and nutrition, MC+ (Medicaid), WIC, and TEL-LINK that is a toll free information and referral line.

--Campaign ads were developed with the Missouri Broadcaster's Association for messages to promote healthy pregnancy through early and adequate prenatal care. Ads promote the importance of the family history to identify health problems that run in the family which can help doctors better determine the risk of disease among their patients and help motivate them into action to stay healthy.

--The WIC Program prescribes and pays for nutritious foods to supplement the diets of pregnant women, new mothers, infants and children up to five years of age, who qualify as "nutritionally at risk," based on a medical and nutrition assessment and state income and federal poverty guidelines. The WIC Program provides various assistance including medical referrals to health care providers to address the WIC participants needs.

--MCH Coordinated Systems Contracts with LPHAs --Title V funds support LPHAs for the purpose of establishing and maintaining a system capable of addressing adequate prenatal care. Two performance measures were addressed in jurisdictions where the data was most disparate:  
 -Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (11 LPHAs); and  
 -Decrease the percent of pregnant women receiving inadequate prenatal care (13 LPHAs).

*/2009/*

***In 2008 contracts with LPHAs have been renewed with the focus on the objectives on injury prevention, obesity and tobacco. Local contractors may continue to address the issue of adequate prenatal care within their communities.***

*//2009//*

--Healthy Babies-This initiative provides educational materials through the Web site and printed materials in English and Spanish that promote healthy pregnancies and healthy birth outcomes and encourages early entry into prenatal care. The Web site ([www.dhss.mo.gov/babyourbaby](http://www.dhss.mo.gov/babyourbaby)) will be active through January 2008.

*/2009/*

***This contract has been renewed through January 2013.***

*//2009//*

--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

--Genetic Services-Title V partially funds the program's contributions in the reduction of morbidity and mortality associated with genetic disorder. The genetic disease program maintains a referral network that connects Missourians in need of diagnostic treatment, counseling and specialized health services with appropriate health care providers.

--FIMR Development-Funds will continue to be used in supporting and expanding existing FIMR boards/projects in local communities to examine the causes of fetal and infant deaths not examined by the Child Fatality Review Board and to recommend policy, program or systems changes which may reduce the rate of fetal infant mortality.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH) programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention and other issues impacting MCH health status.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
---	-------------	--

<b>pregnant women.</b>		
Infants (0 to 1)	2007	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)	2007	300

**Narrative:**

--October 2003, DHSS was awarded the State Planning Grant from the federal Department of Health and Human Services (HHS) to allow the state to study the issue of the uninsured and to develop a state plan with models and options for increasing access to affordable health insurance coverage for MO residents.

Subsequent to the award of this planning grant, the DHSS/DCPH through a contract with the University of Missouri carried out the Missouri Health Care Insurance and Access Survey that was funded with this grant. The survey of 7,000 households conducted in 2004, revealed that about 8.4% of Missouri residents did not have health insurance at the time of the survey. This percentage reflected almost 463,000 Missourians not covered by health insurance. This survey also revealed that about 64,000 of those without health insurance were primarily children whose families earn 300 percent or less of the federal poverty level and parents who earn 75 percent or less of the poverty level who are eligible for insurance coverage but who for whatever reasons are not accessing that insurance coverage.

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to )	2007	133 100
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to )	2007	300 300

**Narrative:**

--October 2003, DHSS was awarded the State Planning Grant from the federal Department of Health and Human Services (HHS) to allow the state to study the issue of the uninsured and to develop a state plan with models and options for increasing access to affordable health insurance coverage for MO residents.

Subsequent to the award of this planning grant, the DHSS/DCPH through a contract with the University of Missouri carried out the Missouri Health Care Insurance and Access Survey that was funded with this grant. The survey of 7,000 households conducted in 2004, revealed that about 8.4% of Missouri residents did not have health insurance at the time of the survey. This

percentage reflected almost 463,000 Missourians not covered by health insurance. This survey also revealed that about 64,000 of those without health insurance were primarily children whose families earn 300 percent or less of the federal poverty level and parents who earn 75 percent of less of the poverty level who are eligible for insurance coverage but who for whatever reasons are not accessing that insurance coverage.

--Coordination and Systems Development-Title V funds are used to support staff in DCPH to carry out activities related to assessment, policy and program development, quality assurance, contract monitoring and program implementation and coordination. Coordination activities between state and local agencies and data collection, analysis and data processing services are also supported with this funding.

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2007	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2007	185

**Narrative:**

--October 2003, DHSS was awarded the State Planning Grant from the federal Department of Health and Human Services (HHS) to allow the state to study the issue of the uninsured and to develop a state plan with models and options for increasing access to affordable health insurance coverage for MO residents.

Subsequent to the award of this planning grant, the DHSS/DCPH through a contract with the University of Missouri carried out the Missouri Health Care Insurance and Access Survey that was funded with this grant. The survey of 7,000 households conducted in 2004, revealed that about 8.4% of Missouri residents did not have health insurance at the time of the survey. This percentage reflected almost 463,000 Missourians not covered by health insurance. This survey also revealed that about 64,000 of those without health insurance were primarily children whose families earn 300 percent or less of the federal poverty level and parents who earn 75 percent of less of the poverty level who are eligible for insurance coverage but who for whatever reasons are not accessing that insurance coverage.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death	3	No

certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	2	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	2	No

**Notes - 2009**

Program staff and the public have access to data from the annual linkage of birth and infant death certificates through web-based profile tools.

Not linked since 1997. USDA approval needed in order to link WIC data.

Linked births for 2002-2004 and part of 2005 to newborn hearing screening data for 2004 & 2005. Will link 2006 newborn screening data in 2008.

Comprehensive information on hospital discharge data is available to program staff and the public on web-based data query and profile tools.

Annual system was in place. FFY05 CDC grant not funded. Currently not funded for this activity.

Started PRAMS in January 2007. 2007 data will be available sometime in 2008.

**Narrative:**

--The current State Systems Development and Initiative (SSDI) cycle has supported a pilot PRAMS, Missouri Pregnancy Related Assessment and Monitoring System (MoPRA), survey for Missouri. The successful completion of this pilot project has resulted in funding from CDC to support a PRAMS surveillance system in Missouri. PRAMS data (related to attitudes and expectations of mothers who have delivered in last six months) will provide crucial information in formulating MCH program access policy for State of Missouri (HSCI 9A).

--BHI is primary source for health data within the state. BHI oversees the statistical support and health care assurance activities of DHSS; collects, analyzes and distributes health-related information which promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians. To assure uniform and consistent reporting of all Title V related data, DCPH Director's Office works

with ITSD to integrate the eleven core health systems capacity indicators and some of the health status indicators into MOHSAIC.

DHSS Web pages provide access to MCH data through the Community Data Profiles and MICA system. The Community Data Profiles are resource pages that provide information on specific MCH indicators, including a definition of the indicator, risk factors, description of the condition, intervention strategies, state-related programs, community programs and resources, contracts and grants, educational material, studies and reports and other Web sites pertaining to the MCH indicator.

DCPH/ITSD provides continued integration of multiple single purpose databases into a single system which supports a child-centered record. The initial child record is created from birth records for children born in Missouri. DCPH/ITSD supports documentation of services received and/or results of screenings for the child. The system also includes data on immunizations, tuberculosis skin testing, Medicaid status, results of newborn blood spot, newborn hearing screenings results and blood lead level.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	Yes
Pediatric Nutrition Surveillance System (PedNSS)	3	Yes
WIC Program Data	3	Yes
Pregnancy Risk Assessment Monitoring System (PRAMS)	3	No

**Notes - 2009**

**Narrative:**

--Tobacco use among public high school students in Missouri is monitored through the Youth Risk Behavior Survey conducted every odd numbered spring since 1995 by DESE and funded by the CDC Division of Adolescent and School Health. DHSS Tobacco Use Prevention Program conducted for the first time the Youth Tobacco Survey in 2003 with public middle and high school students, funded by CDC Office on Smoking and Health. Results are in a fact sheet on DHSS Web site, [www.dhss.mo.gov/SmokingAndTobacco/youth\\_use.html](http://www.dhss.mo.gov/SmokingAndTobacco/youth_use.html).

The Youth Tobacco Survey was also conducted in 2005 and results are on the Web site given above.

/2008/

Missouri consistently ranks among the highest in the nation in adult and youth smoking prevalence. Among adults, 23.4% smoked in 2005, which was eleventh highest among all States (CDC, BRFSS, 2005). Among youth, 8.3% of middle school and 23.7% of high school students were current smokers in 2005, both slightly above the national average. (DHSS, Youth Tobacco Survey, 2003) Additionally, over one third (35.4%) of middle school students and almost two thirds (62.8%) of high school students have used some form of tobacco product in their lifetime. According to the MoPRA survey conducted by DHSS during 2004-2006, 20.4% of mothers

smoked during the last three months of their pregnancy.

//2008//

--MCH Coordinated Systems Contracts with LPHAs --Many community-based interventions will be focused on youth tobacco prevention.

/2008/

In 2007, 51 LPHA contractors are working to reduce smoking or prevention smoking initiation through the MCH Coordinated Systems contracts.

In 2008, the MCH Coordinated Systems contracts with LPHAs will be renewed with one of the focus areas as preventing tobacco use among adolescents and women. Each contractor will have a contractual obligation to utilize evidence-based interventions. Local system development to address smoking prevention will include community-based interventions and environmental and policy changes to impact the initiation and cessation of smoking in this population.

//2008//

**/2009/**

***In 2008, 23 LPHA contractors are addressing tobacco prevention/cessation among this population through an improved coordinated system and based on interventions that are evidence-based, field tested or validated by expert opinion.***

***CCHC Program reports 14 hours of training to child care providers on the risks/dangers of smoking/second hand smoke and 24 health promotion programs to young children on the same topic in FFY 2007.***

**//2009//**

--Adolescent Health Projects-Title V funding supports the development and implementation of state and community-based projects to promote adolescent health. The Missouri Council for Adolescent and School Health (CASH) advises the department on priorities for adolescent health initiatives. The Council's priority recommendations for potential funding include projects to more comprehensively address adolescent health through positive youth development and evidence-based strategies. Another statewide strategy is adolescent medicine consultation. Provider education is accomplished through the publication and dissemination of a bimonthly newsletter sent to pediatricians, family practice physicians, advanced practice nurses and school nurses. Newsletter articles cover a wide range of adolescent health concerns.

In 2005, CASH developed the MISSOURI STATE FRAMEWORK FOR PROMOTING THE HEALTH OF ADOLESCENTS that sets forth guiding principles relevant and applicable to any health issue that impacts the health of adolescents and supports the HEALTHY PEOPLE 2010 NATIONAL INITIATIVE TO IMPROVE THE HEALTH OF ADOLESCENTS AND YOUNG ADULTS. MCH block grant funding will also support the implementation of the quality improvement plan that will be based on priority needs identified through the SYSTEM CAPACITY ADOLESCENT HEALTH ASSESSMENT and planning process conducted in January 2006.

**/2009/**

***A DHSS Adolescent Health Leadership Team has been established and merged with CASH to address priority needs identified through the ADOLESCENT HEALTH SYSTEM CAPACITY ASSESSMENT. MCH block grant funding supports the implementation of the quality improvement plan.***

**//2009//**



## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

The Missouri Title V Block Grant Performance Measurement System schematic follows the MCHB system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. Like other states receiving Title V MCH Block Grant funding, Missouri must meet the following requirements:

- Conduct a statewide needs assessment every five years that identifies the need for:
  - Preventive and primary care services for pregnant women, mothers and infants up to age one year;
  - Preventive and primary services for children;
  - Family-centered, community-based services for children with special health care needs and their families; and
  - Review of data and sources of information used to construct the needs assessment.
  
- For each fiscal year, Missouri and other Title V funded states, will:
  - Describe how Title V funds allotted to the State will be used for the provision and coordination of MCH services;
  - Assure "maintenance of effort" (i.e., State will maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level provided in FFY 1989);
  - Use at least 30 percent of Federal MCH Block funds received for preventive and primary care services for children; and
  - At least 30 percent of Federal MCH Block Grant funds received for services for children with special health care needs.

Accountability for Title V MCH Block Grant funding awarded, is also achieved through:

- Measuring the progress towards successful achievement of each individual performance measure;
- Having budgeted and expended dollars spread over all four of the recognized MCH services: direct health care, enabling services, population-based services and infrastructure building services and;
- Having a positive impact on MCH outcome measures.

Missouri's priority needs are discussed in Section II, Needs Assessment (5. Selection of State Priority Needs) and Section IV. B, State Priorities. National and State Performance measures are examined in Section II as well as in Section IV. C and D.

/2007/

For the entire 2005 Needs Assessment, go to:

<https://perfddata.hrsa.gov/mchb/mchreports/documents/NeedsAssessments/2006/MO-NeedsAssessment.pdf>

Section II of this 2007 application/2005 report has an attachment with an update to the matrix of the comparison of the performance measures, health systems capacity indicators and state priorities that was included in the Needs Assessment.

//2007//

The MCH pyramid of "Core Public Health Services Delivered by MCH Agencies" by levels of service serves as a guide for the Missouri pyramid of services.

The two pyramids and the lists of Missouri's 10 priority needs, the 6 mandated national outcome measures, the 18 national performance (NP) measures and the state performance (SP) measures are in the document attached to this Section IV. A. The file also contains a listing of the

Health Systems Capacity Indicators (HSCIs) and Health Status Indicators (HSI).

The NP and SP measures are also listed in Tables 4a and 4b that identify the specific pyramid level of service and the key activities for each.

The NP measures are examined in Section IV. C. Also, Form 11 has the report on Missouri's status relative to the 18 NP measures and Missouri's five-year objectives relative to each of these. See Section VII for the NP and SP measure detail sheets.

In FFY 2005, DHSS/DCH completed a five-year MCH needs assessment identifying the need(s) for:

- Preventive and primary care services for pregnant women, mothers and infants;
- Preventive and primary care services for children; and
- Services for children with special health care needs (CSHCN).

This assessment included but was not limited to the following methods:

- Review of Missouri state profiles compiled by HRSA, CDC and AMCHP to ascertain external perspectives of MCH needs in Missouri;
- Qualitative primary data generated through 12 focus groups conducted throughout Missouri divided into client (user) group and provider or agency group;
- Review of CHART survey of local coalition members, state and county profiles (with selected MCH indicators and related priorities) generated by the CHIME and local public health priorities formulated by the CLPHS;
- MCH population group(s) forecasts developed from demographic data drawn from the U.S. Census and from analysis provided by the Missouri State Demographer's Office;
- A composite analysis of selected MCH indicators to compare (county by county) the relative MCH health status of women and children living in different geographical regions in Missouri: infant mortality; unintended pregnancies (teenage pregnancies); tobacco use among mothers during pregnancy; STDs among women of childbearing age; abortions; obesity; percentage of MCH population groups with insurance coverage;
- Data provided by the DSS, DMH, MPCA and other professional associations concerning the infrastructure capacity (in Missouri) to deliver basic health services to MCH population groups;
- Nominal group process used by selected MCH stakeholders to suggest possible MCH priorities for Missouri; stakeholders reviewed a draft version of the assessment presented in this application, reflected upon their own experiences and developed a ranking of needs that captured the collective thinking of the group; and
- An MCH priority setting methodology developed by the Office of Epidemiology and CHIME (MICA priorities) was constructed and applied to data collected for MCH population groups in Missouri.

See Section II, Needs Assessment, for further details.

See Table 4b in D. State Performance Measures of Section IV Priorities, Performance and Program Activities and Form 16, State Performance Measure Detail Sheets, for descriptions of the state selected measures that includes their category on the pyramid, the Missouri goal, the measure used, how the measure is defined, the measure's relationship to Healthy People 2010 (if applicable), data sources and data issues and the significance of the indicator or why this particular indicator was chosen.

***An attachment is included in this section.***

## **B. State Priorities**

### **B.1. RELATIONSHIP AMONG PRIORITIES, PERFORMANCE MEASURES and HEALTH SYSTEMS CAPACITY INDICATORS**

MO is transitioning from MCH resources (including MCH block funding) now supporting MCH priority needs identified in 2000 to realigning MCH resources to support MCH priority needs identified in MO MCH Five Year Needs Assessment.

#### 2000 MCH Priority Needs

- Healthcare Access
- Prevention of Smoking Among Children and Adolescents
- Reduction of Unintended Pregnancies
- Reduction of Child Abuse and Neglect
- Minority Health Disparities
- Expanded MCH Information Systems

#### 2005 MCH Priority Needs

- Early Childhood Development and Education
- Improve Access to Care
- Reduce and Prevent Oral Health Conditions
- Improve Mental Health Status of MCH Population
- Reduce Obesity Among Children, Adolescents and Women
- Reduce Disparities in Birth Outcomes
- Prevent and Reduce Smoking
- Reduce Intentional and Unintentional Injuries
- Enhance Environmental Supports/Policy Development for Prevention of Chronic Disease
- Reduce Interpersonal/Domestic Violence in MCH Populations

MO 2005 MCH Five Year Needs Assessment details state MCH capacity available to support newly identified MCH priorities which will establish framework for allocation of Title V MCH funding for priority need areas not already receiving adequate support, such as early childhood development, prevention of smoking and reduction of obesity. Overriding MCH need for Missouri was to improve access to care.

## B.2. DIRECT SERVICES AND ENABLING SERVICES

DHSS is addressing access to care and reduction and prevention of oral health conditions through OPCRH to ensure access to primary health care services for all populations.

*//2009/*

***PSP provides oral health surveillance, education and preventive services to children under 18, through community-based system of care including representation of all aspects of community and health care delivery system. Core components include community governance coalition, dental referral system, standardized screening/surveillance methodology and provision to participating communities of fluoride varnish, screening forms and supplies, data analysis and oral health educational materials.***

*//2009//*

Access to health care services in MO is contingent on more than adequate health insurance. Health insurance plans or managed care plans provide "paper benefits" and must be coupled with adequate supply of qualified health practitioners in all regions and infrastructures to reduce geographical or cultural barriers. Some barriers are due to lack of resources, such as community clinics, medical equipment and practitioners and to disparity of health resources in underserved areas.

DHSS/DCH, through UM contract, carried out in 2004 Missouri Health Care Insurance and Access Survey of 7,000 households, showed:

- about 8.4% (almost 463,000) did not have health insurance at time of survey
- about 64,000 without health insurance were primarily children whose families earn 300% or less of FPL and parents who earn 75 % or less of poverty level who are eligible for insurance

coverage but who are not accessing insurance coverage.

Outside of I-70 corridor, 68% of MO counties are not covered by Medicaid managed care plans and many have few if any practitioners who accept Medicaid.

93% MO counties are designated as Health Professional Shortage Areas (HPSA) for primary medical care services.

33.9% have FQHCs in operation that can serve persons with no insurance or who live in area with providers that will not accept Medicaid.

85% are designated as Dental HPSAs.

/2007/

See MC+ Managed Care Web site.

//2007//

**/2009/**

**For MO HealthNet Managed Care (formerly MC+ Managed Care) see**

**<http://www.dss.mo.gov/mhd/mc/index.htm>**

**//2009//**

Based on information from Child and Adolescent Health Measure Initiative, Data Resource Center on Children and Youth with Special Health Care Needs, December 2004, Missouri reported dental care (9.8%), mental health care (13.6%) and specialist care (7.0%) as needed by CSHCN but did not received.

**/2009/**

**According to NSCSHCN 2005-06, of CSHCN in MO who needed specific health care services, but did not receive all the care they needed accounted for 10% for preventive dental care, 9.3% for mental health care, and 3.8% for specialist care.**

**//2009//**

Based on unweighted estimates from Behavioral Risk Factors Surveillance System (BRFSS), 2004:

--6.7% of MO households with children reported having one or more children under 5 currently has asthma

--12.8% of households with children reported having one or more children 5 to 17 years of age currently has asthma.

American Academy of Allergy, Asthma and Immunology and Asthma and Allergy Foundation of America ranked 100 largest metropolitan areas by asthma severity based on prevalence, risk factors and medical factors. St. Louis was ranked 3rd; Kansas City 8th.

**/2009/**

**Based on National Survey of Children's Health in 2003 of MO's children:**

**--11.5% under 18 ever had doctor-diagnosed asthma, compared with 12.1% nationwide**

**--among those ever having asthma, 68.7% experienced one or more asthma-related health issue in past 12 months, compared with 66.9% nationwide.**

**Lifetime asthma prevalence among MO children increased by age:**

**--7.8% for 0-5 years**

**--11.5% for 6-11 years**

**--14.9% for 12-17 years**

**According to MO BRFSS conducted in 2006, estimated 15.9% lifetime and 11.7% current**

**asthma prevalence was among children under 18.**

**NOTE: Childhood asthma prevalence for 2003 and 2006 were obtained from two different data systems and may not be comparable.**

**//2009//**

Among enabling programs to address issues are home visiting, CSHCN Hope Program, WIC, CSHCN Service Coordination, FP and HCY.

### B.3. POPULATION-BASED SERVICES

Interpersonal/Domestic violence (DV) against women affects all economic, educational, cultural, racial and religious lines. In 2000, 37,898 DM cases were reported to MO law enforcement; 50 of 88 women murdered were attributed to DV. In 2001 of female high school students, 10% reported having been forced to have sexual intercourse; almost 9% reported being hit, slapped or physically hurt on purpose by their boyfriend in past 12 months.

*/2007/*

DV cases reported to law enforcement in 2004 totaled 39,097 with 51 DV homicides in 2004. Per 2003 YRBS, 13.1% high school girls reported having been forced to have sexual intercourse. 8.5% high school students reported being hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend in past 12 months.

*//2007//*

*/2008/*

In 2005 in MO:

--39,851 DV cases were reported to law enforcement, 6.9 per 1,000 residents (slightly up from 6.8 cases per 1,000 in 2000) (Missouri Uniform Crime Reporting Statistics)

--estimated 10.9% female high school students (14,617 students) reported having been forced to have sexual intercourse

--estimated 8.3% female high school students (11,209 students) reported being hit, slapped or physically hurt on purpose by their boyfriend in past 12 months (CDC, YRBS 2005).

*//2008//*

*/2009/*

***In 2007 in MO:***

***--37,215 DV cases were reported to law enforcement, 6.4 per 1,000 residents (Missouri Uniform Crime Reporting Statistics)***

***--14% females and 6.6% males reported ever having been physically forced to have sex***

***--9% female and 12% male high school students reported being hit, slapped or physically hurt on purpose by their boyfriend or girlfriend in past 12 months (CDC, YRBS 2007 survey of 1,561 students in 23 Missouri public high schools in grades 9-12.)***

*//2009//*

Reduction and prevention of smoking is priority in MO which is ranked 10th in 2003 out of 31 states participating in YRBS that included question regarding smoking cigarettes on 1 or more days in past 30 days in 2003. Missouri 2003 Youth Tobacco Survey conducted by DHSS June 2003, determined 43.5% middle school students and 65.8% high school students have used some form of tobacco product in their lifetime. Smoking among pregnant females aged 15-19 was 27.2% in 2001-2002 and overall smoking during pregnancy ranked Missouri 8th highest among all states.

*/2007/*

MO consistently ranks among highest in nation in adult and youth smoking prevalence. Among adults, 23.4% smoked in 2005 which was 11th highest among all states (CDC, BRFSS, 2005).

Among youth, 8.3% middle school and 23.7% high school students were current smokers in 2005, both slightly above national average. (DHSS, Youth Tobacco Survey, 2003)

35.4% middle school students and 62.8% high school students have used some form of tobacco product in their lifetime.

There is no statistical difference between MO teenagers who smoked during pregnancy in 1995 and 2004.

//2007//

/2008/

According to MoPRA survey conducted by DHSS during 2004-2006, 20.4% mothers smoked during last 3 months of pregnancy.

In 2007, MCH Coordinated Systems contracts have 51 LPHA contractors working on community-based initiatives related to smoking prevention or cessation.

In 2008, MCH Coordinated Systems contracts with LPHAs will be renewed with one of the focus areas as preventing tobacco use among adolescents and women. Each contractor will have contractual obligation to utilize evidence-based interventions. Local system development to address smoking prevention will include community-based interventions and environmental and policy changes to impact initiation and cessation of smoking in this population.

//2008//

/2009/

**MO consistently ranks among highest in nation in adult smoking prevalence. Among adults, 23.2% were current smokers in 2006, 11th highest among all states (CDC, BRFSS, 2006).**

**34.6% middle school students and 58.9% high school students have used some form of tobacco product in their lifetime.**

**According to YRBS, smoking prevalence among MO high-school students steadily declined from 40.3% in 1997 to 21.3% in 2005 though slightly increased to 23.8% in 2007. Smoking prevalence in MO in 2005 (most recent data available for both MO and U.S.) was slightly lower than national figure (21.3% vs. 23%).**

**There has been steady decline in smoking prevalence from 14.9% in 1999 to 6.9% in 2007 based on DHSS Youth Tobacco Survey conducted of middle school students,**

**CCHC provided in FFY 2007 14 hours of adult education on risks of smoking/second hand smoke and 24 health promotion programs to young children on risks of smoking/second hand smoke.**

//2009//

Reduction in obesity among children, adolescents and women is a priority. In 2002 overweight rate for children 2-5 years participating in WIC was 12%, 18th highest overweight level in nation. Data from MO School-Age Children Health Service Program for 5th graders show 18.5% are overweight. Prevalence of overweight in children in grades 6-8 was 15.9% in 2003, up from 9.1% in 1999. In 2002 prevalence of overweight high school students was 12%. During last 10 years, obesity rate among pregnant women in Missouri has increased from 13.8% in 1993 to 21.3% in 2003.

/2007/

MO Facts About Overweight among Missouri Children and Adolescents

--12.0% of children participating in WIC are overweight (CDC. 2003. PedNSS Reports.)

--22.8% of elementary school students participating in Missouri School-aged Children Health Service Program are overweight (Missouri Department of Health and Senior Services. Dietary

Intake and Physical Activity Summary Report. MO School-Age Children's Health Services Program School Year 2002-2003.)

--14.5% of middle school students are overweight

--13.6% of high school students are overweight

(Missouri Department of Health and Senior Services. 2005. Youth Tobacco Survey.)

Obesity rate among pregnant women in MO increased from 14.6% in 1994 to 15.4% in 1995; and from 22.2% in 2004 to provisional 2005 rate of 22.4%.

//2007//

/2008/

--13.8% of children aged 2-5 years participating in WIC are overweight

(PedNSS Reports, 2004.)

--13.9% ( $\pm 2.4\%$ ) of high school students are overweight (CDC, YRBS 2005.)

Overweight rate among pregnant women increased from 35.2% in 2000 to 38.5% in 2005 (Birth MICA).

/2009/

**--13.6% of children aged 2-5 years participating in WIC are overweight (PedNSS Reports, 2006.)**

**Prevalence of overweight in MO in 2007 was 11.9% among middle school students and 12.3% among high school students (DHSS, Youth Tobacco Survey, 2007.)**

**Overweight rate among pregnant women has increased from 35.2% in 2000 to 39.0% in 2006 (Birth MICA).**

//2009//

In 2007 14 MCH coordinated system contracts related to youth obesity prevention with community interventions aimed at preschool through middle schools students and prenatal WIC clients.

In 2008 MCH Coordinated Systems contracts with LPHAs will be renewed with one of the focus areas to reduce obesity in MCH population.

//2008//

/2009/

**In 2008, 48 LPHAs are addressing reducing obesity in MCH populations.**

**In FFY2007 CCHC delivered obesity prevention education through 293 hours of group education on socializing healthy nutritional habits in young children to 1,827 child care providers and young parents and 256 hours of group education on socializing healthy physical activity habits in young children to 1,472 child care providers and young parents. 23 hours on-site consultation and 336 health promotion programs to young children on same topics were provided.**

//2009//

Reduction in disparities in birth outcomes is included as a priority due to disparities between African-Americans and whites.

Neonatal death rate per 1,000:

African-American: 10.8; White: 4.1

Pre-term birth rate per 1,000:

African-American: 17.4; White: 9.5

Low birth weight rate per 1,000:  
African-American: 13.3; White: 6.8  
(DHSS Community Data Profiles, 2000-2002)

/2007/  
For 2004:

Neonatal death rate (Birth MICA and Vital Statistics):  
African-American: 9.1; White: 4.2

Pre-term birth rate (Birth MICA):  
African-American: 20.2; White: 12.1

Low birth weight rate (Birth MICA):  
African-American: 14.0; White: 7.3  
//2007//

/2008/  
For 2005:

Neonatal death rate per 1,000 live births (Birth MICA and Vital Statistics):  
African-American: 9.5; White: 3.9

Pre-term birth rate per 100 (Birth MICA):  
African-American: 20.5; White: 12.5

Low birth weight rate per 100 (Birth MICA):  
African-American: 14.4; White: 7.0  
//2008//

**/2009/  
For 2006:**

**Neonatal death rate per 1,000 live births (Birth MICA and Vital Statistics):  
African-American: 10.1; White: 3.9**

**Pre-term birth rate per 100 (Birth MICA):  
African-American: 19.3; White: 12.0**

**Low birth weight rate per 100 (Birth MICA):  
African-American: 13.6; White: 7.1  
//2009//**

Based on MO Child Abuse and Neglect (CA/N) Calendar Year 2003 Annual Report, number of children reported as victims of child abuse or neglect in 2003 was 54,581 in 35,452 reported incidents. Of 9,712 confirmed as abused or neglected, neglect accounted for 44.9%; physical abuse 24.5%; and sexual abuse 23.9%. 37.5% of abused and neglected children were under 6. Of abused and neglected fatalities, 80% were under 6.

/2007/  
2004 total hotline reports of child abuse:  
--56,169 reports involving 85,133 children  
--9,262 cases of substantiated abuse of which 47.1% were neglect; 25.2% physical abuse; and 22.7% sexual abuse  
--73.2% of fatal child abuse occurred to children under 6  
--36.7% of non fatal child abuse occurred to children under 6

--87.5% of child abuse were perpetrated by somebody known to the child  
--12.5% were stranger abuse  
//2007//

/2008/

Based on CA/N Calendar Year 2005 Annual Report, children reported as victims of child abuse or neglect in 2005 was 80,577 in 54,108 reported incidents. Of 8,158 confirmed as abused or neglected, neglect accounted for 47.9%; physical abuse 25.8%; and sexual abuse 24.1%.

Among victims of abuse and neglect 36.3% were less than 6. Of 32 abuse and neglect fatalities, 81.3% were under 6.

NOTE from Report: All counts of children are duplicated because a child may be reported more than once during the year.

//2008//

**/2009/**

**Based on CA/N Calendar Year 2006 Annual Report, children reported as victims of child abuse or neglect in 2006 was 75,474 in 51,383 reported incidents. Of the 7,222 confirmed as abused or neglected, neglect accounted for 41.5%; physical abuse 31.2%; and sexual abuse 22.4%.**

**Among victims of abuse and neglect, 35.3% were less than 6. Of 27 abuse and neglect fatalities, 81.5% were under 6.**

**NOTE from Report: Counts of children are duplicated because a child may be reported more than once during the year**

**FFY 2007 CCHC delivered 38 hours of training to child care providers on recognition and prevention of child abuse. 55 programs were provided to young children on prevention of child abuse.**

**//2009//**

Based on DHSS "Injuries in Missouri: A Call to Action", December 2002, Missouri exceeded U.S. average in 3 of 5 leading causes of premature death among MCH populations: motor vehicle-related fatalities; suicides; and deaths caused by firearms. In 1998 15-19 year olds had high rate of death due to motor vehicle accidents. Death rate among 15-24 year olds due to motor vehicle accidents in 2003 was 37.3 per 100,000, DHSS MICA.

/2007/

2004 rates for unintentional motor vehicle injuries and deaths for 15-24 year olds:  
--224.5//100,000 population for injuries related to non-fatal motor vehicle traffic crashes  
--37.5/100,000 were deaths from motor vehicle crashes.

//2007//

/2008/

2005 rates for unintentional motor vehicle injuries and deaths for 15-24 year olds:  
--215.4/100,000 injury hospitalizations related to non-fatal motor vehicle traffic crashes  
--40.6/100,000 deaths from motor vehicle crashes.

//2008//

**/2009/**

**2006 rates for unintentional motor vehicle injuries and deaths for 15-24 year olds:  
--213 per 100,000 injury hospitalizations related to non-fatal motor vehicle traffic crashes  
--36.1/100,000 deaths from motor vehicle crashes  
(Injury MICA and Death MICA).**

***FFY 2007 CCHC provided 21 hours of group education to child care providers on child passenger safety; 50 hours on injury prevention in child care; 91 hours on emergency preparedness; 18 hours on poison prevention; and 14 hours on safe sleep. 283 programs were provided to young children on injury prevention topics.***

***//2009//***

Priorities are being addressed by programs such as Injury and Violence Prevention, MCH (Local Agency) Services, School Health, Nutrition and Obesity Education and Folic Acid and Healthy Babies Education.

***/2009/***

***Also, Adolescent Health Program, and Missouri Department of Transportation Traffic Safety Youth Committee and partners.***

***//2009//***

***/2007/***

Through contracts with state and community-based initiatives, LPHAs provide array of population-based services to help address many of these priority need areas.

***//2007//***

***/2008/***

In 2007 24 local MCH coordinated systems contracts with local agencies addressed motor vehicle deaths, unintentional injury and/or suicide.

In 2008 MCH Coordinated Systems contracts with LPHAs will be renewed with 3 MCH health issues addressed. Reducing Intentional and Unintentional Injuries will be focus of some contracts with population-based services and community initiatives addressing injury prevention in MCH population.

***//2008//***

***/2009/***

***In 2008 41 LPHAs are addressing intentional and unintentional injuries in their MCH Coordinated Systems contracts.***

***//2009//***

#### B.4. INFRASTRUCTURE SERVICES

Infrastructure building services encompass centralized data collection system and surveillance systems and research. Collection, management and dissemination of data on MCH health status, outcomes, process and structure develop effective and accountable delivery system serving MCH populations. Customized data systems track national and state MCH performance measures. MCH health status indicators are integrated in data systems already supported by CHIME partnerships with managed care plans to track and analyze best practice MCH indicators, a crucial element of Missouri's evolving MCH electronic information system.

Also included in coalitions, surveillance systems and networks providing data and research are ECCS Coalition, MCH Information Systems, MICA, PedNSS, PNSS, PRAMS, FAS Surveillance System, Infant Morality and Healthy Birth Outcomes research, MCH epidemiological services, women's health networks and continuous quality improvement teams.

***/2007/***

BHI continues the partnerships.

***//2007//***

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	92.4	99.2	96.2
Numerator	79	73	85	127	101
Denominator	79	73	92	128	105
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

#### Notes - 2007

Decreasing percentages since 2005 are partially attributed to the increased number of conditions screened and the complexity of the follow up testing that leads to diagnosis which may require several months for completion.

#### Notes - 2005

Higher no. of screen positive newborns in 2005 due, in part, to addition of tandem mass spectrometry screening tests on Jul 1, 2005 (leading to 6 confirmed positive screening tests - see Form 6).

#### a. Last Year's Accomplishments

A Web-based electronic birth certificate was being developed which will include newborn hearing and metabolic and other screening of newborns. This will facilitate the ability to see completeness of screening by hospital on a more timely basis. The project is scheduled for implementation on January 1, 2010.

The Newborn Screening Program continued to work with ITSD to improve the current data management and report system to allow reliable statistics based upon all metabolic newborn screen results in the system.

DHSS continued to contract with the four genetic tertiary centers to support infrastructure for a statewide program of genetic services that includes follow up of babies with abnormal screens.

In addition DHSS continued to contract with the four accredited cystic fibrosis care centers and hemoglobinopathy resource centers to follow-up on babies with an abnormal newborn screen result.

The new State Public Health Laboratory (SPHL) was completed in the summer of 2007 and the Newborn Screening Laboratory moved into the building. A pilot to screen for cystic fibrosis began on January 8, 2007, and cystic fibrosis was added to the newborn screening panel on June 1, 2007. It is anticipated that biotinidase deficiency will be added to the newborn screening panel in late 2008.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All infants born in Missouri are screened for 28 of the 29 disorders recommended by the American College of Medical Genetics and the March of Dimes		X	X	
2. Provision by Genetic Tertiary Centers in four university-affiliated medical schools of genetic diagnostic evaluations and counseling, genetic screening and genetic education		X	X	
3. Web sites for Newborn Screening		X	X	X
4. Provision by the four nationally accredited cystic fibrosis care centers in Missouri to provide confirmatory testing for CF, education, counseling and follow-up to assure newborns are receiving appropriate care		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

It is anticipated that a pilot to screen for biotinidase deficiency will start in the fall of 2008. If the pilot is successful it will be added permanently to the newborn screening panel at the end of calendar year 2008. With the addition of biotinidase deficiency to the screening panel, Missouri's newborn screening program will be compliant with the 29 conditions recommended by the American College of Medical Genetics and the March of Dimes.

Screening newborns for severe combined immunodeficiency syndrome (SCID) was discussed at both the Newborn Screening Standing Committee and the Genetic Advisory Committee. At least two St. Louis area hospitals are interested in participating in a pilot with additional blood spots being sent to Cardinal Glennon Memorial Hospital for Children which would compile the regional results.

The program continues contracting and partnering with the four genetic tertiary centers for tracking, follow-up and consultation on abnormal newborn screens. This partnership has been very successful and has resulted in increased communication among those health care providers who provide treatment for these infants and children.

The program also continues contracting with the four nationally accredited cystic fibrosis care centers in Missouri for confirmatory testing and follow-up of newborns with CF as well as contracting with the adult and pediatric hemoglobinopathy centers for those identified with sickle cell disease or trait.

**c. Plan for the Coming Year**

It is anticipated that a pilot to screen for biotinidase deficiency will start the fall of 2008. If the pilot is successful biotinidase deficiency will be added permanently to the newborn screening panel at the end of 2008. With the addition of biotinidase deficiency to the screening panel, Missouri's newborn screening program will be compliant with the 29 conditions recommended by the American College of Medical Genetics and the March of Dimes.

Screening newborns for Severe Combined Immunodeficiency Syndrome (SCID) was discussed

at both the Newborn Screening Standing Committee and the Genetic Advisory Committee. At least two St. Louis area hospitals are interested in participating in a pilot, which could mean additional blood spots would be sent to Cardinal Glennon Memorial Hospital for Children and this hospital would compile the regional results. A determination has not been made as yet.

The program will continue contracting and partnering with the four genetic tertiary centers for tracking, follow-up and consultation on abnormal newborn screens. This partnership has been very successful and has resulted in increased communication among those health care providers who provide treatment for these infants and children.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	59.5	61.8	64.1	57.2	57.2
Annual Indicator	57.2	57.2	64.1	64.1	64.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	64.5	64.7	64.9	65.1	65.3

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey, and data were comparable across the two time periods

Only two points of data are available, which prevent capacity of performing trend analysis. The 2005-2006 percentage in Missouri (64.1%) was close to the 90th percentile state level of 64.2%. An annual increase of 0.2% was chosen starting from 2006 to create 2008-2012 objectives, based on past performance 2001 and 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May, 2008: The data in 2006 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC in 2005-2006.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2006-2010 annual performance objectives have been conservatively held at 57.2%. The data for this performance measure is based on the most recent SLAITS survey, which was conducted during 2000-2002. Until more recent data becomes available from the 2005-2006 SLAITS survey, we're not in a position to make future projections for the 2006-2010 annual performance objectives.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

#### **a. Last Year's Accomplishments**

SHCN:

--maintained MO Assistive Technology contract (monitored to assure quality) to improve access and independence of CSHCN. Participants partnered in decisions related to assistive technology services.

--maintained CSHCN Service Coordination Contracts (monitored to assure quality).

Comprehensive Assessment Tools (CATs), Service Plans and Transition Plans were completed through collaboration with participants. SHCN trained, mentored and provided technical assistance opportunities for contract agency staff. SHCN streamlined and improved clarity and accountability of Scopes of Work (SOWs) for the contracts yet maintained integrity of services. Increased MCH Block Grant funding for financial support for contracts ensured successful partnerships with contractors.

--utilized electronic CAT database for statewide data collection consistent with federal data collection and included components to assess if participants were satisfied with services. SHCN will be integrating CAT data into all-inclusive participant database.

--met participant needs; provided culturally competent services and trained contract agency staff to better serve participants. Translated publications enabled non-English speaking people to obtain program and service information. SHCN monitored Missouri demographics to continue addressing translation/interpreter issues and participate in events to increase knowledge of cultural diversity, i.e., planning meeting for American Indian Council Symposium, West Central Multicultural Forum, Ozark Regional Alliance meeting, Annual Ethnic Festival, Vietnamese Community Center, Community Works, Cross Cultural Interpreter training.

--maintained contract (monitored to assure quality) with LPHA to administer Family Partnership Initiative and build support network for family members providing input on specific special needs issues. Family Partners provided outreach activities encouraging Family Partnership participation resulting in increased participation. SHCN participated in various family focused coalitions.

--continued Record Review process with programs implemented through SHCN employees to include components of family participation and satisfaction.

--recruited health care professionals to assure participant satisfaction. SHCN staff trained in GIS mapping to identify participant and provider needs. Provider Fact Sheet provided participants with information to obtain adequate providers and improve satisfaction.

--continued to promote staff participation in professional development by utilizing presentations about SHCN programs and services; continued SHCN Training Academy requirements to promote staff participation in professional development, creating educated, efficient workforce to improve participant services and satisfaction.

--participated in emergency preparedness activities to ensure SHCN populations are considered. SCs contacted participants/families after significant weather events to assure participant safety and disaster planning was successful; provided American Red Cross (ARC) Disaster Preparedness Booklets to SHCN participants; partnered with participants in completion of plans and discuss emergency preparedness with participants/families.

Family Care Notebook was updated and revised based on feedback received from participants/families. Statewide electronic version was maintained and distributed. Notebook categorizes medical information about community-based service systems and assists families in locating appropriate services that best meet their needs.

Missouri Child Care Resource and Referral Network (MOCCRRN) assisted 1,136 families with CSHCN in finding and maintaining child care that meets each family's needs and collected data regarding family's satisfaction with services. Child Care Health Consultation (CCHC) Program provided on-site consultation to support all other child care health consultation efforts, including educating child care providers on care of CSHCN. CCHC and MOCCRRN trained child care providers and parents to accomplish goals of health needs and inclusion services.

School Health Services in 2006 collaborated with UM Medical Center and Missouri School Board's Association to develop a DVD/CD for use by school health professionals and school educators on managing children in school setting with diabetes, epilepsy or asthma. School Health Services also partnered with Sickle Cell program to develop and disseminate an Educator's Guide to Children with Sickle Cell Disease.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assistive Technology for CSHCN	X	X		X
2. Comprehensive Assessment Tool (CAT)		X		X
3. Cultural Competency Education and Translated Publications		X		X
4. Family Partnership Initiative (support network for family members)		X		X
5. Provider Recruitment and Provider Fact Sheet		X		X
6. Service Coordination for individuals with special health care needs and Service Coordination Competency		X		X
7. SHCN Staff Training Requirements		X		X
8. Inclusion Specialist and families work together to find appropriate child care for children with SHCN		X		
9. Child Care Health Consultation provided consultation and education to child care providers on the care of children with SHCN		X	X	
10. DVD/CD developed for use by school health professionals and school educators on managing children in the school setting with diabetes, epilepsy or asthma				X

**b. Current Activities**

SHCN continues to:

- maintain and monitor contracts for MO Assistive Technology; CSHCN service coordination; Family Partnership Initiative.
- provide culturally competent services and training and activities as described above.
- participate in family-focused coalitions.
- conduct Record Review process.
- recruit health care professionals; distribute Provider Fact Sheet and develop/utilize GIS tools.
- require staff training to promote professional development and education; revise processes for operational effectiveness and efficiency.
- participate in emergency preparedness activities.
- maintain Family Care Notebook.

MOCCRRN continues to assist families with CSHCN in finding and maintaining child care; collect data regarding families' satisfaction with services. Parent Central is electronic resource to share information with over 70,000 parents. Inclusion Specialists provide child care providers with technical assistance on inclusive care. CCHC provides child care providers on-site consultation and education on care of CSHCN and assists in creation of individualized health plans for CSHCN and development of policies around care of CSHCN.

School Health Services continues to require Individualized Healthcare Action Plans (IHAP) for students with significant SHCN in need of specialized procedures. It serves as written agreement with student's parent/guardian, health care provider and school personnel. Program tracks number of plans developed for CSHCN.

### **c. Plan for the Coming Year**

MOCCRRN will assist families with CSHCN in finding and maintaining child care that meets each family's needs and to collect data regarding families' satisfaction with services provided. Efforts address state priority needs of supporting early childhood development and education, improving mental health of MCH populations and reducing intentional/unintentional injuries among infants, children and adolescents.

CCHCs will provide education and consultation to child care providers and parents of children in child care on care of CSHCN and assist child care providers to create individualized health plans for CSHCN and child care policies as indicated.

SHCN will:

- maintain and monitor MO Assistive Technology, CSHCN service coordination and Family Partnership Initiative contracts.
- provide culturally competent services and activities described above.
- participate in family-focused coalitions.
- conduct Record Review.
- require staff training to promote professional development and education; revise processes for operational effectiveness and efficiency.
- participate in emergency preparedness activities.
- maintain Family Care Notebook.
- integrate CAT data into participant database and continue statewide data collection.
- begin Phase 2 of statewide electronic database enhancement to focus on Financial Management.
- recruit health care professionals and distribute Provider Fact Sheet.
- develop skills and utilize GIS tools.
- collaborate with UMKC on State Implementation Grants for Children and Youth with Special Health Care Needs (CYSHCN) to implement statewide plan of integrated services at individual, community and state levels. Goal is to improve and sustain access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families.
- collaborate with UMKC on Family-to-Family Health Information and Education Center to build significant partnerships between consumers, families and professionals to include addressing needs of families from diverse racial, ethnic and cultural backgrounds. Goal is to provide information, training and personal support to families of CYSHCN and professionals through partnerships to create improved access to healthcare, positive health outcomes, successful transitions and improved quality of life.

School Health Services has new performance measure to increase the percent of children with chronic conditions/special health care needs that participate in the development of individualized health care plans to address mutually desired goal(s). Plans are developed by the School Nurse in collaboration with parents and health care provider when appropriate. This year, School Nurses will receive training on writing measurable goals, finding evidence-based practices and health literacy. School Health Services serves nearly 50% of the schools in Missouri.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	56.7	58.6	59.6	60.6	61.6
Annual Indicator	55.7	55.7	51.8	51.8	51.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	52.2	52.4	52.6	52.8	53

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Trend analysis cannot be conducted until we have future data available. The 2005-2006 percentage in Missouri (51.8%) was close to the 75th percentile state level of 51.6%. An annual increase of 0.2% was chosen starting from 2006 to create 2008-2012 objectives, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

**a. Last Year's Accomplishments**

SHCN:

--completed CATs with SHCN participants; the CAT is a comprehensive view of participant needs and contains criteria to identify whether the participant has a medial home (MH), consistent with the MCHB definition of MH. If it is determined the participant does not have a MH, MH educational materials are provided to the family to ensure coordinated, ongoing, comprehensive care for SHCN participants.

--utilized electronic CAT database for statewide data collection consistent with federal data collection, and included components to assess if participants were satisfied with services. SHCN will be integrating CAT data into an all-inclusive participant database.

--continued Record Review process with programs implemented through SHCN employees that

include MH components.

--promoted MH philosophy through education and training opportunities; the MH Fact Sheet was distributed through the SHCN Web site, the Family Care Notebooks and at health fairs/conferences.

--completed Reynolds County Health Center contract that implemented MH initiative. Grant funding through Missouri Foundation for Health (MFH) was used to promote and maintain the MH contract.

Referral network for genetic services continued 4 contracts with genetic tertiary centers.

School Health Services tracked number of: completed referrals for hearing and vision screenings and children with dental provider and dental examination within last 12 months and used School Nurses, Social Workers and SHACs to address barriers to referral completion in local communities. 5,878 vision referrals were completed; 1,477 school children received professional follow-ups related to failed hearing screenings; 9,956 children were referred for dental care.

Oral Health PSP continued to work with communities to implement PSP in early childhood learning centers, Early Head Start and Head Start Programs and schools with a total of 17, 655 children receiving PSP preventive care as of April 17, 2008, during the 2007-2008 school year (3,031 Early Head Start and Head Start children.)

The Oral Health Program and Health Resources and Services Administration Maternal Child Health Bureau in partnership with the Missouri Head Start State Collaboration Office, the Missouri Head Start Association, Central Missouri Community Action Head Start and the Missouri Primary Care Association presented Infant Oral Care Training focusing on oral health and pregnancy and oral health care for infants.

MOCCRRN assisted 1,136 SHCN families in finding/maintaining child care and medical services. Inclusion Specialists provided training and on-site technical assistance to child care providers on SHCN. Child Care Health Consultation Program educated child care providers on the management of asthma in the young child and provided education/consultation regarding the care of other CSHCN.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Assessment Tool (CAT) and Record Review		X		X
2. Promotion of Medical Home		X		X
3. Statistical Data				X
4. Genetic services provided diagnostic evaluation and counseling for individuals and families at risk for genetic conditions		X	X	
5. School Health Services worked with schools to increase access to primary and preventive health care for school-age children; CSHCN were identified and referred into a system of care		X	X	X
6. Regional workshops for School Nurses and School Social Workers on access to care, Medicaid eligibility, outreach and enrollment are conducted on an annual basis		X	X	X
7. Elk's Mobile Dental Units provided primary clinical and preventive dental services for CSHCN and other vulnerable children with referral to Truman Medical Center for more comprehensive care	X			

8. 127 Head Start programs have participated during school year 2007-08 in Oral Health PSP involving 3,031 children		X	X	X
9. MOCCRRN assisted SHCN families in finding/maintaining child care and medical services; Inclusion Specialists provided training and on-site technical assistance to child care providers on SHCN		X	X	
10. CCHC educated child care providers/parents on the management of young children with asthma and other SHCN		X	X	

**b. Current Activities**

SHCN continues to:

- complete CAT with participant and utilize the MCHB definition of MH to identify participants with a MH; provide MH educational materials to families of CSHCN; ensure coordinated, ongoing comprehensive care for SHCN participants through service coordination.
- collect CAT information electronically and integrate data into an all-inclusive participant database.
- utilize MCHB MH definition of MH to identify participants with a MH.
- promote MH through education and training.
- continue to conduct a Record Review with programs implemented through SHCN employees that include MH components.
- distribute MH Fact Sheet on SHCN Web site, in Family Care Notebooks and at health fairs/conferences to improve services and promote assurance of sustainability of MH system.

MOCCRRN provides technical assistance to families and providers regarding the importance of establishing and maintaining a MH for children with SHCN. Inclusion Specialists provide training and on-site technical assistance to child care providers on SHCN. In addition, MOCCRRN provides referrals to First Steps and to the CSHCN Service Coordination Program.

**c. Plan for the Coming Year**

MOCCRRN will continue to provide technical assistance to families and providers regarding the importance of establishing and maintaining a MH for children with SHCN. In addition, MOCCRRN will continue to provide referrals to First Steps and to the CSHCN Service Coordination Program. These efforts also address the state priority need of "Improving the Mental Health Status of MCH Populations in Missouri".

CCHCs will continue to facilitate communication between child care providers, parents and health care providers regarding CSHCN in child care.

SHCN will:

- complete Service Coordination Assessment with participants, utilizing MCHB definition of MH to identify participants with a MH; ensure coordinated, ongoing comprehensive care for SHCN participants through service coordination.
- complete integration of CAT data into all-inclusive participant database and continue statewide data collection using Web-based Service Coordination Assessment.
- work on Phase 2 of statewide electronic database enhancement to focus on Financial Management in the electronic database.
- promote MH through education and training by providing MH educational materials to CSHCN populations.
- persist with Record Reviews of programs that include MH components, implemented by SHCN employees.
- continue distribution of MH Fact Sheet on SHCN Web site, in Family Care Notebooks and at health fairs/conferences.

Missouri School Health Services Program has performance measure to "increase the percent of

students whose health record indicates an identified medical provider/clinic". School Nurses and School Social Workers work with students, parents and providers to assure continuity of care. This program reaches approximately 300,000 school age children. This year the program will continue with professional development activities related to health literacy, cultural competency and principals of social marketing.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	66.6	67.2	67.8	68.4	69
Annual Indicator	66	66	64.8	64.8	64.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	64.8	64.8	65	65	65

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey, and the data were comparable across the two time periods.

Only two points of data are available, which prevent capacity of performing trend analysis. The 2005-06 percentage in Missouri (64.8%) was at the 65th percentile state level. In light of potential changes in policy and other environmental factors, it is difficult to make predictions on this measure. 2008-2012 objectives were chosen, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

**a. Last Year's Accomplishments**

**SHCN:**

- maintained standard protocols for SCs to monitor the status of Medicaid referrals and the ability to obtain participants' Medicaid status through data linkage with DSS.
- continued to participate in various activities, collaborating with other entities to promote adequate insurance for participants.
- distributed the Insurance Comparison Checklist and the Insurance Fact Sheet, which empower families with the necessary resources for obtaining adequate insurance. Both were available on the SHCN Web site, in Family Care Notebooks and at health fairs/conferences.
- trained SCs on how to assist potential participants in determining available resources for adequate insurance.
- collaborated with managed care organizations, Systems of Care Board (SCBs), DSS, DMH and DESE to obtain information about CSHCN that transition within the systems of care.
- completed the CAT with SHCN participants, which included assessing adequacy of insurance.
- utilized electronic CAT database for statewide data collection consistent with federal data collection and compared participant data with data reported through national surveys. SHCN will be integrating CAT data into an all-inclusive participant database.
- administered CSHCN-Hope Program (RSMo, CCS), which provides early identification and health services that includes service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who require sub-specialty, specialty, preventive and primary care. Medicaid referral and enrollment, or verification of active enrollment, was required of all participants. ACM continued to be provided through a cooperative agreement SHCN maintained with DSS-MHD. SHCN authorized the medical necessity of in-home nursing services and provided service coordination for participants.

Baby Your Baby Web site ([www.dhss.mo.gov/babyyourbaby](http://www.dhss.mo.gov/babyyourbaby)) provided information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including MC+ and financial resources for pregnant women and children. This Web site will remain active through January 2013.

All School Health Services Program school contracts have a performance measure to increase number and percent of school-age children with a medical home; track children without health insurance; assist families with Medicaid applications. School Nurses and School Social Workers in the School Health Services Program received an annual update in regional settings on Medicaid for Children and enrollment procedures. Barriers to enrollment were addressed in regional settings.

MCH Coordinated Systems contracts strengthened LPHAs' efforts to target children without insurance and assisted their families in obtaining public/private health care coverage.

MOCCRRN provides all families calling for child care referrals with Medicaid/MC+ information. CCHC program assisted with referrals/assistance with accessing MC+/Medicaid as requested.

DCPH/ITSD provided integration of multiple single purpose databases into single system to support child-centered record including Medicaid status.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with other entities to promote adequate insurance for participants		X		X
2. Exchange of information conducted with MCOs, DSS, DMH and DESE for children transitioning within systems of care		X		X
3. Comprehensive Assessment Tool (CAT) assesses adequacy		X		X

of insurance				
4. CSHCN Hope Program provided early identification and health services	X	X		
5. Baby Your Baby Web site provided info for pregnant women, their families and communities including info on MC+ and financial resources			X	X
6. MCH Coordinated Systems contracts with LPHAs developed community specific interventions to target risk factors such children without health insurance and incorporated early identification and referrals to MC+ into direct services	X	X	X	X
7. CCHC program referred/connected children in child care with a source of health care coverage		X		
8. MOCCRRN provided resource information to each caller including information regarding access to health insurance and/or Medicaid		X		
9. DCPH/ITSD's child-centered record included Medicaid status			X	X
10.				

**b. Current Activities**

SHCN continues:

- protocols for SCs to monitor the status of Medicaid referrals.
- data linkage with DSS.
- collaboration to promote adequate insurance.
- distribution of Insurance Comparison Checklist and Insurance Fact Sheet.
- training on how to determine available adequate insurance resources.
- collaboration with entities listed above for CSHCN transitioning within systems of care.
- determination of participant's insurance by completing a CAT.
- utilization of statewide electronic CAT database.
- CSHCN-Hope Program and cooperative agreement with DSS-MHD for ACM.

School Health Services continues to track number and percent of children in School Health Services Program with regular source of medical care and provide outreach to families with no or inadequate health insurance. Regional meetings are conducted with School Nurses and School Social Workers to provide information regarding community-based systems such as FQHCs as well as tips to assisting families enroll in Medicaid.

MOCCRRN provides all families calling for child care referrals with Medicaid/MC+ information. CCHC program assists families of children in child care with accessing a source of health insurance or primary health care provider as requested.

DCPH/ITSD continued to provide integration of multiple single purpose databases into a single system that supports a child-centered record including Medicaid status.

**c. Plan for the Coming Year**

MOCCRRN will continue to provide all families calling for child care referrals with Medicaid/MC+ information. These efforts also address state priority need of "Improving the Mental Health Status of MCH Populations in Missouri".

CCHCs will continue to provide information to child care providers and parents regarding Medicaid/MC+ as well as local programs of assistance for CSHCN.

SHCN will:

- maintain protocols and evaluate methods (modifying if necessary) to improve SHCN procedure

- for SCs to monitor the status of MO HealthNet; continue to enable SCs ability to attain the participants' MO HealthNet status through data linkage with DSS.
- collaborate with other entities to promote adequate insurance for participants.
- distribute Insurance Comparison Checklist and Insurance Fact Sheet to empower families with resources to obtain adequate insurance.
- persist with SC training on how to determine available resources for adequate insurance.
- collaborate with managed care organizations (i.e., SCBS, DSS, DMH and DESE) to obtain information about CSHCN transitioning within systems of care.
- assess if a participant has adequate insurance by completing the Service Coordination Assessment with SHCN participants.
- complete integration of CAT data into all-inclusive participant database and continue statewide data collection using Web-based Service Coordination Assessment.
- work on Phase 2 of statewide electronic database enhancement to focus on Financial Management.
- administer CSHCN Program and uphold cooperative agreement with DSS-MHD for ACM.

School Health Services Program has performance measure to increase percent of children with regular source of medical care. This year the program will again sponsor regional meetings with School Nurses and School Social Workers on MO HealthNet (Missouri Medicaid program) enrollment procedures for families, eligibility guidelines and suggestions to frequently identified barriers. Additionally the FQHC system will be highlighted. The MO HealthNet Outreach Speaker will provide in-depth orientation for new School Nurses. A Back-to-School E-Newsletter will be sent to all School Nurses in August (approximately 1,300) regarding MO HealthNet. Outreach information for parents and posters for School Nurses' Offices will be offered.

DCPH/ITSD will continue to provide integration of multiple single purpose databases into a single system that supports a child-centered record including Medicaid status.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	76.8	78.4	80	81.6	83.2
Annual Indicator	75.2	75.2	90.1	90.1	90.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	90.5	90.7	90.9	91.1	91.3

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Trend analysis cannot be conducted until we have future data available. The 2005-06 percentage in Missouri (90.1%) was close to the 75th percentile state level of 90.8%. An annual increase of 0.2% was chosen starting from 2006 to create 2008-2012 objectives, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

#### **Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

#### **Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

#### **a. Last Year's Accomplishments**

SHCN:

- utilized electronic CAT database for statewide assessment data consistent with federal data collection and included components to assess if providers were accessible and services filled participant needs at community level. SHCN will integrate CAT data into all-inclusive participant database.
- maintained MO Assistive Technology contract (monitored for quality) to improve access and independence of CSHCN; encouraged community-based partnership among assistance technology services, participants and SHCN.
- participated in outreach activities with external agencies to promote organized community-based service systems for CSHCN.
- maintained CSHCN Service Coordination Contracts (monitored for quality) and conducted outreach and promotional activities to increase public knowledge of SHCN services. CATs, Service Plans and Transition Plans were completed with participants. SHCN trained, mentored and provided technical assistance opportunities for contract agency staff. SHCN streamlined and improved clarity and accountability of contracts' SOWs yet maintained integrity of services. Increased MCH Block Grant funding for financial support for contracts ensured successful partnerships with contractors.
- provided culturally competent services and trained contract agency staff to better serve participants. Translated publications enabled non-English speaking people to obtain program and service information. SHCN monitored Missouri demographics to continue addressing translation/interpreter issues and participated in events to increase knowledge of cultural diversity, i.e., planning meeting for American Indian Council Symposium, West Central Multicultural Forum, Ozark Regional Alliance meeting, Annual Ethnic Festival, Vietnamese Community Center, Community Works, Cross Cultural Interpreter training.
- maintained LPHA contract (monitored for quality) to administer Family Partnership Initiative and build support network for family members providing input on specific special needs issues. Family Partners provided outreach activities encouraging Family Partnership participation resulting in increased participation. SHCN participated in family-focused coalitions.
- recruited health care professionals to assure adequate medical care for participants to receive community-based services. SHCN staff trained in GIS mapping to identify participant and provider

needs.

--participated in statewide promotional activities increasing knowledge, understanding and availability of all programs and services for SHCN individuals resulting in more Missourians receiving service.

--promoted staff participation in professional development by utilizing presentations about SHCN programs and services; continued SHCN Training Academy requirements, creating educated, efficient workforce with emphasis on community needs and outreach activities.

--participated in emergency preparedness activities to ensure SHCN populations were considered. SCs contacted participants/families after significant weather events to assure participant safety and disaster planning was successful; provided ARC Disaster Preparedness Booklets to SHCN participants; partnered with participants in completion of plans and discuss emergency preparedness with participants/families.

--Family Care Notebook was updated and revised based on feedback received from participants/families. Statewide electronic version was maintained and distributed. Notebook categorizes medical information about community-based service systems and assisted families in locating appropriate services to best meet their needs.

School Health Services collaborated with LPHAs, mental health community-based agencies, local education agencies and other child serving agencies on confidentiality barriers. DVD/CD was distributed to all school districts related to Confidentiality of Student Information in the Public Schools.

MOCCRRN distributed child care resources and referral services information for CSHCN at 156 local community events; provided access to training for child care providers through electronic training calendar; provided technical assistance for parents/providers regarding SHCN; made referrals to First Steps, Thompson Center for Autism and Neurodevelopmental Disorders and other area resources. SCCR prioritized 2008 standardized hands-on training for child care providers with supporting material. CCHC provided families with assistance accessing a source of health care coverage or a health care provider as needed.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Assessment Tool (CAT)		X		X
2. Assistive Technology for CSHCN	X	X		X
3. Cultural Competency Education and Translated Publications		X		X
4. Family Partnership Initiative (support network for family members)		X		X
5. Provider Recruitment		X		X
6. SHCN staff participated in outreach activities assuring collaboration with external agencies and promoting organized community-based service systems for CSHCN		X		X
7. Six regional workshops for school, public health and mental health professionals using the Bright Futures in Practice: Mental Health framework		X	X	X
8. MOCCRRN distributes information regarding child care referral services at local community events and through physician's offices		X	X	
9.				
10.				

**b. Current Activities**

SHCN continues many of the preceding including:

- collection of CAT information electronically for statewide assessment.
- MO Assistive Technology contract to improve access.
- LPHA contracts to provide CSHCN service coordination, outreach, promotional activities.
- LPHA contract to administer Family Partnership Initiative to focus on community needs.
- culturally competent services and activities as described above.
- recruitment of health care professionals.
- GIS mapping training.
- participation in statewide promotional activities.
- promotion of staff professional development.
- participation in emergency preparedness activities.
- maintenance of Family Care Notebook.

SHCN and OHP with DMH, SSSH and Sheltered Workshops are developing local oral health care services systems for vulnerable populations.

School Health Services continues to offer consultations and workshops for School Nurses and school staff on community and Web-based resources.

MOCCRRN promotes inclusion services at local community events and physician offices and provides referrals to community services statewide in response to phone or electronic inquiries from families. Inclusion Specialists provide training to child care providers regarding the needs of families through the delivery of "Building Partnerships with Parents and Families", which is Module IV of Child Care plus, Missouri's standardized inclusion-related curriculum. CCHC program provides consultation/education to child care providers on the care of CSHCN.

### **c. Plan for the Coming Year**

MOCCRRN will promote services at local community events; provide referrals to community services in phone calls with families; provide training to child care providers on needs of families through delivery of "Building Partnerships with Parents and Families". Efforts address state priority needs of adequate early childhood development and education, mental health status of MCH populations and reducing intentional and unintentional injuries among infants, children and adolescents.

CCHCs will continue to facilitate communication between child care providers, families and community-based services for CSHCN.

SHCN will:

- complete integration of CAT data into all-inclusive participant database and continue statewide data collection.
- maintain and monitor MO Assistive Technology contract; LPHA contracts to provide CSHCN service coordination; LPHA contract to administer Family Partnership Initiative.
- participate in outreach activities to promote organized community-based service systems for CSHCN.
- provide culturally competent services; and participate in activities described above.
- recruit health care professionals.
- train staff to use GIS mapping tool match participant needs with providers.
- promote activities statewide to incite referrals for more CSHCN to receive services.
- promote staff professional development.
- participate in emergency preparedness activities.
- maintain Family Care Notebook.

SHCN will collaborate with UMKC:

- on the State Implementation Grants for CYSHCN to implement a statewide plan of integrated

services at individual, community and state levels. Collaborative goal is to improve and sustain access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families.

--on the Family-to-Family Health Information and Education Center to build significant partnerships between consumers, families and professionals, which include addressing the needs of families from diverse racial, ethnic and cultural backgrounds. The collaborative goal is to provide information, training and personal support to families of CYSHCN and professionals through collaborative partnerships that create improved access to healthcare, positive health outcomes, successful transitions and an improved quality of life.

SHCN and OHP with DMH, SSSH and Sheltered Workshops are developing local oral health care services systems for vulnerable populations.

This year, the Missouri School Health Services Program will work to infuse Health Literacy and Cultural Competency concepts into the practices of School Nurses and School Social Workers so that they can be better advocates for the families they serve.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	7.6	9.4	6	6.5	7
Annual Indicator	5.8	5.8	54.4	54.4	54.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	54.4	54.4	54.6	54.6	54.6

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Trend analysis cannot be conducted until we have future data available. Missouri had the highest percentage in this measure among all states in 2005-2006. 2008-2012 objectives were chosen, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

**a. Last Year's Accomplishments**

SHCN continued to:

--utilize electronic CAT database for statewide data collection consistent with federal data collection and included components to assess if youth with SHCN received necessary services and supports for transitions. SHCN will be integrating CAT data into an all-inclusive participant database.

--collaborate with programs and services that served adults to assist youth in transitioning smoothly to appropriate adult services.

SCs continued to work with participants and collaborated with key agencies to plan for transitions, utilizing several planning tools. SHCN staff continued to provide training to SCs and identified participants who have upcoming life stage transitions. SHCN reviewed transitional materials to determine if additional resources were necessary to improve transition planning. SHCN also explored ways to measure satisfaction of transitions to include SHCN participants of all ages.

The School Health Services Program continued to offer training programs for School Nurses to address students with special healthy care needs and IHAPs. The Individualized Health Care Plans are developed in partnership with parents and when appropriate other health care professionals.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Assessment Tool (CAT)		X		X
2. Transition Plans		X		X
3. Collaboration with adult programs and services		X		X
4. School Health Services Program continued to offer training programs for School Nurses to address students with SHCN			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

SHCN continues to:

--collect CAT information electronically including components to assess if youth with SHCN receive necessary services and supports for transitions. Data analysis focuses on regional needs

and is an efficient caseload management tool. SHCN is integrating CAT data into an all-inclusive participant database.

--work with participants and agencies to plan for transitions. SHCN will utilize several planning tools, provide training and identify participants who have an upcoming life stage transition. SHCN reviews transitional materials to determine if additional resources are necessary to improve transition planning. SHCN will also explore ways to measure satisfaction of transitions to include SHCN participants of all ages.

--collaborate with adult services to assist and plan for participants' smooth transitions to appropriate adult services, work with programs and agencies that serve adults to assist in planning for youth transitions; review and revise processes to assure effective youth transition planning.

**c. Plan for the Coming Year**

SHCN will:

--continue collection of Service Coordination Assessment data that will include components to assess if youth with SHCN receive the necessary transition services and support. Data analysis will continue to focus on regional needs and continue to be an efficient tool for caseload management. SHCN will complete the integration of CAT data into an all-inclusive participant database and continue statewide data collection using a Web-based Service Coordination Assessment.

--work with participants and agencies to plan for transitions. SHCN will continue to use several planning tools, provide training and identify participants who have an impending life stage transition. SHCN will persist in the review of transitional materials to ascertain if additional resources are necessary to improve transition planning. SHCN will continue to explore ways to measure satisfaction of transitions to include SHCN participants of all ages.

--collaborate with adult services to assist/plan for smooth participant transitions into appropriate adult services, work with programs and agencies that serve adults to assist in planning for youth transitions; and continue to review and revise processes assuring effective youth transition planning.

--collaborate with UMKC on the State Implementation Grants for CYSHCN to implement a statewide plan of integrated services at individual, community and state levels. The collaborative goal is to improve and sustain access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families in Missouri.

--collaborate with UMKC on the Family-to-Family Health Information and Education Center to build significant partnerships between consumers, families and professionals, which include addressing the needs of families from diverse racial, ethnic and cultural backgrounds. The collaborative goal is to provide information, training and personal support to families of CYSHCN and professionals through collaborative partnerships that create improved access to healthcare, positive health outcomes, successful transitions and an improved quality of life.

The School Health Services Program will continue with professional development sessions for School Nurses on the role of the School Nurse on the Individualized Education Plan (IEP) team.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	76	77.1	81.6	85.2	82.3
Annual Indicator	76.4	83.3	79.3	79.7	82.1

Numerator	57522	62614	61029	61934	64487
Denominator	75290	75167	76960	77709	78547
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	82.9	83.9	85	86.1	87.2

**Notes - 2007**

Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q3/2006-Q2/2007. Population of infants <1 year of age in 2005 used as denominator estimate of 19-35 month olds in 2007.

2008-2012 objectives are based on trend analysis on data 1998-2007, and discussions with the immunization program, MO DHSS.

**Notes - 2006**

Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q3/2005-Q2/2006. 2007-2011 annual performance objectives based on a logistic regression of 1999-2006 indicators. Population of infants <1 year of age in 2004 used as denominator estimate of 19-35 month olds in 2006.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q1/2005-Q4/2005. 2006-2010 annual performance objectives based on a logistic regression of 2001-2004 indicators. Population of infants <1 year of age in 2003 used as denominator estimate of 19-35 month olds in 2005.

**a. Last Year's Accomplishments**

TEL-LINK, DHSS's toll-free information and referral line for maternal, child and family health services, continued to provide a wide variety of referrals including immunization and well child checkups. During this year, collaboration efforts were made with other state programs such as Medicaid, diabetes and the fetal alcohol syndrome program. Advertising of the toll-free number was also accomplished through parenting magazines and newspapers in Kansas City, Springfield and Columbia. Also in the St. Louis area, kingsize busboards were developed and interior cards were posted on the MetroLink. Participation at exhibits for various conferences and health fairs (Missouri Black Expo, Cambio de Colores, Child Support Enforcement, Missouri State Teachers Association, Missouri Head Start Association, Pathways Conference, Missouri League for Nursing and Employees Health Fairs) has provided an excellent opportunity to promote the TEL-LINK program and distribute a variety of health-related literature to the public and professional organizations. The Hispanic population was targeted in the Kansas City area by advertising TEL-LINK and referrals for immunization in the bilingual newspaper known as DOS MUNDOS.

The Home Visiting and Alternatives to Abortion programs continued to educate mothers on the needs for immunizations and help mothers to obtain a medical home for their infants. Home Visiting programs collected data on immunization compliance for the targeted child for the families enrolled in the programs.

Baby Your Baby Web site ([www.dhss.mo.gov/babyyourbaby](http://www.dhss.mo.gov/babyyourbaby)) provided information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including prenatal care, immunizations, well child checkups and

special health care needs. This Web site will remain active through January 2013.

MOCCRRN provided families with information regarding immunizations when families requested child care referrals through phone or electronic inquiries. Immunization schedules as well as explanation of the requirement of up-to-date immunizations for enrollment in child care programs were provided. Child Care Health Consultation Program provided consultation/technical assistance to child care programs in keeping their child enrollment immunization records current and in preparing mandatory reports regarding the status of immunizations in children enrolled in child care.

Immunization Registry, an electronic registry database designed to hold immunization records for Missouri children, was maintained.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Care Health Consultants (CCHCs) provided technical assistance and consultation on immunizations for children enrolled in child care		X		
2. MOCCRRN promoted up-to-date immunizations to families calling for child care referrals				X
3. LPHAs developed community specific interventions to target up to date immunizations for two-year olds and increase the number of children entered into the state immunization registry		X	X	X
4. Home visiting and Alternatives to Abortion programs educated mother/families on the need for immunizations and immunization schedules		X	X	
5. Baby Your Baby Web site provided information for a wide range of topics including immunizations and well child checkups			X	X
6. TEL-LINK DHSS's toll-free telephone line provided information and referrals concerning health services including immunizations and well child checkups			X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

TEL-LINK provides information and referrals to Missourians concerning immunizations and a wide range of other health services.

Home Visiting programs and Alternatives to Abortion continue presenting immunization information to their clients.

Baby Your Baby Web site continues to provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies and will remain active through January 2013.

MOCCRRN provides families with information regarding immunizations and explains immunizations need to be up-to-date prior to enrollment in child care. CCHCs provide consultation/technical assistance to child care providers on maintenance/monitoring immunization records and preparation of annual immunization status report to DHSS.

In 2008, MCH Coordinated Systems contracts with LPHAs were renewed with the focus areas of unintentional and intentional injury, obesity and tobacco prevention in MCH population. Each has community-based interventions and environmental and policy changes to impact these issues and may use address immunizations.

Immunization Registry holds immunization records for Missouri children.

**c. Plan for the Coming Year**

TEL-LINK will provide information and referrals to Missourians concerning immunizations and a wide range of other health services.

MOCCRRN will provide families with information regarding immunizations as they call for child care referrals and to explain to parents that immunizations need to be up-to-date prior to enrollment in a child care program.

CCHCs will provide education and consultation to child care providers/parents regarding maintaining up-to-date immunizations and records for children in child care' facilitate children receiving appropriate, timely immunizations; and assist child care providers in submitting required reporting for immunizations.

MCH coordinated systems staff will continue to support LPHA efforts to assure appropriate immunizations for children through technical and consultative services as needed. The focus of support will be on local system development and educational resources on best practice methods through local, regional and statewide training opportunities and shared resources.

Contractors in the Alternatives to Abortion program have been encouraged to educate mothers enrolled in the program on the need for immunizations and immunization schedules. Information has been provided to the contractors on educational materials they can use to accomplish this.

The Baby Your Baby Web site ([www.dhss.mo.gov/babyyourbaby](http://www.dhss.mo.gov/babyyourbaby)) will continue to provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including prenatal care, immunizations, well child checkups and special health care needs. This Web site will remain active through January 2013.

The Building Blocks and Missouri Community-Based Home Visiting programs educate mothers on immunization schedules of infants and children and utilize the Baby Your Baby information for mothers. Status of immunizations for each individual infant is tracked in the data system and the program is evaluated on the effectiveness of the home visitors on educating parents and the completion of immunization schedules.

Immunization Registry will be further developed as a Web-based system for electronic submission of immunization data.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	20.6	19.1	19.6	18.4	17.2
Annual Indicator	21.5	21.9	20.8	22.7	21.6

Numerator	2573	2623	2555	2828	2687
Denominator	119801	119611	123065	124660	124660
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	21.4	21.2	21	20.8	20.6

#### Notes - 2007

Source: Missouri Information for Community Assessment (MICA) Birth, MICA Population, and Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008. 2007 final data of birth file will be available in October, 2008. 2007 denominator of population estimate for females 15-17 years of age is not available yet, and 2006 population estimate is used as a proxy for 2007. 2007 population estimate will be available in November, 2008.

An annual decrease of 0.2% was set to create future objectives 2008-2012, with considerations of trend analyses on past performance 1998-2007, as well as the fact the teen birth rate rose in 2006 for the first time in the past 15 years in both Missouri and the nation.

#### Notes - 2006

Data source is Missouri Information for Community Assessment (MICA). 2006 provisional numbers used for denominator as of July 2, 2007.

Annual performance objectives for 2007-2017 based on reasonable estimate of future indicators based on past performance.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

#### Notes - 2005

2005 provisional numbers as of May 5, 2006.

2001 and 2002 rates have been revised based on updated population estimates.

Annual performance objectives for 2006-2010 based on reasonable estimate of future indicators based on past performance.

#### a. Last Year's Accomplishments

Adolescent Health Program continued to provide consultation and education; and promote community, school and health care best practices to promote adolescent health. CASH advised DHSS on priorities for adolescent health and initiatives including continuance of adolescent medicine consultation contract and bimonthly professional newsletter, ADOLESCENT SHORTS addressing adolescent growth/development, preventive health care, vaccines, healthy eating, HPV and other STDs and fostering healthy relationships among family and friends.

DHSS was a co-sponsor of Region VII 2007 "Teaching Strategies for Successful Partnerships in HIV, AIDS, STDs & Human Sexuality Conference".

Section 510 State Abstinence Education Program served 31,205 adolescents and their families. A statewide media campaign to encourage parents and adolescents to talk to each other about relationships, sex, and abstinence was conducted.

Implementation of Building Blocks of Missouri Program continued. Building Blocks of Missouri was reported by Healthy Teen Network and Brookings Institute as a best practice and cost effective measure in decreasing teen pregnancy.

School Health Services Program continued to fund school nursing and school social work positions in small, rural school districts with no identified health services. These programs are advised by SHACs comprised of local community members, parents and educators. More than 700 SHAC meetings were held statewide. The community then addresses sensitive issues such as teen parenting and risky youth behaviors.

School Health Services co-sponsored conferences (Pathways to Students at Risk, Coordinated School Health and American School Health Association's Annual Conference) and provided scholarships for school personnel targeting youth at risk.

State School Nurse Consultant fostered collaborative relationships with local school districts and STD/HIV investigators by hosting regional meetings for school staff and STD/HIV investigators.

DHSS Adolescent Health Program, CASH, and HIV/STD and Hepatitis Programs collaborated to develop comprehensive, statewide community, school, and peer-based HIV, STD, and teen pregnancy prevention strategies.

Teen Outreach Program (TOP) was implemented through three LPHAs (Phelps, Washington, Columbia/Boone). Wyman, the national TOP center, in St. Louis provided training and technical assistance. TOP is a comprehensive youth development approach that has proven effective in increasing school success and protecting youth from risk factors that contribute to teen pregnancy and other negative behaviors. TOP was also offered as an option for abstinence education contractors to implement as strategy to strengthen abstinence education programs for young adolescents.

DHSS programs and partners collaborated with public and professional education on adolescent reproductive health issues (pregnancy prevention, STDs, HPV vaccine and sexual assault).

MCH Coordinated Systems used Title V funds to support community-based interventions through LPHAs to reduce rate of births to teens using best practices, model programs or evidence-based interventions; 32 contractors addressed this issue.

TEL-LINK provided information and referrals to females concerning family planning, prenatal care and prenatal drug abuse along with collaboration of state programs (e.g., breastfeeding, WIC, prenatal birth defects) to educate females about these topics. Early and regular prenatal care was promoted through radio spots along with other advertising such as news releases, posters, parenting/health magazines and at conferences and health fairs. TEL-LINK Web site provides access/link to other statewide health services.

BHI provided teen births and number of 15-17 female teens.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adolescent medicine and health consultation services contract supported the services of a Board-Certified Adolescent Medicine Consultant, training and technical assistance to adolescent health providers, newsletter and ADOLESCENT SHORTS		X	X	
2. Building Blocks of Missouri Program		X		

3. DHSS and DESE joined public health and education agencies for Kansas, Iowa and Nebraska in co-sponsoring regional "Teaching About HIV/AIDS/STDs and Human Sexuality Education" conference		X	X	
4. Teen Outreach Program (TOP) continued with LPHAs and community partners		X		
5. MCH Coordinated Systems had contracts with LPHAs that developed community specific interventions to target risk factors that relate to the rate of pregnancy among teens aged 15-17			X	X
6. TEL-LINK provided information and referrals concerning health services such as family planning, prenatal care, prenatal drug abuse			X	X
7. BHI provided from the vital statistics system teen births, and from population estimates, the number of female teens aged 15 to 17 needed to produce the data for this measure				X
8.				
9.				
10.				

**b. Current Activities**

3 LPHAs have TOP; Wyman provides training and technical assistance.

Statewide abstinence education campaign continues.

Abstinence Education contracts with 9 school/community organizations for abstinence education for adolescents, parents and TOP youth development strategies.

Children's Mercy Hospital contract is for training, technical assistance and ADOLESCENT SHORTS.

DHSS co-sponsors professional development and awareness trainings (MO Coordinated School Health Coalition, Region VII, MO Public Health Assn, MCH Institute, School Board Assn, Jericho Day, etc.) on youth development, teen pregnancy and school and adolescent health issues.

CASH, HIV/STD and Teen Pregnancy Prevention Education for Youth Committee promote best practice curricula and programs. 18-24 year-olds social marketing campaign is being developed on STDs/HIV awareness and screening.

Adolescent Health System Capacity Crosswalk Team merged with CASH to address priorities including State Framework for Promoting Health of Adolescents and integrated approach across DHSS programs.

AMCHP and NAACHO grant was applied for to develop:

--evidence-based approaches on teen pregnancy and HIV/STI prevention with state, local and community partners.

--DHSS and LPHA (Mississippi County Health Dept) model to replicate.

Building Blocks and MCBHV educate women on birth spacing to decrease recurrent teen pregnancies.

TEL-LINK provides info on family planning and is advertised in Kansas City bilingual newspaper DOS MUNDOS.

BHI provides data.

### **c. Plan for the Coming Year**

TEL-LINK will provide information and referrals as described above plus interior bus cards, targeting minorities in Metro areas. Health communication strategies for public awareness will be researched.

DHSS will contract with LPHAs to implement TOP and with Wyman in St. Louis to provide training and technical assistance to TOPs.

Missouri is 1 of 5 states developing state/county collaborative project (sponsored by AMCHP, National Association of County & City Health Officials [NACCHO] and Annie E. Casey Foundation) for "Evidence-Based Approaches to Teen Pregnancy and HIV/STI Prevention". DHSS programs (Adolescent Health, HIV/STD Prevention, CLPHS, OMH, etc.) will collaborate with Mississippi County public health, school, and community.

Adolescent Health System Capacity Crosswalk Team will address system capacity priorities by implementing strategies in state framework for promoting adolescent health and developing integrated approaches across DHSS programs to improve 10-24 year-olds health.

DHSS will contract with Children's Mercy Hospital for adolescent medicine and health consultation services for adolescent providers and ADOLESCENT SHORTS to provide information and best practices on issues (adolescent growth/development, preventive health care, teen immunizations, healthy eating, HPV, other STDs, etc.).

DHSS will co-sponsor trainings to promote healthy youth development, adolescent-friendly health care, teen pregnancy prevention and health issues.

Adolescent Health Web page will continue media campaign and educational resources.

DHSS will administer State Title V, Section 510 Abstinence Education Grant by contracting with 9 school and community organizations to provide abstinence education for 12-14 year-olds, positive youth development programs and parent/family/adolescent sexuality education and communication strategies.

MCBHV and Building Blocks will educate young women on birth spacing to decrease teen pregnancies. Building Blocks of Missouri is continually referenced by Healthy Teen Network and Brookings Institute as a best practice and cost-effective measure.

Newborn Health provides brochures and literature on importance of preconceptual care. Through a March of Dimes grant, it will be working with middle and high schools in mid-Missouri in Fall 2008 to educate students on importance of Folic Acid and need for preconceptual planning. Many include family planning education in health classes.

MCH Coordinated Systems will offer consultation and technical assistance to LPHAs to improve local systems ability to address teen pregnancy prevention through evidence-/research-based methods and best practice models.

OMH will conduct 8 focus groups and/or listening sessions with teenagers in St. Louis high infant mortality rate areas to determine key variables that influence infant care behaviors and produce health education campaign.

BHI will provide teen births from vital statistics system and number of female teens aged 15-17 from population estimates.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	14	14	14	30	35
Annual Indicator	14.0	14.0	28.6	28.6	28.6
Numerator	10055	10055	18686	18795	19355
Denominator	71823	71823	65337	65718	67677
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	31.6	32.6	33.6	34.6	35.6

**Notes - 2007**

Missouri Oral Health Survey was conducted every five years. The most recent data from the 2005 Missouri Oral Health Survey is used as proxy for 2007. Denominator is 3rd grade Fall enrollment figure for 2006-2007 school year. Numerator is estimated based on the 2005 percent.

An annual increase of 1% starting from 2005 was chosen to create future objectives for 2008-2012, with consideration of both past performance and discussions with staff from the Oral Health Program, Missouri Department of Health and Senior Services.

**Notes - 2006**

Numerator estimate for 2006 is based on 2005 Missouri Oral Health Survey. Denominator is 3rd grade Fall enrollment figure for 2005-2006 school year.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Numerator estimate for 2005 is based on 2005 Missouri Oral Health Survey. Denominator is 3rd grade Fall enrollment figure for 2004-2005 school year.

Annual performance objectives for 2006-2010 based on reasonable estimate of future indicators based on past performance.

**a. Last Year's Accomplishments**

In March 2007, OHP offered oral health education PowerPoint presentations designed specifically for Kindergarten-High School Seniors and are accessible for free downloading by school health nurses or teachers as well as by other health care/child care professionals in conjunction with health curriculum. These presentations have been very well received nationally as well as internationally. Other states have been given permission to adapt the presentations for their populations.

Elks Mobile Dental Program continued to provide primary clinical and preventive dental services to special health needs population. Elks Mobile Dental Program received PSP training during 2007 and continued to reinforce good oral hygiene and education for CSHCN and mental

retardation and developmental disabilities.

MCH Coordinated Systems used Title V funds to support local efforts to improve oral health and the use of protective sealants by offering technical assistance and consultation. Focus continued on best practice efforts within collaboratives with schools, private providers and local coalitions to enhance local systems capacity to address the issue of oral health.

School Health Services Program funded School Nurse positions in areas of rural Missouri with high poverty and limited resources. All school contractors track number of school-age children with regular source of dental care and partner with community-based services to increase number of children seen by a dentist. Nine school contracts track number of children with a dental sealant and partner with community-based services to provide sealant services at school or in the community. School Nurses use SHACs as resource to assist in developing outside systems to address availability and accessibility of services. 9,956 school children were referred for dental care.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Elks Mobile Dental Program provided primary clinical and preventative dental services to CSHCN and other vulnerable children populations	X		X	
2. Patients needing comprehensive care were referred to Truman Medical Center with all expenses paid by the Elks	X		X	
3. Missouri schools participated in the FMR and began transitioning to PSP			X	
4. Head Start, Early Head Start, pre-school and elementary school children received screenings, education, referrals and fluoride varnish applications to prevent/control growth of caries/cavities through Oral Health Preventive Services		X	X	
5. Missouri population on public water systems had access to fluoridated water systems			X	
6. Cadre of Registered Dental Hygienists in communities aided in the development of oral health interventions and acted as liaisons in regard to oral health issues, including public water fluoridation			X	
7. Missouri Oral Health Preventive Services Initiative			X	
8. Second annual Oral Health Summit for Missouri				X
9. OHP provided oral health radio spots statewide focusing on good oral health habits for children/youth			X	
10. MCH Coordinated Systems had contracts with LPHAs that developed community specific interventions increase the percent of third grade children who have received protective sealants		X	X	X

**b. Current Activities**

Dental Advisory Group helps OHP evaluate DHSS oral health programming and provides guidance in public health interventions for oral health.

Approximately 76,110 children in 317 schools participated in FMR during 2007-08 school year. Schools were alerted to 5-year transition from FMR to PSP (screenings, education, toothbrushes, referrals for care and fluoride varnish applications).

Discussions with DMH address ways to increase access to dental care for CSHCN. Dental care

access survey was conducted in 2007 with DMH MRDD Regional Centers and SHCN population; results indicate 41% have not seen a dentist in last 12 months; 44% have unmet dental needs. Barriers are cost, no dentist to accept patient, fear of treatment and transportation.

Elks Mobile Dental Program continues their services.

Missouri Donated Dental Program provides primary and preventive dental services to children with SHCN and mental retardation and developmental disabilities. Spin toothbrushes were provided to SSSHs to assist with oral hygiene. PSP will be implemented in SSSHs in 2008.

OHP provided DNR data for updating CDC's Water Fluoridation System (WFRS) in 2007 and is working on 2008 updates.

School Health Services continues activities described above. School Nurses used SHACs as resource to develop outside systems for availability and accessibility of services. This year contractors elected to implement oral health promotion curriculum or increase children participating in program promoting topical fluoride

### **c. Plan for the Coming Year**

School Health Services Program will continue to fund school health services contracts in small rural areas of Missouri. These contractors are required to be advised by a SHAC comprised of community and school members. Many SHACs have accepted the challenge of working with the community to find dental services for children. Also one of the performance measures in the contract is to increase the percent of children receiving topical fluoride.

MCH Coordinated Systems district staff will offer consultative support and technical assistance to School Health Services Program, local School Nurses and LPHAs wishing to address oral health and dental sealants in their communities.

CCHCs will offer adult education and children's health promotion programs on dental health and appropriate dental health habits.

Oral Health Advisory Group (OHAG), formerly Dental Advisory Group, will assist OHP in providing guidance in public health interventions for oral health and assist in development of new 5-year Oral Health Plan.

Part of a 5-year plan is to transition schools currently participating with FMR program to Oral Health PSP by 2012. PSP includes screenings, education, toothbrushes, referrals for care and fluoride varnish applications. During 2007-08 school year schools were alerted that the FMR program would be phased out over the next 5 years and were encouraged to transition to PSP. Efforts are ongoing to implement PSP in schools, early childhood learning centers and Head Start programs throughout the state. For school year 2007-08, 18,238 children participated in PSP. For school year 2008-09, the goal is to provide this oral health preventive care to over 36,000 children. PSP Oral Health Consultants will continue to work with LPHAs to implement PSP in their communities.

Dental care access surveys were conducted in 2007 with results reflecting continual unmet needs of the SHCN population. Additional efforts are underway to meet oral health needs of SHCN children including ongoing discussion with DMH. Elks Mobile Dental Program will provide primary clinical and preventive dental services and to reinforce good oral hygiene and education to the special health needs population. Elks Mobile Dental Program staff was trained in PSP in January 2008 for PSP implementation in 2008. OHP will be implementing PSP in all Missouri SSSHs during school year 2008-09. Donated Dental Program will continue to provide primary and preventive dental services to the SHCN population. Donated Dental Program is currently facing a growing waiting list due to needs of this population. DMH is working with MPCA and FQHCs to

explore additional avenues for providing dental services to the MRDD population.

OHP provided first update to CDC's WFRS in 2007 and is in the process of providing second annual update.

BHI will prepare DNR data for OHP to update CDC's WFRS.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	4.5	3.9	3.3	3.7	3.5
Annual Indicator	5.6	4.4	3.7	3.6	3.6
Numerator	65	50	43	42	42
Denominator	1151402	1141490	1162408	1161417	1161417
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	3.5	3.3	3.1	3	2.8

**Notes - 2007**

Source: Missouri Information for Community Assessment (MICA) Death, and Bureau of Health Informatics, MO DHSS. 2007 provisional death data as of April 28, 2008. 2007 final death data will be available in November, 2008. 2007 denominator of population estimate under 15 years of age is not available yet, and 2006 population estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November, 2008.

Future objectives 2008-2012 were based on trend analysis on data 1999-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

Data source is Missouri Information for Community Assessment (MICA). 2006 provisional numbers used for denominator as of July 2, 2007.

Annual performance objectives for 2007-2011 based on logistic regression on 2001-2005 data. The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

2005 provisional numbers as of May 9, 2006.

Annual performance objectives for 2006-2010 based on logistic regression on 2001-2005 data.

**a. Last Year's Accomplishments**

All school health contractors used CDC School Health Index on Safety Policies and Environment to form multidisciplinary committees to assess healthy/safe school environments. Two-year plans were developed to address safety issues identified by multidisciplinary committees of school and community members.

IVPP partnered with Missouri Injury and Violence Prevention Advisory Committee (MIVPAC) to reduce rate of mortality to Missouri residents 14 years and younger caused by motor vehicle crashes.

IVPP with MIVPAC worked on comprehensive Strategic Planning on Injury and Injury Data Book with focus on this age group.

IVPP supported 9 SAFE KIDS Coalitions for 58 counties to provide primary injury prevention interventions targeted to children from birth through 14 years of age.

IVPP evaluated contract to administer Missouri SAFE KIDS Coalition, provided local coalitions technical assistance, assessed SAFE KIDS expansion of regional injury and violence prevention coalitions web that takes leadership for assessment and policy development for all injury causes within a region.

IVPP supported UMC School of Medicine contract to conduct Think First Missouri activities to provide primary injury prevention interventions through school assemblies and reinforcement programs, specifically related to preventing head and spinal cord injuries.

State Adolescent Health Coordinator continued to represent DHSS on the Governor's Substance Abuse Prevention Initiative Advisory Committee to build prevention capacities and infrastructure at state/community levels focusing on risky drinking behaviors among 12-25 year olds. Proxy measures were alcohol-related emergency room visits, motor vehicle crashes and juvenile offenses. Funding from SAMSHA supported the planning and implementation grants to community coalitions to address youth alcohol-related priorities.

The DHSS-sponsored Home Visiting and Alternatives to Abortion programs provide car seats and booster seats to mothers/families enrolled in these programs and provided education on their use.

MCH Coordinated Systems supported local infrastructure development/community-based interventions in 14 counties to reduce rate of motor vehicle deaths in children 14 and younger. Local agencies implemented strategies to reach families with children for car seat/seat belt safety.

CCHCs educated child care providers with standardized injury prevention materials such as passenger vehicle safety, poison prevention, safe sleep, playground safety, etc., in most areas of the state.

BHI provided data to produce statistics from vital statistics system.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Injury and Violence Prevention Program works closely with the Division of Highway Safety to assure training is available to certify child passenger safety technicians and CPS trainers			X	

2. SAFE KIDS Coalitions conducted car seat check ups, safety /injury prevention events; inspected child passenger safety seat installation; & distributed child passenger safety seats, booster seats, bicycle helmets, gun safety locks & smoke detectors			X	X
3. Contracts were offered to nine local SAFE KIDS Coalitions to provide primary injury prevention interventions targeted to children from birth through 14 years of age			X	X
4. At school assembly programs, conferences and exhibits Think First Missouri provided primary injury prevention interventions for children and adolescents specifically related to preventing head and spinal cord injuries			X	
5. School Health Index: A Self Assessment and Planning Tool		X	X	X
6. Conference for School Nurses, public health professionals and injury and violence prevention practitioners			X	X
7. MCH Coordinated Systems supported local infrastructure development/community-based interventions in 14 counties to reduce rate of motor vehicle deaths in children 14 and younger		X	X	X
8. Local agencies implemented strategies to reach families with children for car seat/seat belt safety		X	X	X
9. CCHCs educated child care providers with standardized injury prevention materials such as passenger vehicle safety, poison prevention, safe sleep, playground safety, etc., in most areas of the state		X	X	X
10. BHI provided vital statistics to produce data for this measure				X

**b. Current Activities**

IVPP continues to partner with: 9 local SAFE KIDS Coalitions; School Health Program; MIVPAC; Think First Missouri; MO Coalition for Roadway Safety to provide injury data for MO's Blueprint for Safer Roadways; LPHAs, district health educators, MCH programs, School Health Nurses, Public Health professionals and injury and violence prevention practitioners.

IVPP is completing Web site and activity for this group.

Contractors in School Health Services Program use School Health Index to involve school and community to identify strengths and weaknesses in school policies and programs.

DHSS Adolescent Health and IVPP participate in MoDOT Highway Safety Youth Summit to strengthen state and community program coordination. DHSS programs provide input for state strategic plan for youth DUI/DWI prevention, treatment and program management.

Youth and teen traffic safety strategies were showcased at AMCHP. Model youth programs will be at June 2008 MCH Institute.

ADOLESCENT SHORTS addresses Missouri's Graduated Driver License Law and best practices to provide teens needed experience to be safe drivers.

Home Visiting and Alternatives to Abortion provide car seats and booster seats.

Reducing Intentional and Unintentional Injuries is focus of 41 MCH contracts. Schools, law enforcement, businesses, child care providers, parents and others implement best practices to promote injury prevention.

BHI provided vital statistics for this measure.

### **c. Plan for the Coming Year**

IVPP will partner with 8 local SAFE KIDS Coalitions and make efforts to reestablish coalition in Central Missouri region to provide primary injury prevention interventions targeted to children from birth through 14 years of age.

IVPP will partner with MIVPAC to reduce rate of mortality of residents 14 years and younger caused by motor vehicle crashes.

IVPP with MIVPAC is working on comprehensive Strategic Planning on Injury and an Injury Data Book with focus on this age group.

IVPP will partner with ThinkFirst Missouri to provide primary injury prevention interventions through school assemblies and reinforcement programs related to preventing head and spinal cord injuries.

IVPP will partner with Missouri Coalition for Roadway Safety to provide injury data to assist with Missouri's Blueprint for Safer Roadways. IVPP and Adolescent Health Program are participating in MoDOT Highway Safety Youth Summit collaboration to plan and implement 2009 conference and regional strategies to strengthen coordination of programs among state and community organizations.

IVPP will complete Web site that will serve as resource to focus and launch prevention activities for this age group.

IVPP will partner with LPHAs, District Health Educators, MCH Programs, School Health Nurses, Public Health professionals and injury and violence prevention advocates and practitioners throughout state to address issues of common interests.

DHSS-sponsored Home Visiting and Alternatives to Abortion programs provide car seats and booster seats to mothers/families enrolled in these programs and provide education on their use.

BHI will provide deaths due to motor vehicle crashes from vital statistics system and number of children aged 14 and younger from population estimates.

MCH Coordinated Systems contracts with LPHAs will address one of three MCH health issues. Reducing intentional and unintentional injuries will be focus of some contracts with population-based services and community capacity building initiatives addressing injury prevention in MCH population. Collaborative efforts with schools, law enforcement, businesses, child care providers, parents and other partners will implement community-based best practice interventions to promote healthy choices, decision making, advocating for policy changes and general injury-prevention educational campaigns. Interventions will include health and safety fairs, community educational campaigns, child safety seat technician training for local public health staff, promotion and education related to booster seat laws, education to child care providers and distribution of motor vehicle child safety devices among others.

CCHCs will offer education and consultation to child care providers, parents of children in child care and young children on child passenger safety (CPS).

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				32	34
Annual Indicator	30.4	29.9	29.9	34.7	34.7
Numerator	23396	23235	23235	28229	28412
Denominator	76960	77709	77709	81353	81879
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	34.9	35.1	35.3	35.5	35.7

#### **Notes - 2007**

Breastfeeding percentage is from CDC's National Immunization Survey. 2007 final data are not available yet, and the data collected in 2006 (2004 birth cohort) were used as proxy for 2007 data. 2007 final data will be available in August 2009. Denominator is number of live births in Missouri in 2007 (provisional data as of April 28, 2008). 2007 final birth data will be available in October 2008.

The percent of mothers who breastfed their infants at 6 months of age in Missouri showed a gradual increase from 2003 to 2006. An annual increase of 0.2% was set to create objectives 2008-2012 based on past performance and discussions with the Section of Healthy Families and Youth, MO DHSS.

#### **Notes - 2006**

Breastfeeding percentage of 32.6%, +/- 4.2%, is from CDC's National Immunization Survey in 2005. 2006 breastfeeding data not yet available. Denominator is number of live births in Missouri during 2006.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

#### **Notes - 2005**

Breastfeeding percentage of 29.9%, +/- 5.7%, is from CDC's National Immunization Survey in 2004. Denominator is number of live births in Missouri during 2004. 2005 numbers not available, yet - 2004 numbers used as proxy.

2006-2010 annual performance objectives based on reasonable estimate of future rates.

#### **a. Last Year's Accomplishments**

Breastfeeding educational Web site was available to healthcare professionals for continuing education.

CDC funded a state plan to prevent obesity. Breastfeeding focus groups were conducted in St. Joseph, MO, as part of an obesity intervention activity. An evaluation was completed of the focus groups and a decision will be made in 2008 on what intervention to use based on focus groups.

Program updated Web-based breastfeeding curriculum for schools of medicine, nursing and dietetics. Additional updates are planned.

Program conducted month-long statewide promotional project including a breastfeeding

message. Fiscal year 2007 message was Breastfeeding Support: Ties That Bind A Healthy Community focusing on community acceptance that breastfeeding is the gold standard for infant feeding.

Program expanded its evidence-based WIC Breastfeeding Peer Counseling Program that is part of WIC services in 49 agencies. Statewide initiative provided over 75 trained peer counselors to support breastfeeding mothers. Breastfeeding Peer Counseling mandatory workshop was provided to peer counselors to help promote and support breastfeeding within WIC.

Lactation rooms were included in Worksite Wellness plans for DHSS strategic plan and expansion of these rooms to all state agencies.

USDA funds were used for the Breastfeeding Peer Counseling Program to promote and educate prenatal and postpartum women, WIC moms.

Baby Your Baby Web site ([www.dhss.mo.gov/babyyourbaby](http://www.dhss.mo.gov/babyyourbaby)) continues to provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies. Site included wide range of topics including prenatal care, breastfeeding, immunizations, well child checkups and special health care needs. This Web site will remain active through January 2013.

Home Visiting programs provided breastfeeding education to clients seen for prenatal services; provided breastfeeding support for post-partum clients; referred mothers to lactation consultants and DHSS-supported peer counselor groups as indicated and provided incentives for mothers who chose to breastfeed.

Child Care Health Consultants provided technical assistance and consultation for child care providers on being supportive of mothers continuing breastfeeding following return to the workplace.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide breastfeeding promotion project including media campaign		X		
2. Enhancement of Breastfeeding Peer Counseling Program		X		
3. Continuation of Web-based curriculum on breastfeeding available to students in healthcare field		X		X
4. Lactation Rooms in MO State Office buildings		X		
5. Missouri Council on the Prevention and Management of Overweight and Obesity Plan			X	
6. Home Visiting and Newborn Health programs provided breastfeeding education			X	
7. Child Care Health Consultants provided technical assistance and consultation for child care providers on being supportive of mothers continuing breastfeeding following returning to the workplace		X		
8.				
9.				
10.				

**b. Current Activities**

The program continues to:

--enhance and support 49 WIC Breastfeeding Peer Counseling agencies.

- provide breastfeeding education to 118 WIC agencies.
- encourage development of evidence-based strategies for local agency breastfeeding interventions.
- evaluate Breastfeeding Education and Awareness Project with MO Chapter of AAP.
- support hospitals as they adopt evidence-based maternity care practices to promote, protect and support breastfeeding.
- evaluate effectiveness of evidence-based maternity care practices to increase breastfeeding initiation and continuation and recommend implementation of practice statewide.
- proclaim August as MO Breastfeeding Month and conduct social marketing campaign portraying breastfeeding as social norm and gold standard for infant feeding.
- continue working with worksite wellness team to encourage employers to consider lactation room.
- work with Child Care regulation team on developing curriculum for Breastfeeding Friendly Child Care centers.

Baby Your Baby Web site continues to provide information as described above.

Home Visiting programs and Newborn Health continue breastfeeding education and support.

Alternatives to Abortion providers are given resource information to share with pregnant women in their programs on benefits of breastfeeding and referral sources for breastfeeding assistance.

CCHC program educates child care providers on benefits of being supportive of breastfeeding families in child care.

### **c. Plan for the Coming Year**

Breastfeeding Program will work with MOCAN to help increase initiation and duration rates of breastfeeding through grants awarded to specific communities.

Breastfeeding Program is:

- working in partnership with AAP to develop plan to help promote, educate and increase breastfeeding initiation and duration; educating nurses, doctors and hospital staff with up-to-date information about breastfeeding and developing "breastfeeding friendly" model that can be successful.
- working to educate nurses, Lactation Consultants, peer counselors, and physicians on importance of continuation of breastfeeding exclusively for 6 months or longer. A conference will be held in September 2008 to promote this message.
- working to update Web-based lactation education program and to obtain continuing education credits for those who utilize the site.
- educating all Missourians regarding importance of breastfeeding and benefits to mothers, infants, families and employers. Information is being made available regarding Missouri laws concerning breastfeeding.
- collaborating with DHSS-sponsored Home Visiting programs to improve knowledge of the home visitors on breastfeeding. Data collected through home visiting databases will be used to identify those programs with lowest incidence of breastfeeding and to target those mothers and home visitors.

Alternatives to Abortion contractors have been educated on importance of breastfeeding to newborn infant and advantages to both mother and infant. Educational materials and information on WIC Peer Counselor program have been provided to contractors. Breast pumps can be purchased for participants if there is no other source of funding.

Baby Your Baby Web site ([www.dhss.mo.gov/babyyourbaby](http://www.dhss.mo.gov/babyyourbaby)) will provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies. It includes a

wide range of topics including prenatal care, breastfeeding, immunizations, well child checkups and special health care needs. This Web site will remain active through January 2013.

CCHCs will provide continued education to child care providers and parents on support of breastfeeding families in child care.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	96.5	97	99	99	99
Annual Indicator	98.7	99.2	99.9	96.6	97.1
Numerator	75989	77084	78487	78576	79499
Denominator	76960	77708	78547	81353	81879
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	99	99	99	99	99

**Notes - 2007**

Numerator number of newborns screened before discharge in 2007 is provisional data, and final data will be available by the end of December 2008. Denominator is number of live births in Missouri in 2007 (provisional data as of June 24, 2008). 2007 final birth data will be available in October 2008.

2008-2012 performance objectives set at 99.0%. There may be annual variations in the percent of newborns who are screened (including indicators > 100.0%) since mothers delivering babies in MO or IL may have their babies screened in MO, or vice versa.

The decrease in the percent of newborns screened prior to discharge since 2006 is due to upgrades implemented in the data management system that allow the system's reports to accurately reflect the actual number of infants screened prior to discharge.

**Notes - 2006**

2007-2011 performance objectives set at 99.0%. There may be annual variations in the percent of newborns who are screened (including indicators > 100.0%) since mothers delivering babies in MO or IL may have their babies screened in MO, or vice versa.

The decline of the % of newborns screened from 2005 to 2006 was due to a data retrieval problem with the MO Department of Health and Senior Service's computer system (MOHSAIC) that has now been fixed to accurately reflect the %of newborns screened.

**Notes - 2005**

2006-2010 performance objectives set at 99.0%. There may be annual variations in the percent of newborns who are screened (including indicators > 100.0%) since mothers delivering babies in MO or IL may have their babies screened in MO, or vice versa.

2005 numbers not available, yet - 2004 numbers used as proxy.

**a. Last Year's Accomplishments**

DHSS continued to contract in 2008 with MSU to provide technical assistance, training and consultation services to birthing hospitals and centers operating universal newborn hearing screening programs.

MNHSP worked with DESE in two areas. First, the MNHSP continued to work with DESE to ensure System Points of Entry (SPOEs) request consent to share personally identifiable information from parents of newborns diagnosed with hearing loss in order to allow the sharing of information related to Part C intervention as a result of newborn hearing screening. Second, MNHSP continued to work closely with DESE to ensure the Pilot Hearing Loss Service Coordination Project is successful and put into regular, statewide use in 2008.

MNHSP also continued its outreach into Mennonite, Amish and other homebirth communities through training and equipment loans in order to ensure babies in those communities receive a hearing screen.

A Web-based electronic birth certificate which will include hearing screening results is continuing to be developed to facilitate more timely reporting of screening results and provide an ability to see completeness of screening by hospital. The hearing portion is to be in place by January 1, 2010.

ITSD fixed many aspects of the case management system and reporting ability of the newborn hearing application within MOHSAIC.

MNHSP worked with ITSD to improve the current data management and report system to allow reliable statistics based upon all hearing cases in the system. BHI conducted an analysis of the Missouri Early Hearing Detection and Intervention (EHDI) system.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Missouri Newborn Hearing Screen Program screenings conducted		X	X	X
2. Nurses trained to conduct initial screenings for homebirth populations		X	X	
3. Pilot Hearing Loss Service Coordination Project		X	X	X
4. DESE information shared with HFY/GHC			X	X
5. A Web-based birth system is being developed which will facilitate timelier reporting and an ability to see completeness of screening by hospital				X
6. MOHSAIC Case Management and statistical reports repairs made				X
7. Evaluation of Missouri EHDI system by DHSS Health Informatics				X
8. Consultant Audiologist provides monitoring and training expertise				X
9.				
10.				

**b. Current Activities**

October 2007 MNHSP began to evaluate successes of Service Coordination Pilot Project which in collaboration with DESE pairs newborn hearing loss service coordinator with First Steps service coordinator during initial visit to family with infant diagnosed with permanent, bilateral severe to profound hearing loss. Due to smaller than anticipated number in pilot area, evaluation has been extended and geographic boundaries of pilot expanded. If successful, MNHSP will seek to continue project by expanding pilot or by implementing it as permanent feature MNHSP.

Plans for electronic birth certificate for MO have been postponed until January 2010. Once implemented, it is expected the ability to submit results electronically will improve hospitals' reporting rates and ability for MNHSP to determine if initial hearing screenings occurred prior to baby's discharge from hospital. MNHSP is working closely with DHSS Vital Records and DHSS ITSD staff to ensure implementation.

DHSS continues to contract in 2008 with MSU to provide technical assistance, training and consultation services to birthing hospitals and centers operating universal newborn hearing screening programs and work with DESE to obtain parental permission to share identifiable information and early intervention details for children identified with permanent hearing loss through MO EHD system. DHSS created an "Explanation of Consent" document for Part C staff to use when attempting to obtain consent.

**c. Plan for the Coming Year**

MNHSP will implement following activities in FY09:

- site visits to hospitals that do not regularly send rescreen results to the program.
- pilot program in which poorly performing hospitals will use a script to remind parents of the importance of follow-up, make the appointment for the newborn and send notification of the appointment to DHSS.
- appointment reminder phone calls made by DHSS staff to the identified families.
- inclusion of an electronic outpatient screening result form in Missouri Chapter of AAP newsletter and on DHSS Web site.
- continued efforts to work with ITSD to ensure hearing screening data management application is accurate and capable of producing meaningful reports related to loss to follow-up.

In October 2008 MNHSP will evaluate successes of expanded Service Coordination Pilot Project which, in collaboration with DESE, pairs newborn hearing loss service coordinator with First Steps service coordinator during initial visit to a family with infant diagnosed with permanent, bilateral severe to profound hearing loss in western and central regions of Missouri. If deemed successful by DHSS and DESE, MNHSP will seek to continue project by expanding pilot or by implementing it as permanent feature of the program.

By January 2010 it is expected that hospitals will have means to submit initial hearing screening results to MNHSP via new electronic birth certificate. Once implemented, it is expected that the ability to submit results electronically will improve the hospitals' reporting rates and the ability for program to determine if initial hearing screenings occurred prior to baby's discharge from hospital. MNHSP will work closely with DHSS Vital Records and ITSD staff to ensure implementation.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Performance Objective	4.7	4.7	8.1	8.2	7.9
Annual Indicator	7.3	7.4	7.7	9.1	10.5
Numerator	103000	103000	106000	127000	151000
Denominator	1406000	1386910	1378232	1398000	1442000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	10.5	10.4	10.4	10.3	10.3

**Notes - 2007**

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, Table HI05.

The percent of children without health insurance in Missouri showed a gradual increasing trend from 2001 to 2007. In light of potential policy changes and various environmental factors, it is difficult to make predictions on this measure. Objectives 2008-2012 were set based on discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

2006 health insurance coverage data not available, yet - 2005 numbers from Health Insurance Coverage tables from Census Bureau's Current Population Survey used as proxy.  
[http://pubdb3.census.gov/macro/032006/health/h05\\_000.htm](http://pubdb3.census.gov/macro/032006/health/h05_000.htm)

The percent of uninsured kids is conservatively predicted to drop by 0.3% per year, based on the yearly change seen in past rates from Census Bureau data. However, in light of impending Medicaid reforms in Missouri, it is difficult to make accurate predictions of the percent of uninsured children.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

2005 health insurance coverage data not available, yet - 2004 numbers used as proxy.

The percent of uninsured kids is conservatively predicted to drop by 0.3% per year, based on the yearly change seen in past rates from Census Bureau data. However, in light of impending Medicaid reforms in Missouri, it is difficult to make accurate predictions of the percent of uninsured children.

**a. Last Year's Accomplishments**

MOCRRN provided all families who requested child care referrals with Medicaid/MC+ information. CCHC program provided assistance with locating a source of health care coverage for families upon request.

Each School Health contract required an increase in percent and number of children with regular source of medical care on an annual basis.

School Health and Maternal Child Health Programs partnered with Heartland Centers at St. Louis

University School of Public Health and DMH to provide 12 regional workshops based on BRIGHT FUTURES IN PRACTICE: MENTAL HEALTH to collaborate on children's mental health. Over 800 participated in Year One.

Home Visiting and Alternatives to Abortion program providers shared information with their clients on the availability of the SCHIP program for their children.

LPHAs targeted children without health insurance and assist families in obtaining health care coverage through partnerships with local schools, insurance providers and childcare facilities.

**SHCN:**

- maintained standard protocols for SCs to monitor the status of Medicaid referrals and the ability to obtain participants' Medicaid status through data linkage with DSS.
- collaborated with other entities to promote adequate insurance for participants.
- distributed the Insurance Comparison Checklist and the Insurance Fact Sheet, which empowered families with the necessary resources to obtain adequate insurance. Both were available on the SHCN Web site, in Family Care Notebooks and at health fairs/conferences.
- trained SCs on how to assist potential participants in determining available resources for adequate insurance.
- collaborated with managed care organizations, SCBs, DSS, DMH and DESE to obtain information about CSHCN that transition within the systems of care.
- completed the CAT with SHCN participants, which included assessing adequacy of insurance.
- utilized electronic CAT database for statewide data collection consistent with federal data collection and compared participant data with data reported through national surveys. SHCN will be integrating CAT data into an all-inclusive participant database.
- administered CSHCN-Hope Program (RSMo, CCS), which provides early identification and health services that included service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who require sub-specialty, specialty, preventive and primary care. Medicaid referral and enrollment, or verification of active enrollment, was required of all participants. ACM continued to be provided through a cooperative agreement SHCN maintained with DSS-MHD. SHCN authorized the medical necessity of in-home nursing services and provided service coordination for participants.

OHP continued support of FQHC services and sites expansion. With the support of OPCRH, at least three dental clinics were established in 2007-2008 or are being established with additional FQHCs requesting support. This will have a definite impact on improving access to dental care.

Oral Health PSP included early childhood learning centers, Head Start and Early Head Start Programs and additional rural/urban school districts. OHP and SHCN along with DMH MRDD conducted oral health care access survey with the special health care needs population as explained in previous section. Discussions were held and are ongoing as to how to assure dental care access through Elks Mobile Dental Program, Donated Dental Services and other services/sites.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MOCCRRN and CCHCs' technical assistance and consultation to access health insurance and/or Medicaid provide		X		
2. School Health Services Program increased access to primary and preventive health care and CSHCN identified and referred into a system of care		X	X	
3. MCH Coordinated Systems contracted with LPHAs that developed community specific interventions to target risk factors			X	X

such as children without health insurance				
4. Home Visiting and Alternatives to Abortion program providers shared information with their clients on the availability of the SCHIP program for their children		X		
5. Baby Your Baby Web site included MC+ and financial resources for pregnant women and children			X	X
6. OHP supported FQHC services; provided PSP services; collaborated on dental care access through Elks Mobile Units, Donated Dental Services, etc.	X		X	X
7. SHCN collaborated with other entities to promote adequate insurance for participants		X		X
8. Exchange of information conducted with MCOs, DSS, DMH and DESE for children transitioning within systems of care		X		X
9. Comprehensive Assessment Tool (CAT)		X		X
10. CSHCN-Hope Program provides early identification and health services including service coordination	X	X		

**b. Current Activities**

MOCCRRN provides all families who request child care referrals with Medicaid/MC+ information. Parent Central was added to MOCCRRN's Web site this year to provide resources and information to families. CCHC program works with families to locate health care coverage or appropriate health care as requested.

Contractors in the School Health Services Program have a performance measure to increase the percent and number of students whose health record indicates an identified health provider/clinic.

School Health Services facilitates outreach to families with no or inadequate health insurance by partnering with the MC+ Coalition (the Missouri Medicaid program) in regional meetings with School Nurses and sponsoring Web-linked information for outreach during back-to-school campaigns.

Home Visiting and Alternatives to Abortion program providers share information with their clients on the availability of the SCHIP program for their children.

MCH Coordinated Systems continues to offer consultation and technical support to LPHAs and School Nurses addressing children without health insurance. Best practice interventions and research information related to linking families to local resources are shared with partners as needed.

SHCN continues activities listed in the section above and evaluates methods, modifies if necessary to improve operations, and maintains the linkage with DSS to obtain participants' Medicaid status and establish system improvements if applicable.

**c. Plan for the Coming Year**

MOCCRRN will provide all families calling for child care referrals with information regarding Medicaid/MC+. Efforts address state priority need of improving mental health status of MCH populations.

CCHCs will provide information to child care providers and parents regarding access to Medicaid/MC+ and community level resources related to coverage for health care.

SHCN will:

--maintain protocols and evaluate methods, modifying if necessary, to improve SHCN procedure

for SCs to monitor status of MO HealthNet and enable SCs ability to attain participants' MO HealthNet status through data linkage with DSS.

--collaborate with other entities to promote adequate insurance and distribute materials to empower families with resources to obtain adequate insurance.

--persist in staff training to determine available resources for adequate insurance and collaborate with agencies to obtain information about CSHCN population that transition within systems of care.

--complete integration of CAT data into all-inclusive participant database and continue statewide data collection using Web-based Service Coordination Assessment in collaboration with participants to determine if they have adequate insurance.

--administer CSHCN Program that provides early identification and health services including service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who require sub-specialty, specialty, preventive and primary care and verify and monitor participant referrals and enrollment status in MO HealthNet.

ACM will continue cooperative agreement SHCN maintains with DSS-MHD where SHCN authorizes medical necessity of in-home nursing services and provides service coordination for those participants.

Alternatives to Abortion providers share information with their clients on availability of MO Health Net Program for their children.

School Health Services has performance measure to increase percent and number of students whose health record indicates an identified health provider or clinic. Outreach activities such as posters, letters to parents and personal conversations at school events occur to identify barriers to health care enrollment. Barriers will be addressed by school staff (School Nurses and Social Workers) and by infusing concepts of health literacy and cultural competency into school practices. Information is distributed to schools via E Newsletter to all School Nurses (School Nurse Update, new initiative in School Health Program). E-letter has potential to reach 1,400 School Nurses.

Building Blocks and MCBHV share information on availability of MO HealthNet program for children with the parents enrolled in their programs.

MCH Coordinated Systems will offer consultation and technical support to LPHAs and School Nurses addressing children without health insurance. Best practice interventions and research information related to linking families to local resources will be shared with partners as needed.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				30	30
Annual Indicator	29.7	30.4	30.4	30.2	30.3
Numerator	16735	17506	17506	16182	16665
Denominator	56346	57587	57587	53585	55001
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	30	29.5	29	28.5	28

**Notes - 2007**

Source: CDC. Data Tables of the Pediatric Nutrition Surveillance System (PedNSS), Missouri.

Although Missouri is being affected by the same social and demographic factors contributing to childhood obesity as the rest of the nation. As reducing obesity among children is a stated priority of the state, we intend to make every effort to make progress in this performance measure.

**Notes - 2006**

Data obtained from Pediatric Nutrition Surveillance System (PedNSS).

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

2005 numbers not available, yet - 2004 numbers used as proxy.

**a. Last Year's Accomplishments**

BHI produced data for the measure of children, ages 2-5 years, receiving WIC services with a BMI at or above the 85th percentile (considered to be overweight or at risk of overweight). This data was provided on the WIC Child MICA as two indicators: children at risk of being overweight, and children considered to be overweight. Inclusion of the "at risk of overweight" component, including historical data, was an addition to the WIC Child MICA. BHI also provided data for the "overweight" component of this measure for children ages 2-5 years and receiving WIC services on the Child Health Profile. The "at risk of overweight" component of this measure will be added to the Child Health Profile in the future.

The MCH Coordinated Systems contracted with 48 LPHAs addressing obesity reduction. Promising practices or research-based approaches may include interventions that involve local child care providers and Head Start facilities on policy changes related to physical activity and nutritional intake and/or increased organized physical activity programs. Additionally some may incorporate age appropriate physical activity education into existing WIC clinics.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BHI produced data for the measure of children, ages 2-5 years, receiving WIC services with a BMI at or above the 85th percentile (considered to be overweight or at risk of overweight)		X		X
2. 48 LPHAs contracts addressing obesity with some incorporating physical activity education into existing WIC clinics		X		
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

**b. Current Activities**

BHI continues to produce data for children ages 2-5 years receiving WIC services with a BMI at or above the 85th percentile for this measure and provides it on the WIC Child MICA. BHI continues to provide data for children aged 2-5 years at or above the 95th percentile on the Child Health Profile.

The MCH Coordinated Systems contracts with 48 LPHAs addressing obesity reduction. Promising practices or research-based approaches may include interventions that involve local child care providers and Head Start facilities on policy changes related to physical activity and nutritional intake and/or increased organized physical activity programs. Additionally some may incorporate age appropriate physical activity education into existing WIC clinics.

**c. Plan for the Coming Year**

BHI will produce data for children ages 2-5 years receiving WIC services, with a BMI at or above the 85th percentile for this measure; and will provide it on the WIC Child MICA and the Child Health Profile. BHI will update the Child Health Profile for prior years to correspond with the 85th percentile measure.

The MCH Coordinated Systems contracts with LPHAs will address one of three MCH health issues. Reducing obesity in the MCH population will be the focus of some contracts with population-based services and community capacity building initiatives addressing obesity on the local level. Promising practices or research-based approaches may include interventions that involve local child care providers and Head Start facilities on policy changes related to physical activity and nutritional intake and/or increased organized physical activity programs. Additionally some may incorporate age appropriate physical activity education into existing WIC clinics.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				17	19
Annual Indicator			17.7	20.4	20.4
Numerator			13940	16591	16703
Denominator			78549	81353	81879
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	19.6	19.2	18.8	18.4	18

**Notes - 2007**

Missouri has participated in the Pregnancy Risk Assessment Monitoring System (PRAMS) since 2007. 2007 estimate of smoking during last 3 months of pregnancy from PRAMS is expected to be available by the end of December 2008. An estimated percent from the Missouri's pilot PRAMS survey (2005-2006 Missouri Pregnancy Related Assessment and Monitoring System, MoPRA) was used as a proxy for 2007. Denominator is estimated using the number of live births in Missouri in provisional 2007 as of April 28, 2008. 2007 final birth data will be available in October 2008.

Despite limited funding for tobacco prevention and cessation programs in Missouri, we intend to make every effort to make progress in this measure. An annual decrease of 0.4% was used to create objectives 2008-2012, with consideration of trend analysis on the measure smoking during pregnancy from the birth file and discussions with the Section of Healthy Families and Youth, MO DHSS.

#### **Notes - 2006**

2005 estimate of smoking during last 3 months of pregnancy is based on a stratified sample of 1,535 women (10 out of 12 batches) responding to the Missouri Pregnancy Related Assessment and Monitoring System (MoPRA), Missouri's pilot PRAMS survey.

The 2006 estimate is based on all 12 batches of MoPRA, a sample of 1,789 women.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

#### **Notes - 2005**

2005 estimate of smoking during last 3 months of pregnancy is based on a stratified sample of 1,535 responding mothers from first 10 out of 12 batches of the Missouri Pregnancy Related Assessment and Monitoring System (MoPRA), Missouri's pilot PRAMS survey. 72,228 mothers giving birth during 11/2002-10/2003 were selected as the sampling frame, out of which 2,995 mothers were randomly selected to receive in the survey in monthly batches of 250 mothers (245 in final batch).

Compare the reported frequency of 17.7% of women who reported smoking during last 3 months of pregnancy with

#### **a. Last Year's Accomplishments**

51 contracts with LPHAs provided community-based interventions to reduce percent of women who smoke during pregnancy. Infrastructure development with direct smoking cessation and prevention efforts with pregnant women continued. Many community-based interventions focused on youth tobacco prevention in schools with community assessment and policy recommendations to local school boards and businesses.

Home Visiting and Alternatives to Abortion programs continued to assess all women enrolled in programs for smoking and educate mothers on dangers of smoking during pregnancy including dangers of secondhand smoke and effects on their infant and worked with the women to decrease the number who smoke using 5 As intervention and refer women to Missouri's Quitline.

ATODPA advised health care providers of availability of medical consultation for health care providers.

The Missouri Model for Brief Smoking Cessation Training (MO Model) was offered in 2007 through a \$25,000 March of Dimes grant awarded to ATODPA. The MO Model is an educational outreach to health care clinicians in support of comprehensive tobacco control program with women of reproductive age, particularly pregnant women. DHSS facilitated MO Model development in 2005 and its implementation in 2006 and 2007. Developed and presented by a research psychologist associated with UMC, the MO Model is based on the U.S. Public Health

Services' five-step intervention (5 As) outlined in the CLINICAL PRACTICE GUIDELINE: TREATING TOBACCO USE AND DEPENDENCE and adopted by American College of Obstetricians and Gynecologists (ACOG). The MO Model also incorporates transtheoretical model on stages of change; motivational interviewing; current cessation pharmacotherapy; Missouri Tobacco Quitline for tobacco cessation and prevention of relapse; and techniques integrating proven cessation strategies into clinical setting. NOTE: Quitline (800-QUIT-NOW) is a free service and provides smoking cessation coaching, self-help materials and optional registration to a free supplemental online Web Coach.

Twelve MO Model trainings, consisting of eight four-hour trainings and four one-hour physician focused trainings were provided to 277 individuals. The four-hour trainings were offered in locations to allow for regional attendance and to accommodate anticipated higher attendance of various disciplines in St. Louis and Springfield regions. Approximately 160 attended these trainings. The one-hour sessions were conducted with established groupings of physicians, two medical societies, one gynecological society and a Medical Center participating. Trainings were attended by 119 individuals of various medical disciplines. Pre- and post-training surveys and follow-up surveys of MO Model participants showed significant differences in knowledge and behavior change in terms of smoking cessation discussions with women and use of resources.

In addition to MO Model trainings, a presentation regarding smoking cessation techniques and highlighting the Missouri Tobacco Quitline was made at the 2007 Missouri Section ACOG meeting. "Evidence-Based Interventions to Help Women Quit Smoking" was well received by the 33 physicians in attendance.

CCHC program provided group education to child care providers on the health risks of smoking or exposure to secondhand smoke.

BHI continued to develop a Web-based birth system to capture "last trimester of pregnancy" (National Center for Health Statistics terminology). It is anticipated these data will be collected in 2010 and will be available for analysis at a later date.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 51 contracts with LPHAs provided community-based interventions to reduce percent of women who smoke during pregnancy through infrastructure development, community interventions and direct services to pregnant women			X	X
2. Home Visiting programs educate all mothers on the effects of smoking during pregnancy and utilized the 5As to decrease smoking among those women who smoke		X		
3. Education about the impact of alcohol, tobacco and other drug exposure on pregnancy to health care providers practicing with at-risk populations		X	X	
4. GHC continued coordinated efforts to address smoking in women of reproductive age		X	X	
5. CCHC program provided group education to child care providers on the health risks of smoking or exposure to secondhand smoke		X		
6. Development continued on a Web-based birth system, to be in place by January 2010, that will capture 'last trimester of pregnancy'				X
7.				

8.				
9.				
10.				

**b. Current Activities**

MCH Coordinated Systems contracts with 23 LPHAs have been renewed with preventing tobacco use among adolescents and women as one focus area. Each has contractual obligation to utilize evidence-based interventions to reduce percent of women who smoke during pregnancy and infrastructure development. Many involve schools and communities to promote healthy lifestyle choices and outreach/education to local health care providers and best practice methods to address smoking during pregnancy.

Home Visiting programs continue training home visitors to promote smoking cessation and refer clients to Quitline.

MO Model is being offered in 2008 through \$18,110 March of Dimes grant awarded to ATODPA and builds on previous years' findings. In 2008, 5 one-hour MO Model trainings are being offered to physicians, dentists, dental hygienists and respiratory therapists.

MO Model participants are being advised of new service with Quitline: 4 weeks of nicotine replacement therapy (NRT) patches or gum can be provided at no cost to callers who are on Medicaid or have no health insurance. NRT gum can be provided at no cost to women who are pregnant and have physician approval to receive NRT.

Self-help materials on smoking cessation and educational brochures in English, Spanish, Vietnamese and Chinese are available.

Progress continues to add smoking status by trimester to Web-based system.

**c. Plan for the Coming Year**

Alternatives to Abortion programs will assess women enrolled for smoking and educate mothers on dangers of smoking and secondhand smoke during pregnancy and effects on their infant and will work with women to decrease number who smoke by referring women to Quitline and other smoking cessation programs.

March of Dimes funding has been secured to offer MO Model Training through December 2008. This educational outreach teaches health care clinicians of disciplines on how to implement evidence-based tobacco cessation programming with women of reproductive age, particularly pregnant women. The last of a series of 5 one-hour MO Model trainings in this March of Dimes award cycle will be offered in October 2008 to Missouri Dental Hygienists' Association.

It is anticipated that ATODPA will re-apply for March of Dimes funding to coordinate these best practice tobacco cessation trainings in remainder of Fiscal Year 2009.

Quitline will be highlighted as resource in MO Model training for cessation of tobacco use and prevention of relapse. Quitline provides tobacco use cessation coaching, self-help materials, nicotine patches or gum for eligible callers, optional registration to free supplemental online Web Coach and expert consultation to health care providers with clinical questions.

Self-help materials on smoking cessation and brochures in English, Spanish, Vietnamese and Chinese addressing tobacco use in pregnant women will be available for health care providers and families.

DHSS-sponsored Home Visiting programs will assess all women enrolled for smoking and

educate mothers on the dangers of smoking and secondhand smoke during pregnancy and effects on their infant and will work with women to decrease number who smoke using 5 As intervention and refer women to Quitline.

MCH Coordinated Systems contracts with LPHAs will be renewed with preventing tobacco use among adolescents and women as a focus area.

CCHCs will offer education to child care providers and young parents on risks of smoking and exposure to secondhand smoke and connect providers and parents to available community resources for smoking cessation.

Starting with 2010 births, Missouri will add smoking status by trimester as recommended by the National Center for Health Statistics. BHI will continue development on Web-based birth system to capture 'last trimester of pregnancy' and anticipates providing this data at a later date.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	7.7	6.9	7.9	5.9	5.3
Annual Indicator	6.8	9.9	6.5	8.5	8.5
Numerator	28	41	27	35	35
Denominator	412964	414314	416034	412670	412670
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	8	7.5	7	6.5	6

**Notes - 2007**

Source: Missouri Information for Community Assessment (MICA) Death, and Bureau of Health Informatics, MO DHSS. 2007 provisional death data as of April 28, 2008. 2007 final death data will be available in November 2008. 2007 denominator of population estimate 15-19 years of age is not available yet, and 2006 population estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November 2008.

Future objectives 2008-2012 were based on trend analysis on data 1999-2007 and discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

2006 Missouri Information for Community Assessment (MICA) data was used for the numerator. A Census Bureau 2006 population estimate was used for the denominator.

2007-2011 annual performance objectives based on a logistic regression of 2001-2005 indicators.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

2005 provisional numbers as of May 3, 2006.

2006-2010 annual performance objectives based on a logistic regression of 2001-2005 indicators.

**a. Last Year's Accomplishments**

MCH Coordinated Systems and UM Center for the Advancement of Mental Health Practices in Schools fostered the development of district/regional leadership teams with mental health, public health, education and Head Start staff.

CASH and partners continued to address the MISSOURI STATE FRAMEWORK FOR PROMOTING THE HEALTH OF ADOLESCENTS priority to promote developmentally appropriate physical and mental health strategies to meet the needs of adolescents.

The State Adolescent Health Coordinator represented DHSS on the Governor's Substance Abuse Prevention Initiative Advisory Committee that is addressing underage drinking and other alcohol-related problems. Substance abuse and other related mental health conditions are linked to suicide prevention. The Coordinator was also appointed to the MO Youth/Adult Alliance (MYAA) against underage drinking.

Current Adolescent Health Issues training in collaboration with adolescent medical specialists and the DSS Foster Care Program were conducted at three regional locations. Physical and mental health issues and Bright Futures in Mental Health resources were presented.

In 2007, ADOLESCENT SHORTS newsletters published related articles including teens' abuse of prescription and over-the-counter drugs; brain development; risks and addiction; and gambling.

TOP contractors addressed bullying prevention in the after-school and service-learning clubs for youth.

MCH and School Health Programs with Heartland Centers at St. Louis University School of Public Health, UM, Center for the Advancement of Mental Health Practices in Schools, Missouri School Success Network, DMH, DSS, Early Childhood, School Boards Association and Head Start formed a collaboration to address shared responsibilities regarding children's mental health issues using BRIGHT FUTURES IN PRACTICE: MENTAL HEALTH as a framework to address mental health promotion, early identification of children with the potential for mental health issues and de-stigmatization of mental illness. Shared funding was being identified and grant funding being sought to pilot three school/community sites.

School Health Program partnered with DMH to present workshops on the Roles of Schools in Suicide Prevention in regional settings for School Nurses, School Social Workers, School Counselors and School Administrators.

Home Visiting programs continued to assess all women enrolled in the programs in post-partum depression using the Edinburgh Post partum depression screening tool. Approximately 50% of the women enrolled are teenagers.

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care, provides information and referrals to Missourians concerning mental health services as requested.

BHI continued to provide the data needed to produce this measure. Teen suicide deaths are collected from the vital statistics system and the number of teens aged 15 to 19 are obtained through population estimates.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adolescent Medicine Consultant provided training on mental health		X	X	
2. Regional Workshops promoted quality mental health care for adolescents		X	X	
3. ADOLESCENT SHORTS newsletter		X	X	
4. Statewide suicide prevention workshops for school staff conducted		X	X	X
5. MCH continued with LPHAs contracts addressing suicide prevention			X	X
6. TEL-LINK provided information and referrals concerning mental health and crisis intervention			X	
7. BHI provided the teen suicide deaths come from the vital statistics system and the number of teens aged 15 to 19 comes from population estimates				X
8.				
9.				
10.				

**b. Current Activities**

48 MCH Coordinated Systems contracts with LPHAs address injury prevention in MCH population. Some with schools, businesses, health providers and faith community address suicide prevention in adolescents.

MCH Coordinated Systems provide assistance to LPHAs and local school health staff on suicide prevention.

MCH Coordinated Systems, UM Center for Advancement of Mental Health Practices in Schools, DMH, Head Start, MSBA, Children's Trust Fund and DESE provide communities assistance to build capacity for mental health issues.

School Health Program, DESE, DMH, LPHAs, community-based mental health providers, Head Start agencies and local school districts use BRIGHT FUTURES. Pilot sites are being identified to implement school/community-based interventions next year.

ADOLESCENT SHORTS provides information on best practices in caring for adolescents. Adolescent Medicine and Health Consultation contract with Children's Mercy Hospital offers adolescent health issues training.

State Adolescent Health Coordinator serves on MYAA and represents DHSS on DMH-coordinated Governor's Substance Abuse Prevention Advisory Committee addressing risky drinking in 12-25 age group.

Adolescent Health and School Health Services participate in national initiative School Mental Health Capacity Building Partnership with HRSA and National Assembly on School-Based Health Care.

School Health, MCH Program and DMH are developing cadre of certified trainers in Olweus Bullying Prevention Program.

BHI provides data.

**c. Plan for the Coming Year**

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care will provide information and referrals to Missourians concerning mental health services as requested.

The newsletter, ADOLESCENT SHORTS, will provide information on best practices in caring for adolescents. Training on current adolescent health issues will be offered through the Adolescent Medicine and Health Consultation contract with Children's Mercy Hospital.

The State Adolescent Health Coordinator will represent DHSS on the DMH coordinated Governor's Substance Abuse Prevention Advisory Committee that is addressing risky drinking (binge and underage) in the age group of 12-25 and the Missouri Youth/Adult Alliance against underage drinking. Substance abuse and other mental health conditions are linked to suicide prevention.

CASH will continue to promote developmentally appropriate physical and mental health services to meet the needs of adolescents as set forth in the State Framework for Adolescent Health.

School Health Program will:

- sponsor a session on "Psychological First Aid for School Staff" at the Coordinated School Health Conference. Additionally, a White Paper on "Mental Wellness, the Role of Schools, Communities, and Families" will be introduced at the conference.
- partner with Children's Trust Fund to sponsor a speaker on adolescent brain development for the Coordinated School Health Conference.
- partner with DMH to provide training for school districts on Olweus Bullying Prevention Program.

The MCH Coordinated Systems contracts with LPHAs will be renewed with 3 MCH health issues addressed. Reducing Intentional and Unintentional Injuries will be the focus of some contracts with population-based services and community initiatives addressing injury prevention in the MCH population. Some contractors may address suicide prevention in the adolescent population through collaboration with schools, businesses, health providers and the faith community. MCH Coordinated Systems staff will continue to provide consultation and technical assistance to LPHAs and local school health staff wishing to address suicide prevention in their communities. Resources on best practice and research-based interventions will be available as needed.

MCH Coordinated Systems continues to partner with the UM Center for the Advancement of Mental Health Practices in Schools, DMH, Head Start, DESE and the MO School Board Association, using the Bright Futures in Practice: Mental Health framework to provide technical assistance to communities wishing to build the capacity of their community to address mental health issues.

BHI will continue to provide the data needed to produce this measure from the vital statistics system the teen suicide deaths and from population estimates the number of teens aged 15 to 19.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	79.5	79.9	80.2	80.6	80.9
Annual Indicator	78.3	79.0	77.6	73.1	76.2

Numerator	944	886	880	825	891
Denominator	1206	1122	1134	1128	1170
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	77	78	79	80	81

**Notes - 2007**

Source: Bureau of Health Informatics, DHSS. Birth Data. Denominator is the number of VLBW infants to Missouri residents delivered in Missouri; numerator is the number of VLBW infants to Missouri residents delivered in Level III hospitals in Missouri. 2007 birth data are provisional, and 2007 final birth data will be available in October 2008.

An annual increase of about 1% was set to create future objectives for 2008-2012, based on discussions with the Bureau of Health Informatics and the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

Data source is Missouri Information for Community Assessment (MICA).

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Data source is Missouri Information for Community Assessment (MICA).

**a. Last Year's Accomplishments**

Home Visiting and Alternative to Abortion program contractors educated women on the need for: early entry into prenatal care, adequate prenatal care and choosing an appropriate prenatal care provider. Educational materials on preconceptual care to decrease the incidence of pre-term visits are available on the DHSS Web site through the Newborn Health program.

MO Model, offered in 2007 through a \$25,000 March of Dimes grant awarded to ATODPA, is an educational outreach to health care clinicians in support of a comprehensive tobacco control program with women of reproductive age, particularly pregnant women. DHSS facilitated MO Model development in 2005 and its implementation in 2006 and 2007. MO Model is based on U.S. Public Health Services' 5 As. Twelve MO Model trainings were provided. Pre- and post-training surveys and follow-up surveys of MO Model participants showed significant differences in knowledge and behavior change in terms of smoking cessation discussions with women and use of resources.

Missouri Tobacco Quitline is a free service, available at 800-QUIT-NOW; provides smoking cessation coaching, self-help materials and optional registration to a free supplemental online Web Coach; and is one of the resources highlighted in MO Model training

Also "Evidence-Based Interventions to Help Women Quit Smoking", regarding smoking cessation techniques and highlighting the Missouri Tobacco Quitline, was presented at the 2007 Missouri Section ACOG meeting and was well received by the physicians in attendance.

TEL-LINK, DHSS's toll-free telephone line (1-800-TEL-LINK) for maternal and child health care

connected callers to various services, including pediatric and delivering hospitals, alcohol and drug abuse treatment centers, community health centers; crisis pregnancy centers, local health departments, mental health centers and prenatal clinics. Collaboration with other state programs regarding fetal alcohol syndrome, folic acid, breastfeeding, healthy babies/children and safe sleep for babies was promoted. Statewide television and radio advertisement of the toll-free number also promoted the importance of early and regular prenatal care.

BHI provided the data needed to produce this measure. Birth weight and place of birth are collected through the vital statistics system. Level of care data is collected through the Annual Hospital Licensing Survey of Missouri Hospitals.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting programs educated clients on need for early entry into and adequate prenatal care		X		
2. Education about the impact of alcohol, tobacco and other drug exposure on pregnancy and interventions to assist in cessation efforts were provided to health care professionals working with women of reproductive age		X	X	
3. Genetic tertiary centers provided genetic screening, counseling, medical referral and outreach		X	X	
4. TEL-LINK connected callers to LPHAs, prenatal clinics, pediatric and delivering hospitals			X	X
5. BHI continues to provide the data needed to produce this measure. Birth weight and place of birth are collected through the vital statistics system. Level of care data is collected through the Annual Hospital Licensing Survey of Missouri Hospitals				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Home Visiting and Alternatives to Abortion educate clients on need for preconceptual care, early entry into and adequate prenatal care and effects of alcohol, tobacco and other drugs; provide smoking cessation referrals to mothers wishing to quit smoking and referrals to CSTAR to mothers using alcohol or other drugs; and assess clients for domestic violence.

MO Model is being offered in 2008 through an \$18,110 March of Dimes grant awarded to ATODPA. The 2008 trainings build on previous years' findings that the 5 As concepts, motivational interviewing techniques and MO Model smoking cessation resources are appropriate. In 2008, 5 one-hour MO Model trainings are being offered to physicians, dentists, dental hygienists and respiratory therapists.

MO Model participants are being advised of new Quitline service: 4 weeks of NRT patches or gum at no cost to callers on Medicaid or with no health insurance or NRT gum at no cost to pregnant women with physician approval to receive NRT.

Self-help materials on smoking cessation and educational brochures in English, Spanish, Vietnamese and Chinese are available for health care providers and Missouri families.

TEL-LINK, provides information/referrals on pregnancy testing and prenatal care. Radio spots on importance of early/regular prenatal care in St. Louis City target minorities. Hispanic population is targeted in Kansas City where TEL-LINK is advertised in bilingual newspaper DOS MUNDOS.

BHI provided the data needed to produce this measure.

**c. Plan for the Coming Year**

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care, will provide information and referrals to females regarding pregnancy testing and prenatal care. The importance of early and regular prenatal care will be promoted through radio advertising.

Home Visiting and Alternatives to Abortion programs will continue to educate clients on the need for early entry and adequate prenatal care; educate clients on the effects of alcohol, tobacco and other drugs; provide smoking cessation referrals to all mothers who wish to quit smoking; refer mothers who are using alcohol or other drugs to CSTAR programs; and assess clients for domestic violence.

BHI will continue to provide birth weight and place of birth from the vital statistics system and level of care data from the Annual Hospital Licensing Survey.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	86.4	86.6	86.8	87	87.3
Annual Indicator	86.6	86.2	86.0	84.7	84.1
Numerator	66641	66980	67571	68919	68859
Denominator	76960	77709	78547	81353	81879
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	84.6	85.1	85.6	86.1	86.6

**Notes - 2007**

Source: Missouri Information for Community Assessment (MICA) - Birth, and Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

There has been a slight decrease in the percent of prenatal care in the 1st trimester since 2006. It has been not clear why the number goes down. Some potential factors are speculated such as limited access to care and capacity of delivering doctors, and changes in prenatal care data collection from using self-reported information by the mother to using electronic medical records. An annual increase of 0.5% is used to create objectives 2008-2012, based on discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

Data source is Missouri Information for Community Assessment (MICA).

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Data source is Missouri Information for Community Assessment (MICA).

**a. Last Year's Accomplishments**

MCH Coordinated Systems continued to use Title V funds to support community-based interventions through contracts with 13 LPHAs to increase the percent of women who enter prenatal care during the first trimester.

OPCRH continued to support the expansion of services and sites of FQHCs, to assure access to essential, primary and preventive medical, dental and mental health services for all MCH populations, without regard to individual's ability to pay. With the support of OPCRH, at least three dental clinics were established in 2007-2008 or are being established with additional FQHCs requesting support. This will have a definite impact on improving access to dental care. OHP in conjunction with Head Start, MPCA and Maternal Child Health Bureau presented Infant Oral Care Training to oral health professionals and medical teams including physicians, nurse practitioners, physician assistants. The trainings emphasized the important role that oral health plays in overall health and birth outcomes and was very well received. OHP expanded educational efforts with the WIC and MCH units of DHSS to expand and enhance oral health education activities. In order to implement the Oral Health PSP throughout Head Starts in Missouri, OHP continued to partner with FQHCs to further assist in developing community support for the PSP.

The MCH population benefited by receiving home visits by registered nurses (Building Blocks and MCBHV) and lay family support workers (MCBHV) who provided: assessment, education, case management, referrals for services, influence on mother's life course development by continuing education and attaining employment, help to improve relationships with family and friends, development of parenting skills, help to improve environmental health, help to improve health of the mother and identified and interacted in situations of domestic violence and child abuse and neglect.

TEL-LINK, DHSS's toll-free telephone line (1-800-TEL-LINK) for maternal, child and family health services, provided information and referrals health services including pregnancy testing and prenatal care. Statewide television and radio advertisement of TEL-LINK also promoted the importance of early and regular prenatal care.

BHI provided this data from the vital statistic system.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH coordinated systems supported community based interventions for early prenatal care through contracts with local public health agency			X	X
2. OPCRH continued to support the expansion of services and sites of FQHCs, to assure access to essential, primary and preventive medical, dental and mental health services for all MCH populations				X

3. Home Visiting programs implemented included Building Blocks of Missouri in Kansas City, Southeast Missouri and St. Louis. MCBHV was implemented in sites targeting high-risk women and promoting the need for early prenatal care		X		
4. Newborn Health and Baby Your Baby Web site provided education promoting prenatal care			X	
5. TEL-LINK referrals for pregnancy testing and prenatal care			X	X
6. BHI provided this data from the vital statistic system				X
7.				
8.				
9.				
10.				

**b. Current Activities**

MCH Coordinated Systems continues to offer consultation and technical support to LPHAs addressing adequate prenatal care. Best practice interventions and research information related to assuring appropriate prenatal care and linking families to local resources are shared with partners as needed.

Both Home Visiting and Alternatives to Abortion programs educate mothers on the need for prenatal care and the importance of early entry into prenatal care, as well as preconceptual care.

The Baby Your Baby Web site ([www.dhss.mo.gov/babyyourbaby](http://www.dhss.mo.gov/babyyourbaby)) continues to provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including prenatal care, breastfeeding, immunizations, well child checkups and special health care needs..

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care provided information and referrals to females regarding pregnancy testing and prenatal care. The importance of early and regular prenatal care was advertised through radio spots in St. Louis City, targeting the minority population. The Hispanic population was targeted in the Kansas City area by advertising TEL-LINK in the bilingual newspaper DOS MUNDOS.

BHI continues to provide this data from the vital statistics system.

**c. Plan for the Coming Year**

Alternatives to Abortion programs will educate mothers on the need for prenatal care and the importance of early entry into prenatal care. They assist mothers in finding a prenatal care provider.

Baby Your Baby web site ([www.dhss.mo.gov/babyyourbaby](http://www.dhss.mo.gov/babyyourbaby)) will provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including prenatal care, breastfeeding, immunizations, well child checkups and special health care needs. This Web site will remain active through January 2013.

DHSS sponsored Home Visiting programs will encourage early entry into prenatal care and also provides in home education for pregnant mothers.

MCH Coordinated Systems will continue to offer consultation and technical support to LPHAs addressing adequate prenatal care. Best practice interventions and research information related to assuring appropriate prenatal care and linking families to local resources will be shared with partners as needed.

BHI will continue to provide this data from the vital statistics system.

## D. State Performance Measures

**State Performance Measure 1:** *Percent of women who have reported smoking during pregnancy.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	17.9	17.7	17.5	16.3	14.4
Annual Indicator	18.1	18.1	18.2	18.4	17.7
Numerator	13895	14083	14317	14946	14530
Denominator	76960	77709	78547	81353	81879
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	16.5	16.2	15.9	15.6	15.3

#### Notes - 2007

Source: Missouri Information for Community Assessment (MICA)- Births and the Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Despite limited funding for tobacco prevention and cessation programs in Missouri, we intend to make every effort to make progress in this measure. Objectives 2008-2012 were set with considerations of trend analysis on data 1990-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

#### Notes - 2006

Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment). 2005 numbers used, 2006 data not yet available as of July 2, 2007.

Annual performance objectives for 2007-2011 are based on a regression analysis of the maternal smoking during pregnancy trend in Missouri during 1999-2005.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

#### Notes - 2005

Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment).

Annual performance objectives for 2006-2010 are based on a regression analysis of the maternal smoking during pregnancy trend in Missouri during 1999-2005.

#### a. Last Year's Accomplishments

Community-based interventions, in 51 LPHA contracts, addressed reducing the percent of women who smoked during pregnancy. Infrastructure development with direct smoking cessation and prevention efforts with pregnant women continued. Many community-based interventions focused on youth tobacco prevention in schools with community assessment and policy recommendations to local school boards and businesses.

OWH developed a Tobacco Cessation fact sheet for distribution and posted on OWH Web site.

Home Visiting programs continued training of home visitors in promoting smoking cessation and referring clients to Quitline.

Baby Your Baby Web Site, [www.dhss.mo.gov/babyyourbaby](http://www.dhss.mo.gov/babyyourbaby), covered topics including smoking cessation during pregnancy.

Newborn Health educational material in English and Spanish was distributed to service providers and families to promote smoking cessation during pregnancy.

MO Model was offered in 2007 through a \$25,000 March of Dimes grant awarded to ATODPA. The MO Model is an educational outreach to health care clinicians in support of a comprehensive tobacco control program with women of reproductive age, particularly pregnant women. DHSS facilitated the MO Model development in 2005 and its implementation in 2006 and 2007. Developed and presented by a research psychologist associated with the UMC, the MO Model is based on the U.S. Public Health Services' five-step intervention (5 A's) outlined in the CLINICAL PRACTICE GUIDELINE: TREATING TOBACCO USE AND DEPENDENCE and adopted by ACOG. The MO Model also incorporated the transtheoretical model on stages of change, motivational interviewing, current cessation pharmacotherapy, the Missouri Tobacco Quitline for tobacco cessation and prevention of relapse and techniques integrating proven cessation strategies into the clinical setting.

Twelve MO Model trainings, consisting of eight four-hour trainings and four one-hour physician focused trainings were provided to a total of 277 individuals. The four-hour trainings were offered in locations to allow for regional attendance and to accommodate the anticipated higher attendance of various disciplines in the St. Louis and Springfield regions. Approximately 160 attended these trainings. The one-hour sessions were conducted with established groupings of physicians, two medical societies, one gynecological society and a Medical Center participating. Trainings were attended by 119 individuals of various medical disciplines. Pre- and post-training surveys and follow-up surveys of MO Model participants showed significant differences in knowledge and behavior change in terms of smoking cessation discussions with women and use of resources.

In addition to the MO Model trainings, a presentation regarding smoking cessation techniques and highlighting the Missouri Tobacco Quitline was made at the 2007 Missouri Section ACOG meeting. The topic "Evidence-Based Interventions to Help Women Quit Smoking" was well received by the 33 physicians in attendance.

CCHCs provided group education to child care providers on the risks of smoking and secondhand smoke.

BHI provided data from vital statistics system.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Coordinated Systems had contracts with LPHAs to support community-based interventions to reduce the percent of women who smoke during pregnancy through infrastructure development, community interventions and direct services to pregnant women		X	X	X
2. OWH developed a Tobacco Cessation fact sheet for distribution and posted on OWH Web site			X	X

3. Home Visiting programs improved pregnancy outcomes by helping women practice healthy behaviors including decreasing the use of cigarettes, alcohol and illegal drugs		X		
4. Baby Your Baby Web site included helpful information on various healthy pregnancy and healthy baby topics			X	X
5. Newborn Health literature addressed decreasing smoking while pregnant			X	
6. Education about the impact of alcohol, tobacco and other drug exposure on pregnancy to health care providers practicing with at-risk populations		X		
7. Continued coordinated efforts to address smoking in women of reproductive age		X	X	
8. CCHCs provided consultation/education on smoking and secondhand smoke and cardiovascular disease prevention		X		
9. BHI provided this data from the vital statistic system				X
10.				

**b. Current Activities**

23 LPHAs MCH Coordinated Systems contracts have been renewed with preventing tobacco use among adolescents and women as one focus area. Each has contractual obligation to use evidence-based interventions to reduce percent of women who smoke during pregnancy. Some involve schools and communities to promote healthy lifestyle choices and outreach/education to local health care providers and best practice methods to address smoking during pregnancy.

Home Visiting and Alternatives to Abortion train home visitors to promote smoking cessation and refer clients to Quitline.

MO Model, offered in 2008 through \$18,110 March of Dimes grant to ATODPA, builds on previous findings. 5 one-hour trainings are for physicians, dentists, dental hygienists and respiratory therapists.

MO Model participants are advised of new Quitline service: 4 weeks of NRT patches or gum at no cost to callers on Medicaid or have no insurance; NRT gum at no cost to pregnant women with physician approval

Self-help materials on smoking cessation and educational brochures are in English, Spanish, Vietnamese and Chinese.

A contract deliverable for schools in School Health Services Program is active SHAC with community representation and at least one LPHA member to provide LPHA opportunity to promote public health activities.

CCHCs provide group education on smoking, secondhand smoke and cardiovascular disease prevention.

BHI continues to provide data.

**c. Plan for the Coming Year**

Alternatives to Abortion programs will continue to assess all women enrolled for smoking and educate mothers on the dangers of smoking during pregnancy including the dangers of secondhand smoke and effects on their infant and will work with the women to decrease the number who smoke by referring women to the state's Quitline and enrolling in smoking cessation programs.

March of Dimes funding has been secured to offer Missouri Model for Brief Smoking Cessation (MO Model) Training through December 2008. This educational outreach teaches health care clinicians of various disciplines how to implement evidence-based tobacco cessation programming with women of reproductive age, particularly pregnant women. The last of a series of five one-hour MO Model trainings in this March of Dimes award cycle will be offered in October 2008 to the Missouri Dental Hygienists' Association.

It is anticipated that the ATODPA will re-apply for March of Dimes funding to coordinate these best practice tobacco cessation trainings in the remainder of Fiscal Year 2009.

Missouri Tobacco Quitline will be highlighted as a resource in the MO Model training for cessation of tobacco use and prevention of relapse. This free service, available at 800-QUIT-NOW, provides tobacco use cessation coaching, self-help materials, nicotine patches or gum for eligible callers, optional registration to a free supplemental online Web Coach and expert consultation to health care providers with clinical questions.

Self-help materials on smoking cessation and brochures in English, Spanish, Vietnamese and Chinese addressing tobacco use in pregnant women will be available for use by health care providers and Missouri families.

DHSS-sponsored Home Visiting programs screen all pregnant women for tobacco use and refer to the Quitline as needed. Education is done on the dangers of smoking and secondhand smoke. The programs collect data on the smoking habits of women enrolled in the programs and are able to evaluate that data to look at program effectiveness.

The MCH Coordinated Systems contracts with LPHAs will be renewed with one focus area being preventing tobacco use among adolescents and women. Each contractor will have a contractual obligation to utilize evidence-based interventions. Local system development to address smoking prevention and cessation will include direct smoking cessation interventions, community-based interventions and environmental and policy changes to impact the initiation of smoking in this population.

CCHCs offer education to child care providers and young parents regarding the risks of smoking and exposure to secondhand smoke. CCHCs will connect providers and parents to available community resources for smoking cessation.

BHI will continue to provide this data from the vital statistics system.

**State Performance Measure 2:** *Percent of tobacco use among children 14-18 years of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	31	30.5	30	19.4	17.4
Annual Indicator	24.8	24.8	21.3	21.3	23.8
Numerator	62425	62425	59081	60210	68127
Denominator	251713	251713	277374	282678	286247
Is the Data Provisional or Final?				Provisional	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	23.3	22.8	22.3	21.8	21.3

**Notes - 2007**

The annual indicator is from the 2007 YRBS statistic "Percentage of high school students who smoked cigarettes on one or more of the past 30 days". The denominator is estimated using the number of fall enrollment, grades 9-12 for school year 2006-2007, obtained from the the MO Department of Elementary and Secondary Education.

Objectives for 2008-2012 were set with considerations of trend analysis on MO YRBS data 1995-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

YRBS not conducted during 2006. 2005 data is used as a proxy for 2006 since the YRBS is reported every two years. 2007 data available next year.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Data is an estimate based on results from the YRBS statistic "Percentage of students who smoked cigarettes on one or more of the past 30 days" and the summary of Fall enrollment, grades 9-12, during 2004-05 from the Department of Elementary and Secondary Education.

Annual performance objectives for 2006-2010 are based on a regression analysis of YRBS data from Missouri during 1995-2005.

**a. Last Year's Accomplishments**

MCH Coordinated Systems continued to use Title V funds to support community-based interventions through LPHAs to reduce teen tobacco use by involving collaborative efforts with school and community partners to implement best practice interventions which promote healthy lifestyle choices.

The YRBS was completed in June 2007.

The Youth Tobacco Survey (YTS), last conducted in 2005 with public middle and high school students, was scheduled to be repeated in 2007.

Various DHSS programs explored ways to integrate evidence-based tobacco use prevention strategies, including youth development and advocacy, with other related adolescent health concerns into Teen Outreach Programs, contracts with schools and local public health agencies.

An ADOLESCENT SHORTS issue was published on Teen Smoking.

BHI provided data from the YRBS system and the YRBS MICA.

The Smokebusters Program continued and included a total of 116 schools with 210 leaders trained and 1,202 students participating as of April 2007.

CCHCs provided group education to young adults and school age children on the dangers smoking and secondhand smoke.

BHI provided this data from the YRBS system and the YRBS MICA.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Use of tobacco in public high schools was monitored through YRBS, DHSS Youth Tobacco Survey; biennial alcohol, tobacco and other drug use survey by DMH and DESE			X	
2. CDC School Health Index used to assess school policies and practices for tobacco-use prevention		X	X	X
3. MCH Coordinated Systems contracts allowed LPHAs to develop community-specific interventions to target risk factors for adolescents who smoke and smoking prevention education			X	X
4. CCHCs provided group education to young adults and school-age children on the dangers smoking and secondhand smoke		X	X	
5. BHI provided this data from the YRBS system and the YRBS MICA				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The MCH Coordinated Systems contracts with LPHAs have been renewed with one of the focus areas as preventing tobacco use among adolescents and women. Each contractor has a contractual obligation to utilize evidence-based interventions to address the issue of smoking in their community. Local system development to address smoking prevention and cessation will include direct smoking cessation interventions, community-based interventions and environmental and policy changes to impact the initiation of smoking in this population. Many community-based interventions are focused on youth tobacco prevention in schools using best practice interventions to promote healthy lifestyle choices, decision-making, general tobacco prevention educational campaigns and advocating for policy changes with community assessment and policy recommendations to local school boards and businesses.

The Adolescent Health Program consults with BHP on the development of youth tobacco education programs and campaigns. Smokebusters and Teens Against Tobacco will be presented at the MCH Institute as models for partnering with teens to promote health.

CASH and DHSS Adolescent Health Crosswalk Team will address Adolescent Health System Capacity priorities related to this performance measure.

CCHCs provide group education to young adults and school-age children on the dangers smoking and secondhand smoke.

BHI continues provide this data from the YRBS system and the YRBS MICA.

**c. Plan for the Coming Year**

Adolescent Health Program will work with BHP on the new state-funded youth tobacco initiative and strategies to partner with youth to develop and implement tobacco use prevention campaigns, programs and policies.

DHSS Adolescent Health Crosswalk Team and CASH will address adolescent health system capacity priorities related to this performance measure.

This year, the school health contractors are implementing action plans based upon the School Health Index Assessment of policies and practices. 27 school districts have action plans related to tobacco use prevention.

The MCH Coordinated Systems contracts with LPHAs will be renewed with one of the focus areas as preventing tobacco use among adolescents and women. Each contractor will have a contractual obligation to utilize evidence-based interventions to address the issue of smoking in their community. Local system development to address smoking prevention and cessation will include direct smoking cessation interventions, community-based interventions and environmental and policy changes to impact the initiation of smoking in this population. Many community-based interventions will be focused on youth tobacco prevention in schools using best practice interventions to promote healthy lifestyle choices, decision-making, general tobacco prevention educational campaigns and advocating for policy changes with community assessment and policy recommendations to local school boards and businesses.

CCHCs will offer health promotion education to children in child care (up to 12 yrs) on the risks of smoking and exposure to secondhand smoke.

BHI will continue to provide this data from the YRBS system and the YRBS MICA.

**State Performance Measure 3:** *Percent of mothers who are prepregnancy overweight by 20% or more.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				35.2	34.7
Annual Indicator	35.1	36.2	36.5	36.7	36.9
Numerator	27012	28155	28637	29832	30219
Denominator	76960	77709	78547	81353	81879
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	36.8	36.7	36.6	36.5	36.4

**Notes - 2007**

Source: Missouri Information for Community Assessment (MICA) - Birth and Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

The trend analysis on data 1990-2007 shows the increasing trend in prepregnancy overweight in Missouri has tended to slowdown since 2004 but not yet reversed. A slight decrease from the current level would be an improvement. An annual decrease of 0.1% was set to create future objectives 2008-2012.

**Notes - 2006**

2005 numbers used, data not available for 2006 as of July 2, 2007. Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment).

Annual performance objectives for 2007-2011 are based on a regression analysis of data from 1990-2004.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment).

Annual performance objectives for 2006-2010 are based on a regression analysis of data from 1990-2004.

**a. Last Year's Accomplishments**

Home Visiting programs continued data collection and worked with mothers on diet counseling and nutrition.

Evaluation of the Pregnancy Associated Mortality Review (PAMR) data continued to obtain a better understanding of the problem and the ability to develop interventions.

CCHCs provided nutrition education to child care providers.

BHI provided data from the vital statistic system.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting staff in the MCBHV and Building Blocks Programs collected weight gain on all women during pregnancy		X		
2. Evaluation of the Pregnancy Associated Mortality Review (PAMR) data continued			X	X
3. Child Care Health Consultants provided Nutrition education to child care providers			X	
4. BHI provided this data from the vital statistic system				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The MCH Coordinated Systems contracts with LPHAs address one of three MCH health issues. Reducing obesity in the MCH population is the focus of 48 contracts with infrastructure building, population-based services and community capacity initiatives addressing obesity on the local level. Promising practices or research-based approaches include interventions that involve policy changes related to physical activity at local businesses or increased access to physical activity programs and resources within the community. Some rural contractors are addressing the availability of wholesome and nutritious foods in their communities.

Home Visiting programs continue data collection and work with mothers on diet counseling and nutrition.

CCHCs provide group education on nutrition and physical activity to child care providers.

BHI continues to provide data from the vital statistics system. Currently, BHI provides the value for pre-pregnancy weight and will do so for next year. Starting with 2010 births, Missouri will add mother's weight at birth of her child. These data will be available for analysis at a future date.

**c. Plan for the Coming Year**

Alternatives to Abortion programs will be encouraged to refer overweight women to WIC and their physician for diet counseling.

DHSS-sponsored Home Visiting programs will encourage pregnant women to utilize WIC and seek diet counseling.

The MCH Coordinated Systems contracts with LPHAs will address one of three MCH health issues. Reducing obesity in the MCH population will be the focus of some contracts with infrastructure building, population-based services and community capacity initiatives addressing obesity on the local level. Promising practices or research-based approaches, may include interventions that involve policy changes related to physical activity at local businesses or increased access to physical activity programs and resources within the community. Some rural contractors may address the availability of wholesome and nutritious foods in their communities.

BHI will continue to provide data from the vital statistics system. Currently, BHI provides the value for pre-pregnancy weight and will do so for next year. BHI will continue development on a Web-based birth system that will capture mother's weight at birth of her child starting with 2010 births. Data will be available for analysis at a later date.

**State Performance Measure 4:** *Percent of high school students who met currently recommended levels of physical activity.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				71.2	72.8
Annual Indicator	66.6	66.6	36.0	36.0	43.5
Numerator	167641	167641	99854	101764	124517
Denominator	251713	251713	277374	282678	286247
Is the Data Provisional or Final?				Provisional	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	44.5	45.5	46.5	47.5	48.5

**Notes - 2007**

The question used to estimate the indicator SPM # 4 "percent of students who participated in vigorous physical activity" was discontinued in the 2007 YRBS questionnaire: "On how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard?". Instead, to reflect the current physical activity recommendation for youth, defined as "participation in any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on >=5 of the 7 days preceding the survey", a new question has been added to YRBS since the 2005 survey: "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? (Add up all the time you spend in any kind of physical activity that increases your heart rate and makes you breathe hard some of the time.)"

2007 YRBS estimate was obtained from the Missouri Department of Elementary and Secondary Education. The 2007 data was based on the new indicator "percent of students who were physically active for a total of at least 60 minutes per day on >=5 of the past 7 days". The data reported for 2007 is comparable with the data for 2005 but not comparable with data before 2005, which reflect previously recommended physical activity for youth. Denominator is number of fall enrollment of grades 9-12 during school year 2006-2007 from the Missouri Department of

Elementary and Secondary Education.

YRBS data for the new indicator were only available for two years 2005 and 2007, which prevented the ability to conduct trend analyses. An annual increase of 1% on the new indicator was chosen to create future objectives for 2008-2012, based on estimates of the new indicator in 2005 and 2007, comparisons with other states, and discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

Data is an estimate based on results from the YRBS statistic "Percentage of students who exercised or participated in physical activity that made them sweat and breathe hard for 20 minutes or more on three or more of the past seven days" and the summary of Fall enrollment, grades 9-12, during 2004-05 and 2002-03 from the Department of Elementary and Secondary Education.

YRBS survey not conducted in 2006. Since YRBS is conducted every two years, 2005 data is used as a proxy for 2006. 2007 YRBS numbers unavailable until next year.

Annual performance objectives for 2007-2011 are based on a regression analysis of YRBS data from Missouri during 1995-2005.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

UPDATED field note as of May 2008:

2005 YRBS data is used as a proxy for 2006. 2005 numbers are revised based on a newly added question in the 2005 YRBS survey to reflect the currently recommended physical activity for youth: "participation in any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on  $\geq 5$  of the 7 days preceding the survey". Therefore, data reported in 2005 and later are not comparable with data before 2005.

**Notes - 2005**

Data is an estimate based on results from the YRBS statistic "Percentage of students who exercised or participated in physical activity that made them sweat and breathe hard for 20 minutes or more on three or more of the past seven days" and the summary of Fall enrollment, grades 9-12, during 2004-05 and 2002-03 from the Department of Elementary and Secondary Education.

Annual performance objectives for 2006-2010 are based on a regression analysis of YRBS data from Missouri during 1995-2005.

UPDATED field note as of May 2008:

2005 numbers are revised based on a newly added question in the 2005 YRBS survey to reflect the currently recommended physical activity for youth: "participation in any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on  $\geq 5$  of the 7 days preceding the survey". Therefore, 2005 data are not comparable with data before 2005.

**a. Last Year's Accomplishments**

CASH and the Adolescent Health Program in collaboration with MoCAN consulted on the development of the physical activity and nutrition campaign targeted to young adolescents. CASH selected this campaign as a 2008-09 priority.

Adolescent Health Program and adolescent medical consultants presented sessions on "healthy habits for teens: nutrition and physical activity" at the regional Current Adolescent Health Issues

trainings. The Child and Adolescent Healthcare Provider Tool Kit was promoted.

Development of the Child and Adolescent Healthcare Provider Toolkit was completed; copies may be ordered from DHSS Web site.

The School Health Program partnered with Action for Healthy Kids, the Missouri Coordinated School Health Coalition and UM Extension Service to produce and disseminate to all public and private schools in Missouri an Interactive DVD, "Movin and Grovin" for teachers to use to foster 10 minutes of physical activity in the classroom.

The School Health Program partnered with UM Extension to develop a model walking program for staff and students. The program and handouts are available on the School Health Web site.

19 LPHAs' MCH contracts addressed childhood obesity. Collaborative community-based interventions increased children's physical activity with school walking clubs, school physical education and local child care providers' activity policies and organized physical activities.

CCHC program prioritized for 2008 standardized hands-on training for child care providers on topics such as nutrition environment and physical exercise.

BHI provided data from YRBS system and YRBS MICA.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child and Adolescent Toolkit developed and made available			X	X
2. MCH Coordinated Systems supported local efforts to increase physical activity in children through contracts with LPHAs			X	X
3. CCHC program trained child care providers on socializing healthy nutritional and physical activity habits in young children			X	
4. BHI provided this data from the YRBS system and the YRBS MICA				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

48 MCH Coordinated Systems contracts with LPHAs address obesity. Interventions include building on current community-based interventions to increase physical activity in children through school walking clubs, school physical education activities and access to local exercise and physical activity facilities.

MCH Coordinated System, LPHAs and local school health staff collaborate to improve increasing physical activity in student population.

LPHAs with TOPs integrate activities to promote physical activity and nutrition. Local model programs and ways to partner with teens to promote physical activity and nutrition will be presented at June 2008 MCH Institute.

Adolescent Health, School Health Services, CASH, MOCAN and MU School of Journalism are developing statewide physical activity and healthy eating media campaign targeting adolescents.

Healthy eating and physical activity for adolescents will be addressed in 2008 trainings and ADOLESCENT SHORTS.

CASH and DHSS Adolescent Health Crosswalk Team will address Adolescent Health System Capacity priorities.

School Health addresses physical activity and good nutrition using coordinated school health framework and SHACs.

CCHCs provide group education to child care providers and parents on importance of socializing healthy physical activity habits in young children.

BHI provides data from YRBS system and YRBS MICA.

### **c. Plan for the Coming Year**

To support this MCH contract priority, LPHAs implementing TOP will integrate activities to promote physical activity and nutrition through youth education and service learning projects.

Adolescent Health Program and CASH will work with MOCAN, Hughes advertising firm and the MU School of Journalism on developing a statewide media plan and campaign targeted to adolescents to promote physical activity and healthy eating.

Healthy eating and physical activity is a current adolescent health issue addressed in trainings and the ADOLESCENT SHORTS newsletter.

DHSS Adolescent Health Crosswalk Team and CASH will address adolescent health system capacity priorities related to this performance measure.

This year, the school health contractors are implementing work plans based upon their assessment using the CDC Instrument, the School Health Index. 147 schools are addressing physical activity and nutrition.

The MCH Coordinated Systems contracts with LPHAs will address one of three MCH health issues. Reducing obesity in the MCH population will be the focus of some contracts with population-based services and community capacity building initiatives addressing obesity on the local level. Interventions will include expanding and building on the current collaborative community-based interventions to increase the amount of physical activity in children through school walking clubs, promoting appropriate physical education activities in schools and increasing access to local exercise and physical activity facilities.

MCH Coordinated System staff will continue to work with LPHAs and local school health staff to improve collaboration and address the issue of increasing physical activity in the student population.

To support this MCH contract priority, LPHAs implementing TOP will integrate activities to promote physical activity and nutrition through youth education and service learning projects.

CCHCs will provide education to child care providers and young parents on the importance of physical activity in young children. They will also provide health promotion programs to young children on this topic.

BHI will continue to provide data from the YRBS system and the YRBS MICA.

**State Performance Measure 5:** *Percent of women who enrolled in WIC during first trimester of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				51.9	52.1
Annual Indicator	51.7	50.8	42.0	41.6	41.6
Numerator	17725	18077	19101	18502	18502
Denominator	34288	35601	45478	44477	44477
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	42.3	42.5	42.8	43.1	43.3

**Notes - 2007**

Source: CDC. Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS). 2007 numbers will be available in November 2008. 2006 numbers are used as proxy for 2007.

Missouri had the third highest percent of women enrolled in WIC during first trimester of pregnancy among 29 states/territories participating in the PNSS in 2006. Objectives for 2008-2012 were based on trend analysis using the CDC data table of Missouri PNSS 1997-2006, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Data source was changed from Birth certificate records in MICA and WIC Prenatal MICA to Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS) reported by CDC. The change aimed to 1) use the same data source for both numerator and denominator, 2) define the denominator as the number of women enrolled in WIC in either period during pregnancy or postpartum period instead of only the number enrolled in WIC during pregnancy, and 3) make the indicator comparable with other states/territories with PNSS.

The measures in 2006 and 2005 were also revised based on data from the changed data source. Therefore, 2005 and 2006 numbers are not comparable with numbers reported in 2004 and earlier.

**Notes - 2006**

2005 numbers used. 2006 numbers not available as of July 2, 2007. Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment).

Annual performance objectives for 2007-2011 are based on a regression analysis of the trend in percent of women who enrolled in WIC during the first trimester of pregnancy in Missouri during 2000-2005. The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

Updated field note as of May 2008:

Changed data source: CDC. Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS). The numbers for 2006 were revised based on the changed data source. The numerator is the number of women enrolled in WIC during first trimester of pregnancy in CY 2006; the denominator is the number of women enrolled in WIC (either during pregnancy or postpartum period) in CY 2006.

Because of the change of data sources, 2006 and 2005 numbers are not comparable with numbers reported in 2004 and earlier.

**Notes - 2005**

Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment).

Annual performance objectives for 2006-2010 are based on a regression analysis of the trend in percent of women who enrolled in WIC during the first trimester of pregnancy in Missouri during 2000-2005.

Updated field note as of May 2008:

Changed data source: CDC. Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS). The numbers for 2005 were revised based on the changed data source. The numerator is the number of women enrolled in WIC during first trimester of pregnancy in CY 2005; the denominator is the number of women enrolled in WIC (either during pregnancy or postpartum period) in CY 2005.

Because of the change of data sources, 2005 numbers are not comparable with numbers reported in 2004 and earlier.

**a. Last Year's Accomplishments**

Home Visiting programs continued current interventions to refer pregnant and post partum women to WIC.

BHI provided data from the WIC Prenatal MICA.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting Programs refer all women who are not currently enrolled to WIC services.		X		
2. BHI provided this data from the WIC Prenatal MICA				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care provides information and referrals to Missouri women regarding WIC. Literature on the WIC program will be distributed at various health fairs and conferences to educate women and the public about WIC services. TEL-LINK collaborates with the WIC program by including the TEL-LINK number in a new brochure aimed at educating health care professionals. The Hispanic population is targeted in the Kansas City area by advertising TEL-LINK in the bilingual newspaper known as DOS MUNDOS.

Home Visiting and Alternatives to Abortion programs refer all women who are enrolled in their programs to WIC if not currently enrolled.

BHI continues to provide data from the WIC Prenatal MICA.

**c. Plan for the Coming Year**

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care will provide information and referrals to Missouri women regarding WIC. The TEL-LINK program will collaborate with the WIC program by including the TEL-LINK number in the newly designed brochure for educating health care professionals. Literature on the WIC program will be distributed at various health fairs and conferences to educate Missouri women and the public about WIC services.

Alternatives to Abortion programs refer all women who are enrolled in their programs to WIC if not currently enrolled.

DHSS Home Visiting programs encourage women to utilize the assistance of WIC. Many of the women are referred to Home Visiting programs by WIC, but if not already enrolled when home visiting starts they are encouraged to do so.

BHI will continue to provide this data from the WIC Prenatal MICA.

**State Performance Measure 6:** *The incidence of emergency room visits for diseases of teeth and jaw for children ages 15 and under per 1,000 population.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				0.9	0.9
Annual Indicator	1.0	1.1	1.0	0.9	0.9
Numerator	1112	1252	1126	1085	1085
Denominator	1151402	1139446	1162408	1161417	1161417
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	0.9	0.9	0.8	0.8	0.8

**Notes - 2007**

Source: Source: Missouri Information for Community Assessment (MICA) - Emergency Room, and the Bureau of Health Informatics, MO DHSS. 2007 data will be available in December 2008, and 2006 data is used as proxy for 2007.

Objectives 2008-2012 were created based on trend analysis on data 1994-2006, and discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment). 2005 data used in place of 2006 numbers until more current data is available.

Annual performance objectives for 2007-2011 are based on a regression analysis of the trend of incidence of emergency room visits for diseases of teeth and jaw for children < 15 years per

1,000 in Missouri during 1994-2004.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment).

Annual performance objectives for 2006-2010 are based on a regression analysis of the trend of incidence of emergency room visits for diseases of teeth and jaw for children < 15 years per 1,000 in Missouri during 1994-2004.

**a. Last Year's Accomplishments**

Over 17,655 early childhood learning centers, Head Start, Early Head Start and elementary-high school children received oral health screenings, education, referrals (if necessary) and fluoride varnish applications during school year 2007-2008 to prevent and control the growth of caries/cavities through the Missouri Oral Health PSP. The Missouri Oral Health PSP will be expanded in upcoming fiscal years to include all the Head Start and Early Head Start in the state. 317 schools were provided with FMR in 2007-2008 and 76,110 Missouri children received FMR on a regular basis. Schools are being transitioned from FMR to PSP (fluoride varnish) in the next 5-year period. Efforts are ongoing to implement the PSP in schools statewide. The impact of these services is to be evaluated utilizing emergency room admissions data and, after three years, the surveillance data collected in the program processes.

CCHC program provided adult group education and education for young children on the importance of good oral hygiene.

MOCCRRN provided information on dental care to families. Inclusion Specialists provide training and technical assistance on dental care for infants through school age child care providers.

BHI provided data from the patient abstract system.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Over 17,655 Head Start, Early Head Start and school children received screenings, education, referrals and fluoride varnish applications to prevent and control the growth of caries/cavities through the Missouri Oral Health Preventive Services		X	X	
2. CCHC program provided adult group education and education for young children on the importance of good oral hygiene			X	
3. MOCCRRN provides information to parents and training to child care providers on dental care		X		
4. Schools participating in FMR program and transitioning to PSP			X	
5. Number of school contracts participating in fluoride varnish			X	
6. BHI provided this data from the patient abstract system				X
7.				
8.				
9.				
10.				

**b. Current Activities**

PSP will be continued in Early Children Learning Centers, Head Start Programs, and participating school. Goal is to have all Head Start programs participating in PSP as soon as programs are ready to implement. PSP will be implemented in those schools ready to transition from FMR program to PSP as well as in other schools ready to implement PSP (screenings, education, referrals and fluoride varnish applications to prevent and control the growth of caries/cavities).

CCHC program provides adult group education and education for young children on the importance of good oral hygiene.

MOCCRRN provides information on dental care to families. Inclusion Specialists provide training and technical assistance on dental care for infants through school age child care providers.

MCH continues to support to the School Health Services Program and child care health and safety program through consultation and technical support to the local child care providers and local School Nurses addressing oral health in their communities.

The School Health Program began a new performance measure for the school health contract regarding oral health education to be delivered by School Nurses to school age children. Schools may choose to implement oral health promotion programs or to increase the number of children participating in topical fluoride programs. The program is using power point presentations developed by DHSS.

BHI continues to provide data from the patient abstract system.

**c. Plan for the Coming Year**

MCH will continue to support to the School Health Services Program and child care health and safety program through consultation and technical support to the local child care providers and local School Nurses addressing oral health in their communities.

CCHCs will provide education to child care providers and young parents on the importance of dental health in young children. They will also provide health promotion programs to young children on dental health and care of their teeth. Education is also provided to child care providers, parents and young children on safety topics such as fall prevention, safeguarding teeth.

OHP will continue to provide PSP consisting of screenings, education, referrals (if necessary) and fluoride varnish applications to early children learning centers, Head Start Program and schools throughout the state to prevent and control the growth of caries/cavities. Efforts are ongoing to encourage schools currently participating with FMR program to transition to PSP in accordance with a 5-year plan.

BHI will continue to provide data from the patient abstract system.

**State Performance Measure 7: *The incidence of domestic violence per 100,000 population.***

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				666.4	661.4
Annual Indicator	651.9	683.6	672.3	685.5	633.5

Numerator	37285	39373	38998	40053	37239
Denominator	5719204	5759532	5800310	5842713	5878415
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	660.9	659.8	658.8	657.8	656.8

**Notes - 2007**

Numerator is number of domestic violence incidents obtained from the 2007 report of the Uniform Crime Reporting Program (UCR) , Missouri State Highway Patrol. Denominator is the population estimate for 2007, obtained from the U.S. Census Bureau.

Objectives 2008-2012 were based on trend analysis on data 2001-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

Domestic violence rates obtained from Uniform Crime Reporting Program operated by Missouri State Highway Patrol.

Annual performance objectives for 2007-2011 are based on a regression analysis of UCR data from Missouri during 2001-2005.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Domestic violence rates obtained from Uniform Crime Reporting Program operated by Missouri State Highway Patrol.

Annual performance objectives for 2006-2010 are based on a regression analysis of UCR data from Missouri during 2001-2005.

**a. Last Year's Accomplishments**

MOCCRRN provided training to child care providers on recognizing and reporting child abuse and neglect.

OWH collaborated with IVPP and UMC on the Denim Day initiative and to educate, promote and empower individuals to Step Forward and Take a Stand Against Rape. Denim Day was conducted on 5 college and university campuses in Central Missouri and DHSS.

The State School Nurse Consultant presented a concurrent session to Sexual Assault Prevention Contractors on "How Schools Work and How to Work with Schools".

School Health Services Program provided in regional workshops across the state information regarding Denim Day for School Nurses and School Social Workers. Eleven school districts observed Denim Day.

School Health Services Program hosted a one-day workshop for School Social Workers on "Domestic Violence 101" and The Effects on Children Witnessing Intimate Partner Violence.

Adolescent Health Program and Adolescent Medical Consultant provided sessions on related adolescent issues. A new workshop on healthy relationships to prevent interpersonal violence was offered at "Current Adolescent Health Issues" trainings in 2007.

A TOP technical assistance session for contractors was available to address bullying and violence prevention resources for integration into programs and schools.

All women enrolled in the MCBHV and the Building Blocks Programs were assessed for domestic violence.

Through community coalitions' contracts, Governor's Substance Abuse Prevention Initiative addresses risky drinking behaviors, possible precursors to interpersonal and domestic violence.

IVPP supported 19 Sexual Assault Prevention (SAP) and 25 Sexual Assault Victim Services (SAV) grantees with contracts to implement activities to prevent violence against women. Communities were implementing primary prevention interventions linked to the state Violence Against Women plan. Conferences/trainings enhanced capacity of health and human service providers to develop safe and effective prevention, screening, interventions and follow-up strategies for sexual assault. Goals: provide professionals opportunities for discussion and collaboration; establish coordinated community response; promote partnerships among agencies; increase understanding issues faced by victims. The Sexual Assault Forensic Examination (SAFE) program paid hospitals and appropriate medical providers for the collection of evidence for cases of alleged sexual assault.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MOCCRRN provides training to child care providers on recognizing and reporting child abuse and neglect		X		
2. OWH collaborated with Injury/Violence Prevention and UMC to educate and empower individuals to Step Forward and Take a Stand Against Rape; this Denim Day initiative was conducted on 5 college/university campuses in Central Missouri and DHSS			X	
3. The School Health Program provided in regional workshops regarding Denim Day for School Nurses and School Social Workers. Eleven school districts observed Denim Day		X	X	
4. School Health Services hosted one-day workshop for School Social Workers on "Domestic Violence 101" and The Effects on Children Witnessing Intimate Partner Violence		X	X	
5. All women enrolled in the MCBHV and the Building Blocks Programs were assessed for domestic violence		X	X	
6. IVPP had agreements with communities that demonstrated strong partnerships and collaboration to develop community-wide plans that included evidence-based interventions to prevent violence against women			X	X
7. IVPP contracted with communities that had plans to prevent violence against women to begin action in those local plans. Primary prevention interventions began link to the state VAW plan to reflect community alliance			X	X
8. 2nd Annual Sexual Assault Prevention Conference enhanced skills & knowledge of professionals who provided prevention services and worked with individuals experiencing domestic violence, sexual violence, child abuse & other violent situations		X		
9. Conferences for School Staff on Bullying Prevention and Dating Violence		X		
10.				

**b. Current Activities**

TEL-LINK provides information/referrals for domestic violence shelters and resources on sexual assault centers.

MOCCRRN trains child care providers on Recognizing and Reporting Child Abuse and Neglect, Shaken Baby Syndrome and Supportive Responses to Troubled Parent-Child Interactions.

OWH and IVPP continued Denim Day events and expanded to universities, colleges, junior high and high schools statewide; other injury/violence prevention advocates, state agencies, LPHAs; and Offices on Women's Health nationally.

School Health and Adolescent Health training and activities continue.

Public Health Nurses in School Health and Maternal Health Programs are being certified in Olweus Bullying Prevention and are part of trainers cadre.

TOP projects implement bullying prevention strategies.

Home Visiting programs participate in research project with UM-Sinclair School of Nursing and Johns Hopkins University funded through National Institute of Health to assess women enrolled in Home Visiting for domestic violence and enrolled in research-based DOVE intervention.

Home Visiting and Alternatives to Abortion providers are attending July 2008 domestic violence seminar.

Sexual Assault Victim Services (PHHS funded) provides advocacy services, face-to-face counseling and support groups for victims and families of sexual violence; Sexual Assault Prevention and Education funding has been renewed; work continues to engage men and faith-based communities as allies and teens and at-risk youth.

### **c. Plan for the Coming Year**

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care, will provide information and referrals regarding the availability of domestic violence shelters and sexual assault centers.

Alternatives to Abortion programs will attend a seminar on domestic violence and will be educated on training on all clients for domestic violence.

Related topics will be presented in the ADOLESCENT SHORTS newsletter and during training on current adolescent health issues through the Adolescent Medicine and Health Consultation contract with Children's Mercy Hospital.

TOP projects will implement strategies for bullying prevention.

Home Visiting programs screen women for domestic violence and continue to be involved in domestic violence research study funded by the National Institute of Health through the UM-Sinclair School of Nursing and Johns Hopkins University. The DOVE study is funded for 5 years.

Adolescent Health, Violence Prevention and OWH will continue to identify collaborative campaigns and educational strategies to promote Denim Day, prevent sexual assault and dating violence. Abstinence education contractors have requested related training.

DHSS Adolescent Health Crosswalk Team merged with CASH and will address Adolescent Health System Capacity priorities related to this performance measure.

This year, the school health contractors are implementing work plans based upon their assessment of policies and practices using the CDC tool, the School Health Index.

All school districts now must have bullying prevention policies. Many School Social Workers and School Nurses are part of the bullying prevention teams. School Health Services is actively engaged in the Olweus Bullying Prevention Program. Several schools participated in the Denim Days initiative.

Sexual Assault Victim Services contracts (23) have been renewed for FY09. Advocacy, face-to-face counseling and support group services for victims and family members are the focus of this federal funding.

Sexual Assault Prevention and Education contracts (19) have been renewed for FY09. Despite cuts from CDC, contracts were not reduced. Each contractor identifies specific targets and milestones based on their community needs. Engaging men and faith-based communities as allies remains a priority in addition to work being done with teens and at-risk youth and adults.

OWH will collaborate with IVPP to hold events on Denim Day and utilize Denim Day materials to educate, promote and empower individuals to Step Forward and Take a Stand Against Rape. This Denim Day initiative will take place the fourth Thursday of April each year. Participants in this initiative will include universities, other injury/violence prevention advocates, public and private organizations on both state and national levels.

**State Performance Measure 8:** *Percent of women 18-44 years of age who reported frequent mental distress (FDM) for fourteen or more days during the past thirty days their mental health was not good.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				13	12.8
Annual Indicator	12.5	14.1	13.0	15.4	12.5
Numerator	251923	307312	284935	165284	134159
Denominator	2013332	2185986	2185654	1073275	1073275
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	12.5	12.4	12.4	12.3	12.3

**Notes - 2007**

Percent of women 18-44 years of age reporting their mental health not good >=14 days in the past 30 days was obtained from the 2007 BRFSS. Denominator was determined using population estimate of women 18-44 years of age for 2006, obtained from the Missouri Information for Community Assessment (MICA) - Population. 2007 population estimate for specific age groups will be available in November 2008.

A decrease of 0.1% every two years was set to create objectives 2008-2012, based on measures in past years and discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

Rates obtained from annual BRFSS survey data and MICA population data in denominator (2005 data used until more current numbers available).

Annual performance objectives for 2007-2011 are based on a regression analysis of BRFSS data

from Missouri during 2000-2004.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Rates obtained from annual BRFSS survey data and MICA population data.

Annual performance objectives for 2007-2011 are based on a regression analysis of BRFSS data from Missouri during 2000-2004.

**a. Last Year's Accomplishments**

Maternal Child Health and School Health Programs worked with Heartland Centers at St. Louis University School of Public Health, UM Center for the Advancement of Mental Health Practices in Schools, Missouri School Success Network and DMH to provide regional workshops to discuss new ways of collaborating on issues that affect mental health of Missouri's families. Emphasis was placed upon strategies for early identification of mental health issues and identification of what is necessary to achieve and maintain a mentally healthy outlook. The workshops focused on hands-on tools to promote resiliency, strong families and healthy communities. All participants received copies of Bright Futures in Practice: Mental Health.

MCH Coordinated Systems and the School Health Services Program partnered with the UM Center for the Advancement of Mental Health Practices in Schools to foster the development of district/regional leadership teams involving regional staff from mental health, public health, education and Head Start.

CCHC program provided group education on supporting good mental health and stress reduction for child care providers.

BHI provided data from the Behavioral Risk Factor Surveillance System (BRFSS) and the BRFSS MICA.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. HRSA Technical Assistance and Consultation grant to address mental health and promoting resiliency in communities			X	X
2. MCH Coordinated Systems partnered with UM Center for Advancement of Mental Health Practices in Schools to foster development of district/regional leadership teams involving regional staff from mental health, public health, education and Head Start			X	X
3. CCHC program provided group education on supporting good mental health and stress reduction for child care providers			X	
4. BHI provided data from the BRFSS and the BRFSS MICA				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

MCH Coordinated Systems provides optional regional meetings for LPHAs that are facilitated by the MCH District Nurse Consultants, with discussion topics focused on issues specific to MCH system development, as requested by LPHAs. Staff will offer consultation and technical support to LPHAs, School Nurses and community collaborations who wish to address mental wellness through identifying what is necessary to achieve and maintain a mentally healthy outlook, early identification of mental health issues and promoting resiliency for strong families and healthy communities.

CCHC program provides group education on supporting good mental health and stress reduction for child care providers.

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care, provides information and referrals to Missourians concerning mental health services.

BHI continues to provide data from the BRFSS and the BRFSS MICA.

The Home Visiting programs require routine screening for depression on all program participants.

**c. Plan for the Coming Year**

TEL-LINK will provide information and referrals to Missourians concerning mental health services as requested.

School Health Services Program and State School Nurse Consultant are partnering with a multidisciplinary group of agencies on the "Show Me Bright Futures Project" and trying to shift a paradigm from a focus on mental illness to mental health promotion. The materials and concepts for this project are based upon the Bright Futures in Practice: Mental Health work done by MCH and HRSA.

Home Visiting programs require routine screening for depression on all participants. Women who screen positive are referred to their primary health care provider for referral to a mental health provider if indicated.

MCH Coordinated Systems will continue to offer consultation and technical support to LPHAs, School Nurses and community collaborations who wish to address mental wellness through identifying what is necessary to achieve and maintain a mentally healthy outlook, early identification of mental health issues and promoting resiliency for strong families and healthy communities.

CCHCs will provide training for child care providers and young parents on mental health and stress reduction.

BHI will continue to provide data from the Behavioral Risk Factor Surveillance System (BRFSS) and the BRFSS MICA.

**State Performance Measure 9:** *Percent of special needs children ages 3-5 enrolled in public preschool programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				5.9	6.2

Annual Indicator	5.0	4.8	4.8	4.7	5.0
Numerator	10889	10790	10887	10831	11307
Denominator	218898	224535	226072	228356	228356
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	5	5.1	5.1	5.2	5.2

**Notes - 2007**

Source of numerator: Missouri Department of Elementary and Secondary Education, Division of Special Education. Students with Disabilities Child Count as of December 1, 2007.

Denominator of the population estimate for children ages 3-5 in 2007 will be available in November 2008, and 2006 data is used as proxy for 2007.

Objectives 2008-2012 were based trend analysis on data 2001-2007 and discussions with the Section of Healthy Families and Youth, MO DHSS.

**Notes - 2006**

Data obtained from Missouri Department of Elementary and Secondary Education.

Annual performance objectives for 2007-2011 are based on a regression analysis of the trend of percent of special needs children ages 3-5 enrolled in public preschool programs during 2000-2004.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Numerator obtained from Missouri Department of Elementary and Secondary Education. Denominator obtained from Census Bureau.

Annual performance objectives for 2007-2011 are based on a regression analysis of the trend of percent of special needs children ages 3-5 enrolled in public preschool programs during 2000-2004.

**a. Last Year's Accomplishments**

SHCN:

- maintained MO Assistive Technology contract to improve access and independence of CSHCN by increasing their functional capabilities and reducing barriers, which may have promoted participation in public preschool programs for CSHCN. Contract was monitored to assure quality.
- maintained CSHCN service coordination contracts. Contracts were monitored to assure quality. CATs, Service Plans and Transition Plans were completed through collaboration with participants. Participants were linked with resources, which may have included public preschool programs. SHCN trained, mentored and provided technical assistance opportunities for contract agency staff. SHCN continued to streamline, improve clarity and accountability of SOWs for the CSHCN Service Coordination Contracts yet maintained the integrity of services. Increased MCH Block Grant funding for financial support for contracts ensured successful partnerships with contractors.
- distributed the Preventive Services Checklist and maintained the document on the SHCN Web site.
- facilitated HCY and CSHCN Programs; both assisted SHCN in identifying and accessing services and supports increasing health care options and independence, which may have increased participation in public preschool programs. ACM was provided through a DSS-MHD cooperative agreement with the HCY Program. SHCN authorized medical necessity of in-home nursing services and provided participants service coordination. CSHCN Program (RSMo, CCS) was administered through SHCN and provided early identification and health services, including

service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who required sub-specialty, specialty, preventive and primary care. --collaborated with external agencies regarding transitions of participants. SHCN used several transition planning tools, partner participants and agencies to complete Transition Plans. Transition planning included preparing for public preschool programs. SHCN linked families with FS, Head Start, PAT and other resources as appropriate for CSHCN. SHCN revised policy to incorporate a broad scope of transition needs for SHCN participants; ensuring transition planning was continuous and appropriate for each participant.

UMKC coordinated the formulation and completion of a statewide ECCS plan. The MO ECCS Plan structure is a natural continuum from child and family, through community and state. Implementation phase will include collaboration among state agencies and stakeholders to develop plans for data collection and public education in focus areas of MH, parenting information, family support, early childhood programs and social and emotional mental health.

DHSS continued to contract in 2007 with MSU to provide technical assistance, training and consultation services to birthing hospitals and centers operating universal newborn hearing screening programs.

MOCCRRN provided referrals to public preschool programs to families with children with special needs, explaining the types of care available (home, center-based and public preschool), in addition to assisting families in finding vacancies. MOCCRRN also provided technical assistance to public pre-school teachers who care for children with special needs. CCHC Program provided group education to child care providers on the care of CSHCN.

TEL-LINK provides information and referrals to Missourians regarding service coordination for special health care needs.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assistive Technology for CSHCN	X	X		X
2. CSHCN Service Coordination Contracts		X		X
3. Early Childhood Comprehensive Service Grant (ECCS)		X		X
4. Preventive Services Checklist		X	X	
5. HCY and CSHCN-Hope Programs assist CSHCN to identify and access services and supports increasing health care options and independence which may increase participation in public preschool programs	X	X		
6. Transition Plans		X		X
7. MOCCRRN provided referrals to families with CSHCN between the ages of 37 months and five years. Public preschool programs were integrated into the referral database		X		
8. CCHC Program provided group education to child care providers on the care of CSHCN.		X		
9.				
10.				

**b. Current Activities**

SHCN continues to:

--maintain and monitor MO Assistive Technology contract and CSHCN service coordination contracts.

- disseminate Preventive Services Checklist and maintain document on SHCN Web site.
- facilitate HCY and CSHCN Programs and maintain DSS-MHD cooperative agreement for ACM.
- collaborate with external agencies to obtain information about CSHCN transitioning.
- participate in ECCS Plan review by Coordinating Board for Early Childhood; Board will determine if plan will be adopted for implementation. DHSS will maintain contract with UMKC to improve early childhood outcomes by developing replicable and sustainable infrastructure for local communities to implement ECCS Plan.

TEL-LINK provides information and referrals regarding service coordination for SHCN. Hispanic population was targeted in the Kansas City area by advertising TEL-LINK in the bilingual newspaper known as DOS MUNDOS.

MOCCRRN provides referrals to public preschool programs to families with CSHCN and on-site technical assistance and training to public pre-school teachers who care for CSHCN. CCHC Program provides group education and individual consultation to child care providers on the care of CSHCN. These efforts also address the state priority needs of "Supporting Adequate Early Childhood Development and Education in Missouri", "Improving the Mental Health Status of MCH Populations in Missouri" and "Reducing Intentional and Unintentional Injuries Among Infants, Children, and Adolescents in Missouri".

### **c. Plan for the Coming Year**

TEL-LINK will provide information and referrals to Missourians regarding service coordination for children with special health care needs as requested.

MOCCRRN will continue to provide referrals to public preschool programs to families with children with special needs. MOCCRRN will also continue to explain the types of care available (home, center-based and public preschool) to parents, in addition to assisting families in finding openings. MOCCRRN will also continue to provide on-site technical assistance and training to public pre-school teachers who care for children with special needs. These efforts also address the state priority needs of "Supporting Adequate Early Childhood Development and Education in Missouri", "Improving the Mental Health Status of MCH Populations in Missouri" and "Reducing Intentional and Unintentional Injuries Among Infants, Children, and Adolescents in Missouri".

CCHCs provide consultation and education to child care providers, including preschool programs, on the care of CSHCN. They will also assist preschool teachers with the creation of individualized health care plans for children in the preschool setting.

SHCN will:

- maintain and monitor the MO Assistive Technology contract to continue improving access and enhance independence of the CSHCN population.
- maintain and monitor CSHCN service coordination contracts.
- collaborate with participants in the completion of Service Coordination Assessments, Service Plans and Transition Plans.
- link participants with resources that may include public preschool programs through service coordination.
- complete the integration of CAT data into an all-inclusive participant database and continue statewide data collection using a Web-based Service Coordination Assessment that includes information regarding their educational and vocational needs.
- distribute Preventive Services Checklist from SHCN Web site and periodically review/update the document as needed.
- administer the CSHCN Program and uphold the cooperative agreement with DSS-MHD for ACM.
- collaborate with external agencies to obtain information about CSHCN transitioning within the systems of care.

--participate in ECCS Plan review by Coordinating Board for Early Childhood; the Board adopted the plan for implementation. DHSS will maintain a contract with UMKC to improve early childhood outcomes by developing a replicable and sustainable infrastructure for local communities to implement the ECCS Plan.

**State Performance Measure 10:** *Percent of children ages 0-19 years old who received health care at a FQHC.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				7.1	7.5
Annual Indicator	6.0	6.3	6.4	7.2	7.8
Numerator	94232	98456	98456	113777	123458
Denominator	1564366	1555804	1545754	1574087	1574087
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	8.2	8.6	9	9.5	10

**Notes - 2007**

Numerator is the number of children 0-19 years of age receiving health care at a FQHC in 2007, obtained from the Missouri Primary Care Association. The denominator of population estimate for children 0-19 for 2007 will be available in November 2008, and 2006 data is used as proxy for 2007.

Objectives 2008-2012 were based on trend analysis on data 2001-2007 and discussions with the Section of Healthy Families and Youth, MO DHSS and Missouri Primary Care Association.

**Notes - 2006**

Numerator data obtained Uniform Data System Missouri Rollup Reports published by Bureau of Primary Health Care. Denominator obtained from MICA (Missouri Information for Community Assessment) population database.

2006 data is not available for denominator, therefore 2005 data is used until more current numbers are available.

2007-2011 annual performance objectives based on a regression analysis of 2001-2004 data from the Uniform Data System reports.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

**Notes - 2005**

Numerator data obtained Uniform Data System Missouri Rollup Reports published by Bureau of Primary Health Care. Denominator obtained from MICA (Missouri Information for Community Assessment) population database.

2005 data is not available, therefore 2004 data is used as a proxy.

2006-2010 annual performance objectives based on a regression analysis of 2001-2004 data from the Uniform Data System reports.

**a. Last Year's Accomplishments**

DCPH entered into a contract with UMKC to design and implement a survey of institutional providers to determine what efforts are being made to recruit, place and retain primary care (PC) serving MCH populations in Missouri.

A new chief for OPCRH (Marie Peoples) was hired to replace Harold Kirbey who was promoted to deputy director for DCPH.

OPCRH partnered with MPCA and Missouri Area Health Education Center (MAHEC) to support recruitment, placement and retention of PCPs, nurses, dentists and dental hygienists in underserved areas. During 2006-2007, 10 dentists were placed in underserved and rural communities.

A plan for the evaluation of the rural health program was finalized. This evaluation included an assessment of where the strategic direction of the rural health program needs to be refocused.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OPCRH supported expansion of services and sites of FQHCs				X
2. FQHCs assisted OPCRH in implementing PSP in Head Start				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Products produced from the contract with UMKC have been reviewed for application to underserved areas in Missouri to improve recruitment, placement and retention of PCPs in those areas.

OPCRH has realigned its resources to support Missouri HealthNet reforms such as the "Healthcare Incentives Access Fund."

The evaluation of the rural health program has been completed as part of the realignment of resources in OPCRH.

With the support of OPCRH, three dental clinics have been funded in 2007-2008 with additional FQHCs requesting support for 2008-2009. This will have a definite impact on improving access to dental care.

**c. Plan for the Coming Year**

School Health Services Program will host regional meetings for School Nurses and School Social Workers. One of the topics will be access to care. A representative from a FQHC will present an overview of their system. Additionally, the FQHC system has been invited to submit an article in the School Nurse Update E Newsletter sent to all School Nurses. This E newsletter is a new

initiative for the School Health Services Program and is well received by School Nurses.

OPCRH will continue to work with area health education centers, FQHCs and LPHAs to improve recruitment, placement and retention of health care professionals in underserved areas in Missouri.

## **E. Health Status Indicators**

#01A. THE PERCENT OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS.

14.1% increase during 1990-2005, from 7.1% LBW to 8.1% LBW.

*/2009/*

**14.1% increase during 1990-2006, from 7.1% LBW to 8.1% LBW.**

*//2009//*

#01B. THE PERCENT OF LIVE SINGLETON BIRTHS WEIGHING LESS THAN 2,500 GRAMS.

6.8% increase during 1990-2005, from 5.9% LBW to 6.3% LBW.

*/2009/*

**6.8% increase during 1990-2006, from 5.9% LBW to 6.3% LBW.**

*//2009//*

#02A. THE PERCENT OF LIVE BIRTHS WEIGHING LESS THAN 1,500 GRAMS.

25% increase during 1990-2005, 1.2% VLBW to 1.5% VLBW.

*/2009/*

**25% increase during 1990-2006, 1.2% VLBW to 1.5% VLBW.**

*//2009//*

#02B. THE PERCENT OF LIVE SINGLETON BIRTHS WEIGHING LESS THAN 1,500 GRAMS.

10% during 1990-2005, from 1.0% VLBW to 1.1% VLBW.

*/2009/*

**10% during 1990-2006, from 1.0% VLBW to 1.1% VLBW.**

*//2009//*

----Source: Birth MICA.

For the above health status indicators, increase is generally attributed to changes in medical management of pregnancies.

Among the programs and activities that strive to improve the health of pregnant women and access to care and thereby reduce low weight births are:

--Home Visiting

--TEL-LINK

--ATODPA

--Newborn Health  
--Alternatives to Abortion

MCH Coordinated Systems Contracts with LPHAs --Title V funds support LPHAs for the purpose of establishing and maintaining a system capable of addressing adequate prenatal care. Two performance measures were addressed in jurisdictions where the data was most disparate:  
-Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (11 LPHAs) and  
-Decrease the percent of pregnant women receiving inadequate prenatal care (13 LPHAs).

/2008/

Contracts with LPHAs have been renewed with the focus on the objectives on injury, obesity and tobacco. Local contractors will continue to address the issue of adequate prenatal care with local funds.

//2008//

#03A. THE DEATH RATE PER 100,000 DUE TO UNINTENTIONAL INJURIES AMONG CHILDREN AGED 14 YEARS AND YOUNGER.

33.8% decrease during 1990-2005, from 14.8 per 100,000 to 9.9 per 100,000.

/2009/

**28.4% decrease during 1990-2006, from 14.8 per 100,000 to 10.6 per 100,000.**

//2009//

#03B. THE DEATH RATE PER 100,000 FROM UNINTENTIONAL INJURIES DUE TO MOTORVEHICLE CRASHES AMONG CHILDREN AGED 14 YEARS AND YOUNGER.

44.8% decrease during 1990-2005, from 6.7 per 100,000 to 3.7 per 100,000.

/2009/

**46.3% decrease during 1990-2006, from 6.7 per 100,000 to 3.6 per 100,000.**

//2009//

#03C. THE DEATH RATE PER 100,000 FROM UNINTENTIONAL INJURIES DUE TO MOTORVEHICLE CRASHES AMONG YOUTH AGED 15 THROUGH 24 YEARS.

8.4% decrease during 1990-2005, from 44.3 per 100,000 to 40.6 per 100,000.

/2009/

**18.5% decrease during 1990-2006, from 44.3 per 100,000 to 36.1 per 100,000.**

//2009//

#04A. THE RATE PER 100,000 OF ALL NON-FATAL INJURIES AMONG CHILDREN AGED 14 YEARS AND YOUNGER.

27.7% decrease during 1994-2004 from 275.3 per 100,000 to 199 per 100,000 OF ALL NONFATAL UNINTENTIONAL INJURIES (HOSPITAL INPATIENT) AMONG CHILDREN 14 YEARS AND YOUNGER.

/2009/

**27.8% decrease during 1994-2006 from 275.3 per 100,000 to 198.8 per 100,000 OF ALL NONFATAL UNINTENTIONAL INJURIES (HOSPITAL INPATIENT) AMONG CHILDREN 14 YEARS AND YOUNGER.**

//2009//

#04B. THE RATE PER 100,000 OF NON-FATAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG CHILDREN AGED 14 YEARS AND YOUNGER.

22.3% decrease during 1994-2004, from 74.4 per 100,000 to 57.8 per 100,000 OF NON-FATAL UNINTENTIONAL INJURIES (HOSPITAL INPATIENT) DUE TO MOTOR VEHICLE CRASHES AMONG CHILDREN 14 YEARS AND YOUNGER.

/2009/

**25.5% decrease during 1994-2006, from 74.4 per 100,000 to 55.4 per 100,000 OF NON-FATAL UNINTENTIONAL INJURIES (HOSPITAL INPATIENT) DUE TO MOTOR VEHICLE CRASHES AMONG CHILDREN 14 YEARS AND YOUNGER.**

//2009//

#04C. THE RATE PER 100,000 OF NON-FATAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG YOUTH AGED 15 THROUGH 24 YEARS.

1.1% increase during 1994-2004 from 257.2 per 100,000 to 260 per 100,000 OF NON-FATAL UNINTENTIONAL INJURIES (HOSPITAL INPATIENT) DUE TO MOTOR VEHICLE CRASHES AMONG YOUTH 15 THROUGH 24 YEARS.

/2009/

**2.7% decrease during 1994-2006 from 257.2 per 100,000 to 250.3 per 100,000 OF NON-FATAL UNINTENTIONAL INJURIES (HOSPITAL INPATIENT) DUE TO MOTOR VEHICLE CRASHES AMONG YOUTH 15 THROUGH 24 YEARS.**

//2009//

---Source: Injury MICA.

Injury Prevention Projects -During FY05, the Injury and Violence Prevention program provided direct contractual support for the following local injury and violence prevention activities with MCH Block Grant funding.

/2008/

Injury and Violence Prevention program continued direct contractual support.

//2008//

Injury and Violence Prevention in School Environments --The program had agreements with 41 Missouri schools to assess the school environment related to injury and violence prevention using the School Health Index: A Self Assessment and Planning Tool. Schools developed action plans for implementing the recommendations from the School Health Index assessment. The School Health Advisory Council and the school board approved the action plans.

Community Planning Grants for Preventing Violence Against Women (VAW) --The program had agreements with eight communities that demonstrated strong partnerships and collaboration to develop community-wide plans that included evidence-based interventions to prevent violence against women.

Implementation Grants for Preventing Violence Against Women --Five communities that have

existing community-wide plans to prevent violence against women received contracts to implement activities contained in those local plans. Primary prevention interventions implemented link to the state VAW plan and reflect community collaboration.

SAFE KIDS Missouri --The program contracts with the nine local SAFE KIDS coalitions in Missouri to assist with building local infrastructure. The contracts require coalitions to identify the injury prevention needs in their areas, conduct interventions to address those needs and conduct program evaluation. During 2005, the program funded the purchase of 400 child passenger safety seats for each of the nine SAFE KIDS Coalitions in Missouri (3,600 total) to help assure low income Missourians have access to child occupant protection. In addition, a large quantity of print materials was purchased for the coalitions. During FY2005, MCH funds were used to support a professional development conference for the coordinators and other members of the nine local SAFE KIDS coalitions.

/2008/

During FY2006, with MCH funds nine SAFE KIDS coalitions were able to reach a population of 100,516. Also MCH funds were used to support a professional development conference for the coordinators and other members of the nine local SAFE KIDS coalitions.

//2008//

**/2009/**

**Safe Kids Missouri--The program contracts with eight local Safe Kids coalitions in Missouri to assist with building local infrastructure.**

**During FY2007 with MCH funds, the Safe Kids coalitions were able to reach a population of 134,876. During FY2007, MCH funds were also used to support a leadership workshop for the coordinators and other members of the eight local Safe Kids coalitions.**

**//2009//**

Think First Missouri --The program contracted with the UMC School of Medicine to conduct Think First Missouri activities. This program provides primary prevention activities targeted to elementary and secondary school students related to the prevention of head and spinal cord injuries.

/2008/

In 2006 Think First Missouri reached a population of 17,364 through school assemblies and other activities.

//2008//

**/2009/**

**Revised 2006 number is 17,456.**

**Think First Missouri continues to provide school-based safety and prevention assemblies for junior high, middle and senior high school students.**

**//2009//**

Regional Conference: Interventions to Prevent Violence Against Women --This conference was designed to enhance the skills and knowledge of professionals who work with individuals experiencing domestic violence, sexual violence, child abuse and other violent situations.

Professionals are provided tools regarding how to respond to victims, victim empathy, resources, the victim response and behavior and how to provide appropriate services to an individual who has experienced or witnessed violence. In addition, a large part of the conference focused on violence prevention. The program worked with Mercy Health Plans, The Child Center, the Southeast Missouri Network Against Sexual Assault and St. Francis Medical Center to conduct: Prevention and Interventions for Ending Violence Against Women, Children and Families and

hosted local, statewide and national speakers.

The Injury and Violence Prevention Program provides technical assistance and training as well as materials to support local interventions. This included the purchase of the music video, "The Eleventh Commandment" by Collin Raye for all child advocacy centers and sexual assault prevention contractors to use in sexual assault prevention activities at the local level. The book, BLUEPRINTS FOR VIOLENCE PREVENTION, BOOK NINE: BULLY PREVENTION PROGRAM was purchased for participants at a bullying prevention training.

The Injury and Violence Prevention Program worked with the School Health and Maternal and Child Health programs to conduct a professional development opportunity for school nurses, public health professionals and injury and violence prevention practitioners. The conference, Schools and Public Health: Connection for Healthier Communities, was held in March 2005. The conference included an injury and violence prevention track. The program used MCH funds to support scholarships for injury and violence prevention practitioners to attend the conference and to network with school health and maternal and child health practitioners.

**//2009//**

***The IVPP staffs made several injury and violence prevention presentations during 2007 statewide MCH Spring meetings to various LPHAs' employees and provided handouts, brochures, safety materials and information.***

**//2009//**

During FY2005, the program partnered with the Special Health Care Needs Unit (SHCN) to assess the safety needs of children with special health care needs and acquire equipment to increase the safety of those children. Service coordinators in the SHCN Unit documented unmet needs and coordinated the purchase of safety equipment for children with special health care needs and their families. Items purchased included 166 baby gates, 202 child safety kits, 488 first aid kits, 119 helmets and pads, 52 infant head supports, 321 smoke/carbon monoxide detectors and 207 thermometers.

Through a collaborative relationship with the child care program, a number of injury prevention materials and train-the-trainer educational programs have been made available to approximately 110 local public health agencies that conduct health and safety consultation with child care providers around the state. In addition, the Injury and Violence Prevention program provides articles about specific injury issues for the quarterly child care newsletter.

**//2008/**

The MCH Coordinated Systems contracts with LPHAs will be renewed with three MCH health issues addressed. Reducing Intentional and Unintentional Injuries will be the focus of some contracts with population-based services and community initiatives addressing injury prevention in the MCH population.

**//2008//**

**//2009/**

***Local CCR&R's provide training to child care providers on Recognizing and Reporting Child Abuse and Neglect.***

***In FFY 2007, the CCHC program provided 21 hours of group education to child care providers on child passenger safety; 50 hours on injury prevention in child care; 91 hours on emergency preparedness; 18 hours on poison prevention; and 14 hours on safe sleep. In addition 283 programs were provided to young children on injury prevention topics.***

**//2009//**

#05A. THE RATE PER 1,000 WOMEN AGED 15 THROUGH 19 YEARS WITH A REPORTED

CASE OF CHLAMYDIA.

23% increase during 2000-2004, from 19.6 per 1,000 to 24.1 per 1,000.

*/2009/*

**19.5% increase during 2002-2007, from 29.2 per 1,000 to 34.9 per 1,000.**

*//2009//*

#05B. THE RATE PER 1,000 WOMEN AGED 20 THROUGH 44 YEARS WITH A REPORTED CASE OF CHLAMYDIA.

57.1% increase during 2000-2004, from 4.2 per 1,000 to 6.6 per 1,000.

*/2009/*

**38.6% increase during 2002-2007, from 7.0 per 1,000 to 9.7 per 1,000.**

*//2009//*

----Source: Population MICA; Epidemiologic Profiles.

Among the programs and activities that strive to improve the health of pregnant women and access to care:

--Home Visiting

--TEL-LINK

--ATODPA

--Newborn Health

--Alternatives to Abortion

*/2009/*

***DHSS's Bureau of HIV, STD, and Hepatitis is dedicated to the prevention and intervention of sexually transmitted infections, including syphilis, chlamydia, gonorrhea, HIV/AIDS, hepatitis B and hepatitis C. STDs can have many serious consequences for pregnant women (e.g., ectopic pregnancies and infertility) and for fetus and infants (e.g., stillbirth, preterm births, neonatal sepsis and congenital abnormalities). Preventing the spread of infection between mother and child continues to be of the highest priority. Missouri statute 210.030 requires every pregnant woman, if she consents, to be tested for syphilis and hepatitis B. In addition, CDC and DHSS recommend testing for HIV, chlamydia and gonorrhea during pregnancy.***

***The Bureau's Perinatal Disease Prevention Program offers approximately six "One is Too Many" presentations per year targeting LPHAs, OB-GYN and birthing center staff and the general medical community. The focus of the presentation is to promote CDC and DHSS guidelines regarding screening/testing, treatment, prophylaxis, vaccinations, disease case reporting and follow up of pregnant women and their infant(s). In addition, between 2005 and year to date 2008, 51 of Missouri's 75 birthing hospitals have been visited and evaluated by the program.***

***The Missouri Infertility Prevention Project (MIPP) is a partnership between DHSS and the Missouri Family Health Council (Title X Family Planning). Per CDC guidance, MIPP provides annual chlamydia/gonorrhea screening for women 25 years old and younger and older women and men with signs/symptoms and/or risk factors through Family Planning and STD clinics in Missouri. A limited supply of medications is available for treatment of infected clients and prophylaxis.***

***The Syphilis Elimination Effort (SEE) aims to reduce the rate of syphilis in Missouri***

***through outreach screening and educational events, social marketing campaigns, increased clinical setting screening and the active investigation of each reactive test reported. The current outbreak has primarily been among men who have sex with men (MSM), but recently began experiencing an increase in heterosexual exposures, including commercial sex workers. There are regional increases in heterosexual transmission of syphilis, starting first in Kansas City and expected next in the St. Louis metropolitan area. African American women continue to be at risk. The Bureau provides free testing and treatment for syphilis to LPHAs, family planning providers and community health centers. An epidemiological investigation occurs for each new case to identify and notify sex partners to offer testing and treatment. The project has far-reaching public health benefits by reducing two serious consequences of syphilis, i.e., HIV transmission and serious complications in pregnancy and childbirth.***

***The Bureau collaborates with the Missouri Department of Corrections and the metropolitan jails to provide screening and treatment opportunities for offenders, including women. Adolescent females are screened for chlamydia in the metropolitan juvenile detention facilities.***

***//2009//***

OOE provides epidemiologic leadership and expertise for DHSS divisions and centers, LPHAs and other stakeholders and partners to enhance health and safety of Missouri citizens. OOE has a full-time epidemiologist assigned to HFY and provides epidemiologic consultation on all MCH issues.

Some projects for which OOE plays the lead role are: State Infant Mortality Collaborative; PPOR analyses; MoPRA, a PRAMS-like survey and application for PRAMS funding; Fetal Alcohol Syndrome surveillance; autism surveillance; surveillance of TBI among children and adolescents and application for research funding; design and implementation of a methodology to determine new state priorities; MCH research agenda for Missouri; investigations of perceived clusters of adverse MCH events; and evaluation of several MCH programs.

BHI primary source for health data within the state. BHI oversees the statistical support and health care assurance activities of DHSS; collects, analyzes and distributes health-related information that promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians. To assure uniform and consistent reporting of all Title V related data, DCPH Director's Office works with ITSD to integrate the eleven core health systems capacity indicators and some of the health status indicators into MOHSAIC.

#### **#06A & B. INFANTS AND CHILDREN AGED 0 THROUGH 24 YEARS ENUMERATED BY SUBPOPULATIONS OF AGE GROUP, RACE and ETHNICITY.**

White population aged 20-24 years has increased by 19.6% during 1997-2004, from 296,383 to 354,435.

African-American population aged 20-24 years has increased by 25.8% during 1996-2004, from 44,649 to 56,168.

The oldest among the "Echo-Boomer" or "Generation Y" birth cohort reached 20 years of age in 1998 and have since swelled the 20-24 age range White population. The same trend is seen among the African-American population.

Total Hispanic population in Missouri has increase by 137% during 1990-2004, across the board growth in all age groups, reflects increase Hispanic immigration into Missouri.

/2008/

White population aged 20-24 years has increased by 20.1% during 1997-2005, from 296,383 to 356,016.

African-American population aged 20-24 years has increased by 26.1% during 1997-2005, from 44,887 to 56,596.

The total Hispanic population in Missouri has increased by 157% during 1990-2005, from 60,429 to 155,519, showing significant growth in all age groups, and reflects increased Hispanic immigration into Missouri.

//2008//

/2009/

**White population aged 20-24 years has increased by 16.5% during 1997-2006, from 296,383 to 345,199.**

**African-American population aged 20-24 years has increased by 23.6% during 1997-2006, from 44,887 to 55,482.**

**The total Hispanic population in Missouri has increased by 172% during 1990-2006, from 60,429 to 164,194, showing significant growth in all age groups, and reflects increased Hispanic immigration into Missouri.**

//2009//

----Source: Population MICA.

#07A & B. LIVE BIRTHS TO WOMEN (OF ALL AGES) ENUMERATED BY MATERNAL AGE, RACE AND ETHNICITY.

#08A & B. DEATHS TO INFANTS AND CHILDREN AGED 0 THROUGH 24 YEARS ENUMERATED BY AGE SUBGROUP, RACE AND ETHNICITY.

#09A & B. INFANTS AND CHILDREN AGED 0 THROUGH 19 YEARS IN MISCELLANEOUS SITUATIONS OR ENROLLED IN VARIOUS STATE PROGRAMS ENUMERATED BY RACE AND ETHNICITY.

#10. GEOGRAPHIC LIVING AREA FOR ALL RESIDENT CHILDREN AGED 0 THROUGH 19 YEARS.

#11. PERCENT OF THE STATE POPULATION AT VARIOUS LEVELS OF THE FEDERAL POVERTY LEVEL.

The mission of Missouri Reentry Process (MRP) Interagency Steering Team on which DHSS serves is to integrate successful offender reentry principles and practices in state agencies and communities resulting in partnerships that enhance offender self-sufficiency, reduce reincarceration and improve public safety.

#12. PERCENT OF THE STATE POPULATION AGED 0 THROUGH 19 YEARS AT VARIOUS LEVELS OF THE FEDERAL POVERTY LEVEL.

The Bureau of Immunization, Assessment and Assurance, supported by Title V agency, operates through a CDC grant and provides vaccine for eligible Missouri children through the Vaccines for

Children (VFC) Program. The state's success at ensuring Missouri's children are up-to-date with recommended vaccines is monitored through clinical, school and day care assessments by field staff and the immunization registry. Vaccine safety is monitored by site visits of field staff to VFC provider clinics and county health departments. In addition, yearly influenza outbreaks are monitored through the Sentinel Physician's Network. These Missouri physicians provide specimens to the state public health laboratory for validation of influenza.

The Bureau of Environmental Epidemiology is involved in the investigation and prevention of illnesses and medical conditions related to the environment. The bureau's efforts focus on illnesses and medical conditions associated with exposure to chemical, bacteriological and physical agents in our environment and in water we consume including implementation of the state Childhood and Adult Lead Poisoning Prevention Programs and administering lead grants from CDC and the Environmental Protection Agency.

For all of the preceding HSIs:

BHI is primary source for health data within the state. BHI oversees the statistical support and health care assurance activities of DHSS; collects, analyzes and distributes health-related information that promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians.

To assure uniform and consistent reporting of all Title V related data, DCPH Director's Office works with ITSD to integrate the eleven core health systems capacity indicators and some of the health status indicators into MOHSAIC.

Data generated by the BHI aid and guide the planning, development and evaluation of programs and services of the department as well as the health-related activities of other agencies, institutions and organizations.

General services of the bureau include:

- maintaining the needed Vital Statistics infrastructure and data to analyze and disseminate the health status of Missourians.
- providing specific statistical publications and preparing, editing and publishing other reports for the department.
- disseminating these data via the Web and other media.

Surveillance activities include:

- tracking selected indicators.
- disseminating data reports.
- analyzing and interpreting health data.
- providing guidance as to how the data products are intended to be used.

DCPH/ITSD provides continued integration of multiple single-purpose databases into a single system which supports a child-centered record. The initial child record is created from birth records for children born in Missouri. ITSD supports documentation of services received and/or results of screenings for the child. The system also includes data on immunizations, tuberculosis skin testing, Medicaid status, results of newborn blood spot, newborn hearing screenings results and blood lead level.

MOHSAIC utilizes a data warehouse augmented with surveillance data such as births, deaths, immunization, hospital patient abstracts, cancer registry, etc. Data fields are configured to allow analytic tools to retrieve data in an aggregated format useful for assessment and policy development purposes. Selected data from the MOHSAIC information warehouse is moved to the DHSS Web page for external users to access.

/2008/

MOHSAIC utilizes a data warehouse augmented with surveillance data such as births, deaths and immunization.

//2008//

DHSS Web pages provide access to MCH data through the Community Data Profiles and the MICA system. The Community Data Profiles are resource pages that provide information on specific MCH indicators, including a definition of the indicator, risk factors, description of the condition, intervention strategies, state-related programs, community programs and resources, contracts and grants, educational material, studies and reports and other Web sites pertaining to the MCH indicator.

Coordination and Systems Development-Title V funds are used to support staff in DCPH to carry out activities related to assessment, policy and program development, quality assurance, contract monitoring and program implementation and coordination. Coordination activities between state and local agencies and data collection, analysis and data processing services are also supported with this funding.

Epidemiological Services-Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH) programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention and other issues impacting MCH health status.

Quality Improvement-Funds will be used to develop and assist in implementing and coordinating the ongoing quality improvement plan and activities for DCPH to continually focus on improving the quality of services from Title V programs and contracting agencies. Activities would include evaluation studies, consultation, technical assistance, training workshops and focus groups. The Missouri. Examples are HFY/GHC Data Needs and Evaluation and the assessment and quality improvement of Vital Records processes.

## **F. Other Program Activities**

TEL-LINK, (1-800-TEL-LINK [800-835-5465]), DHSS toll-free information and referral telephone line for maternal, child and family health services, provides referrals and may transfer callers immediately to appropriate agency in local communities or statewide.

/2007/

TEL-LINK Web site, was developed January 2005 and had 9,984 hits in 2005. Collaboration with other state programs and agencies was developed to promote TELLINK and other health care benefits. Outreach was provided through direct mailings and exhibits at conferences and health fairs to promote TEL-LINK and distribute health educational materials.

//2007//

/2008/

In 2006 promotion of TEL-LINK was provided through direct mailings, distribution of health education materials and exhibits at conferences and health fairs. Toll free number was utilized with other state health programs such as Cancer and Chronic Disease Control. TEL-LINK Web page continues and has from DHSS home page.

//2008//

/2009/

***In 2007 promotion of TEL-LINK continued and collaboration included Genetics and Healthy Childhood, WIC and Nutrition Services and Prevent Child Abuse Missouri. TEL-LINK Web page continues with a link from DHSS home page. Special emphasis was given to promoting TEL-LINK to minority populations in St. Louis through Minority Infant Mortality***

**Reduction Campaign. Marketing efforts in Kansas City area targeted Spanish speaking individuals.**

**//2009//**

**MINORITY HEALTH DISPARITIES**

Infant death rates in Missouri have remained stagnant for past 10 years, maintaining large racial disparity for African American infants. State's overall infant mortality rate is just above national average.

Because over 60% of African-American births in Missouri occur in St. Louis metropolitan area, it is imperative that additional attention and resources be channeled to this most needy of communities.

**/2009/**

***In May 2008 OMH through collaborative agreement with MFH released STATE OF MISSOURI HEALTH DISPARITIES REPORT: PROMOTING HEALTH EQUITY & REDUCING HEALTH DISPARITIES IN MISSOURI. It revealed substantial inequities among ethnic/racial and other vulnerable Missouri groups. OMH held focus groups with minority groups to reveal barriers. Report ended with series of standards issued as guidelines to health care organizations to lessen occurrence of health disparities in Missouri. See attachment to Needs Assessment section.***

***In 2007 GHC conducted intense media campaign in high risk zip codes of St. Louis City on issues of Breastfeeding, Safe Sleep and Folic Acid. Campaign involved television and radio advertisements, posters, bus-boards, billboards and distribution of campaign materials through nurse from SIDS Resources who made personal visits to churches and small businesses in the high-risk St. Louis zip codes to promote these messages.***

**//2009//**

Proposed Intervention Strategy: DHSS will create partnership with CDC-Prevention Research Center at St. Louis University, St. Louis Maternal Child Health Coalition and MFH and request technical assistance from HRSA. DHSS will utilize evidence-based model to reduce infant mortality in zip codes at highest risk.

Building Blocks of Missouri (Old's Nurse Family Partnership Model) in St. Louis metropolitan area is intense, interpersonal pre-natal program that provides follow-up for 2 years following birth of child and helps low-income, first-time parents start their lives with their children on sound health course and prevent high-risk parenting behaviors.

**GOVERNOR'S COUNCIL ON PHYSICAL FITNESS AND HEALTH ([www.fitness.mo.gov/](http://www.fitness.mo.gov/))**

Council strives to promote exercising regularly, eating nutritiously and making healthy lifestyle choices by implementing programs, fostering communication and cooperation and developing statewide support. Council oversees such things as Shape Up Missouri/Moving Across America State by State, Show-Me Body Walk, and National Employee Health and Fitness Day, Show-Me State Games. Bureau of Health Promotion provides staff support for activities.

**OBESITY CONFERENCE**

Missouri Takes Action on Obesity Conference, held June 2006, was supported by Missouri

Council for Activity and Nutrition (MoCAN), DHSS, MFH, Missouri Beef Council, Missouri Hospital Association, KC Healthy Kids, UM Extension and MediaCross, Inc.

## OFFICE ON WOMEN'S HEALTH

OWH partnered with many St. Louis Organizations and national Sister to Sister organization for the 2nd annual Everyone has a Heart Campaign in St. Louis; St. Louis was 2nd in nation for attendance.

CARING FOR YOUR HEALTH ([www.dhss.mo.gov/WomensHealth/Caring\\_for\\_your\\_health.pdf](http://www.dhss.mo.gov/WomensHealth/Caring_for_your_health.pdf)) was a collaboration: MCH Title V funding and women' advocacy groups throughout Missouri.

/2008/

OWH partner in St. Louis 3rd Sister to Sister Everyone Has a Heart Campaign, 1st in nation with 923 women screened.

CARING FOR YOUR HEALTH was translated into Spanish, [www.dhss.mo.gov/WomensHealth/WomensHandbook-Spanish.pdf](http://www.dhss.mo.gov/WomensHealth/WomensHandbook-Spanish.pdf).

OWH with IVPP and UMC designed logo that will become national symbol to raise awareness of rape and sexual assault. Logo was made into lapel pin and placed on all materials prepared for Denim Day 2007 when 5 campuses and DHSS campus conducted organized activities. Department of Corrections stitched drawstring pants for care bags to go to Emergency Departments for rape victims.

//2008//

/2009/

**OWH partnered in St. Louis 4th Sister to Sister Everyone Has a Heart Campaign for another successful heart health screening event. Data not yet available.**

**OWH developed and disseminated Denim Day Toolkits statewide to universities and colleges, crime victims advocates, Family and Consumer Science teachers and school health nurses with other state departments. Toolkits were sent nationally to states' OWH and Injury and Violence Prevention programs and DV coalitions. DMH, DESE, Public Safety and Corrections held Denim Day events.**

//2009//

## Alternatives to Abortion Program (A2A)

Additional funds were requested and obtained from the Missouri general assembly for expanding services of A2A Program for contractors for marketing the program statewide. The goals of A2A are:

1. Improved pregnancy outcomes by helping women practice sound health-related behaviors (decreasing cigarette use, alcohol and illegal drugs; improving nutrition, etc.);
2. Improved child health and development by helping parents provide more responsible and competent care for their children;
3. Improved families economic self sufficiency by helping parents develop vision for their own future, plan future pregnancies, continue their education and find jobs.

/2009/

**In 2008 DHSS will launch media campaign through Hughes Group to promote services of A2A. Toll-free information and referral line has been established with implementation in March 2008.**

### **Adolescent Health Program (AHP)**

***AHP developed statewide media campaign to encourage parents and adolescents to talk to each other about relationships, sex, abstinence and other healthy decisions. Campaign included materials, web links and aired radio and television spots; all are posted on DHSS Adolescent Health Web page [www.dhss.mo.gov/AdolescentHealth](http://www.dhss.mo.gov/AdolescentHealth). Title V Abstinence Education grant funds were for media spots.***

***//2009//***

### **AIDS Drug Assistance Program (ADAP)**

Bureau of HIV, STD and Hepatitis administers ADAP, Ryan White Title II, Housing Opportunities for People With AIDS (HOPWA) and Medicaid AIDS Waiver services to eligible low Income Missourians living with HIV with no other access to health care and supportive services.

### **Office of Epidemiology**

OOE conducted epidemiological investigation ("An Epidemiologic Analysis of the Perceived Excess in Infant and Fetal Deaths in St. Charles County, Missouri") on cluster of fetal and infant deaths in St. Charles County in 2003.

OOE assisted in identification and prioritization of MCH-related health problems and health risk behaviors for infants, children, adolescents and women of childbearing age using Priority MICA.

OOE conducted evaluation of Home Visiting program based on participants' perceived changes in satisfaction given in annual survey conducted 10/1/03-12/31/03.

## **G. Technical Assistance**

Technical assistance requests under consideration include:

--Emergency preparation planning for hard to reach populations in Missouri to support the consolidation of Center for Emergency Response and Terrorism (CERT) within the Division of Community and Public Health.

--Evaluation of the CSHCN program.

--Assistance with grant application for Family Partnership Initiative.

--Affect on Poverty on MCH Indicators. While Missouri is 17th in the nation in relation to the 2000 U.S. Census population, the earnings for the state are not consistent with this population ranking. Technical assistance is needed to assist the state in determining the impact of poverty on MCH indicators and to help determine which indicators are/would be affected and in what way along with possible solutions to the issues.

--Medical Home (MH) Measure. Much has been written and discussed regarding MH in Missouri. Missouri has utilized several "factors" in selecting a best measure of "promotion of medical home", such as how many children have a primary care provider listed. Technical assistance from an outside source, such as the American Academy of Pediatrics, is being requested to

identify specific measures of "medical home" to determine the "best" measure of "promotion of medical home" in Missouri.

*//2009/*

***TAs have been submitted and approved to review infant mortality and evaluation of indicators for Missouri.***

***A consultant has been secured for the evaluation of performance measures with the first meeting occurring in July.***

***Missouri is still in the process of locating a consultant to provide technical assistance in identifying ways to improve healthy babies outcomes and reduce infant mortality.***

*//2009//*

## **V. Budget Narrative**

### **A. Expenditures**

Missouri budgeted \$25.5 million of partnership funds for the Federal Fiscal Year 2007 (FFY 2007) application and spent \$23,447,312 including \$12,016,312 in MCH Block Grant funds towards maternal and child health objectives in FFY 2007. MCHBG funds were budgeted at \$13,999,710.

State funds expended were \$10,126,522. State funded programs included direct health care and service coordination for CSHCN, alternatives to abortion services, School Health Services, TEL-LINK phone referral line, genetic services, sickle cell counseling, perinatal substance abuse and healthy babies initiatives, newborn hearing screening, the SAFE CARE Network, newborn screening and core public health assessment and system building. In addition Medicaid income was earned to provide service coordination.

One-time state funding was utilized instead of MCH block funds, which resulted in a corresponding decrease in federal expenditures for Preventive and Primary Care for Children. Other areas also reflect a reduction in expenditures due to delays in filling positions, realignment of duties due to reorganization and the reduction in the related fringe benefits and administrative costs.

### **B. Budget**

Please refer to the All Other Forms Section VI. Reporting Forms-General Information for the required Budget Forms 2, 3, 4, and 5. Estimates have been used in providing FFY 2009 budget details. In the case of "types of individuals served", the budget is based upon a percentage of breakdown by program and service area as to which types of individuals are impacted by the services provided. Form 5, State Title V Programs Budget and Expenditures by Types of Service, parallels the pyramid shown on Page 3 of the Attachment to Section IV. Priorities, Performance and Program Activities, A. Background and Overview, that organizes maternal and child health services hierarchically from direct health care services through infrastructure building.

#### **B.2 Other Requirements**

##### **B.2.1. Maintenance of Effort**

Missouri is in compliance with the maintenance of effort requirements described in Section 505(a)(4). Missouri has maintained and exceeded efforts of the 1989 program year.

##### **B.2.2. Justification**

The program budgets take into account the "30-30-10" requirements of Title V. In addition, Missouri uses a fair method to allocate Title V funds among individuals and areas identified as having unmet needs for maternal and child health services. The State uses its MCH Block Grant funds for the purposes outlined in Title V, Section 505 of the Social Security Act.

The FFY 2009 partnership budget is \$1.3 million more than in FFY 2008. The reason for this change is that the amount to be brought forward from FFY 2008 to FFY 2009 is anticipated to be more than the amount brought forward from FFY 2007 to FFY 2008. As a result of the second year increase, the funding for some programs that was previously reduced in the FFY 2008 partnership will be restored:

- Newborn Health
- Breastfeeding
- Injury Prevention
- School Health Services
- Training and contractor workforce development

--Assistive Technology  
--Child Care Contracts

A salary increase of 3% for state employees is included in the budget.

The Form 4 shows increases in funding for all categories. Funding has increased for Pregnant Women due to increased funding for Alternatives to Abortion. The increase in the Children category is due to increased funding for SAFE CARE Network. An increase in federal and matching funds for the School Health program is included in the preventive and primary care for children category. This category also reflects an increase in Injury Prevention and training and contractor workforce development. The CSHCN category has increased due to additional funding for Home Visiting and Information Technology Web support. The Other category reflects increases in funding for personnel costs and related fringe benefits.

The Form 5 shows an increase in all levels with the exception of Direct Care Services. This decrease is due to a reduction in funding for Rape Medical and the Elks Mobile Dental program. The Enabling category increased due to additional funds budgeted for Alternatives to Abortion. In Population Based Services, decreases in Newborn Screening Lab were offset by increases in Adolescent Health and increases in personnel costs. The infrastructure level increased due to a 3% payroll increase, realignment of personnel and related fringe benefits. This category includes an increase in the anticipated funding of SAFE CARE Network and Information Technology Web support.

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.