



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

**State Narrative for
Mississippi**

**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

The MSDH has a copy of the Assurances and Certifications on file. If you wish to review this file, please contact Ulysses Conley by email (ulysses.conley@msdh.state.ms.us) or phone at (601) 576-7688.

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

/2009/ The Mississippi State Department of Health (MSDH) solicits public input when hosting or presenting at workshops or conferences, and from the agency's webpage to maximize the opportunity for residents and community leaders to make comments and discuss their concerns. Copies of the MCH Block Grant and the Executive Summary are made available to community health centers and each of the nine public health district offices to allow residents the opportunity to visit and view these documents at their convenience. Phone calls and emails are also initiated to encourage district and local health department staff and community health centers to invite key community leaders to share their opinions and/or comments regarding the implementation of MCH block grant services in their communities.

The MCH central office staff also seizes every opportunity to inform other partners and providers of MCH Block Grant goals, objectives and activities at meetings, health fairs, and conferences (see attached document). When the MSDH conducts its five-year needs assessment, public input is again solicited in the form of consumer surveys, focus groups, and needs assessment conferences. Input is provided by professionals and consumers alike.

Public input also continues to be solicited through key parent and family support groups who are affiliated with programs funded by the grant.

An attachment is included in this section.

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

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

III. State Overview

A. Overview

Mississippi is a predominately rural state with approximately three-quarters of the 2.8 million state residents living in non-metropolitan areas. On the south, it borders Louisiana and the Gulf of Mexico; its western border is the Mississippi River; to the north is Tennessee; and to the east is Alabama. Mississippi's 82 counties occupy 47,715 square miles. Although services are offered in high risk areas in Mississippi, the Mississippi Delta area is at greatest risk for disparities in services to occur. However, all of Mississippi's 82 counties are Designated Medically Underserved Areas.

The racial composition of Mississippi residents is mixed, with three fifths of the residents white and about two fifths black. Mississippi has the largest proportion (nearly 40 percent) of black residents among all the states. The Hispanic and non-citizen immigrant populations are small but growing, as Cubans and Central Americans moved in to work for the poultry, forestry, and construction industries in the state. According to 2006 U.S. Census data estimates, Hispanics comprise 2.1% of the state's population. A substantial share of employment in Mississippi is agricultural work. Because national economic statistics do not adjust for the local cost of living, these statistics probably overstate the relative level of poverty in the state. Also, according to 2006 Census data estimates, 29.5% of Mississippi's children aged 18 and under live at or below the federal poverty rate. Because of the high level of poverty, Mississippi faces challenges more severe than those of other states when it tries to craft policies to help low-income families. The state relies on a regressive tax system to generate revenues, with a high sales tax and a low income tax relative to national averages. It also relies heavily on federal funding sources to augment its budget.

Political power in Mississippi is distributed among a number of independent bodies. There is a sense of equitable, if not necessarily shared, influence over state functions between the Governor and the Legislature. Much of this shared influence stems from the organization of state agencies, some of which fall under the Governor's purview and some of which are independent agencies. For example, the Mississippi Development Authority (MDA), the Division of Medicaid, and the Department of Human Services (DHS) are executive branch agencies, while the Mississippi State Department of Health (MSDH) is independent. Independent agencies are governed by boards whose members are appointed by the Governor. The Governor maintains indirect influence through these appointments, but independent agencies must deal more directly with the legislature in negotiating budgets and significant policy changes. With the mix of executive and independent agencies, state agency heads do not function together as a cabinet, a situation that results in a number of horizontal power bases within the state government structure. Thus, economic factors continue to influence the Title V delivery system.

The State Legislature created a Child Health Insurance Task Force in 1998 to develop a State Plan for the implementation of a State Child Health Insurance Program (SCHIP), which began providing coverage in late 1998 to children aged 15 through 18 years of age whose family income was between 33 percent and 100 percent of the federal poverty level (Phase I). A state plan to extend coverage to all children between 100 percent and 200 percent of the federal poverty level was approved by the Centers for Medicare and Medicaid Services (CMMS) in February 1999.

The implementation of Phase II began in January, 2000. This new coverage for children continues the evolution of child health services. SCHIP outreach has resulted in an increase in the number of children enrolled in Medicaid, as well as a cumulative rise in SCHIP enrollment. Over 50,000 children are now enrolled in SCHIP.

/2009/ The 2007 immunization rate for two-year old children is one of the highest among the states at 80.5 percent, and should continue improving because of the development of a statewide immunization registry and outreach campaign. Other measures of child health

and well-being are less encouraging. Compared with the nation as a whole, a greater percentage of children in Mississippi are born out of wedlock and live in single parent households. According to the 2007 Kids Count data, Mississippi ranks 45th of the 50 states in births to females ages 15-17. According to this same source, Mississippi had the highest percentages of low birth-weight babies, ranked 49th in infant mortality and 45th in child death rates, and 48th in teen deaths by accidents, homicide, and suicide. Mississippi, overall, was ranked last among the states in a composite rating of 10 selected measures of child well-being. While the economic outlook for Mississippi has become more positive in recent years, the state still remains one of the poorest in the nation. However, despite such a distinction, Mississippi is working diligently to incorporate several initiatives and/or programs aimed at addressing the risk factors that affect pregnant women, infants, children, adolescents, and children with special health care needs (CSHCN) in our state.

The Office of Health Services of the MSDH, which is responsible for all Maternal and Child Health functions, conducts an annual District Program Review at each of the nine (9) public health districts. A team of health care professionals consisting of a nurse, nutritionist, social worker, and other health-related disciplines meet with district administrative staff to discuss the district's involvement in each Maternal and Child program. Programs such as Family Planning, Maternity, and Early Intervention are discussed to identify opportunities for improvement. To date, the district review process has occurred in 5 (districts IV, V, VI, VII, and VIII) of the 9 public health districts. The remaining District Reviews are slated to occur in public health districts I and III in November, public health district II in September, and public health district IX in October, 2008.

In an effort to eliminate infant mortality in the Mississippi Delta, the Mississippi State Department of Health seized an opportunity to work with the Delta Health Alliance to address the reduction of infant mortality in that area of the state. During February, 2008, an application was submitted and has received funding to initiate a Delta Infant Mortality Elimination (DIME) project, which was scheduled to begin July 1, 2008. The primary focus of the proposed project is to reduce infant mortality in the Mississippi Delta. The DIME project targets gaps in women's and infants' health services in the 18 counties of the Delta Health Alliance initiative. The DIME project is a multidimensional, multicollaborative effort including the MSDH, the University of Mississippi School of Medicine, the University of Mississippi School of Nursing, and the Jackson State University College of Public Service.

The DIME project proposes to accomplish its goal of decreasing infant mortality in the Mississippi Delta by: 1) Filling gaps in healthcare services for women and infants; 2) Increasing efficiency and utilization of available healthcare services for women and infants; and 3) Enhancing knowledge and skills of healthcare consumers and providers in the Delta.

High infant mortality in the Delta region may be caused by gaps in women's and infants' health services including inadequate healthcare resources, inefficient chronic disease management, low utilization of family planning services, high rates of sexually transmitted disease, and limited access to prenatal care, all confounded by scarce enabling services such as transportation assistance and drug coverage. All of these factors in part contribute to high infant mortality rates in the Mississippi Delta. The DIME project will strategically assemble partners to increase the number of providers in the Delta, enhance case management and follow up services, initiate post-partum home visitation activities, and increase access to women's healthcare and chronic disease management. An additional DIME component will be coordinated infant death review conferences among health department and local providers to gain insight on opportunities to improve outcomes for infants and families of the Mississippi Delta. Outreach and educational services will be provided at individual, community, and professional education levels.

Also, legislation establishing a Child Death Review (CDR) Panel went into effect on July 1, 2006. The statute initially provided for the State Medical Examiner's Office to have administrative oversight of the CDR Panel. However, this oversight was moved by statute from the Medical Examiner's Office to the MSDH effective July 1, 2008. The CDR panel reviews data related to infant and child mortality. The primary purpose of the Panel is to foster the reduction of infant and child mortality and morbidity in Mississippi, and to improve the health status of infants and children age 0 to 17 years of age. The CDR Panel is composed of fifteen (15) voting members: the State Medical Examiner or his representative, a pathologist on staff at the University of Mississippi Medical Center, an appointee of the Speaker of the House of representatives, and one (1) representative from each of the following: the State Coroners Association, the Mississippi Chapter of the American Academy of Pediatrics, the Office of Vital Statistics in the Mississippi State Department of Health, the Attorney General's Office, the State Sheriff's Association, the Mississippi Police Chiefs Association, the Department of Human Services, the Children's Advocacy Center, the State Chapter of the March of Dimes, the State SIDS Alliance, and Compassionate Friends. The chairmen of the review panel is elected annually by the panel members.

Mississippi, being declared one of the most obese states in the nation, is addressing this issue by working to implement the BodyWorks Program throughout the state. BodyWorks is a program designed to help parents and caregivers of adolescents improve family eating and exercise habits. Using a Toolkit, the program focuses on parents as role models and provides them the hands-on tools to make small, specific behavioral changes to prevent obesity and help families maintain a healthy weight. In addition to implementing the BodyWorks program, the MSDH will also utilize existing programs such as Blue Cross and Blue Shield of Mississippi and the Governor's Office "Let's Go Walkin' Mississippi" Program, the Association of State and Territorial Public Health Nutrition Directors (ASTPHND), "Blueprint for Nutrition and Physical Activity: Cornerstones of a Healthy Lifestyle" to improve the health status of all Mississippians, the Division of Medicaid's "Roads to Good Health Guide Book", and the American Cancer Society's "Body and Soul Program." This and other statewide initiatives will be achieved by conducting education and outreach activities that encourage citizens to eat healthier, increase physical activity, participate in preventive health screenings that promote the utilization of community health care providers, and eliminate tobacco usage.

Tobacco use is the leading preventable cause of death and disease in the United States. In Mississippi, 4,700 adults die each year from their own smoking. More than 4,400 youth become regular smokers each year, and 192,000 children are exposed to secondhand smoke at home. Tobacco use results in \$719 million in annual healthcare costs in Mississippi.

The Mississippi State Department of Health is working to address the impact of tobacco use through the programs of the Office of Tobacco Control. Established by SS 41-113-3 of the Mississippi Code of 1972, the MSDH Office of Tobacco Control is charged with developing and implementing a statewide and comprehensive tobacco education, prevention and cessation program based on the Centers for Disease Control and Prevention's Best Practices for Comprehensive Tobacco Control Programs. Eight million dollars has been appropriated to MSDH during FY 08 to implement the statewide and comprehensive tobacco education, prevention and cessation program. In addition, the program receives funds through a Cooperative Agreement with the Centers for Disease Control and Prevention. Both funding sources allow the MSDH Office of Tobacco Control to provide evidence-based tobacco prevention and control programs and interventions to all Mississippians.

In addition to the establishment of the MSDH Office of Tobacco Control, SS 41-113-9 of the Mississippi Code of 1972, also created the Mississippi Tobacco Control Advisory Council

to advise the State Board of Health on the development and implementation of the program. The MS Tobacco Control Advisory Council is comprised of thirteen members who are appointed by state and university officials. Since 2007, the MS Tobacco Control Advisory Council has maintained a high level of involvement in the development and implementation of the programs.

The mission of the MSDH Office of Tobacco Control is to promote and protect the health of all Mississippians by reducing tobacco-related morbidity and mortality. The program accomplishes this mission by utilizing a systemic approach to tobacco prevention and control. Program components include: state and community interventions; health communication interventions; tobacco cessation interventions; and, surveillance and evaluation. Each program component is developed and implemented based on evidence-based strategies and the recommendations outlined in CDC Best Practices -- 2007.

Since its inception in July 2007, the MSDH Office of Tobacco Control has worked diligently to develop the statewide and comprehensive tobacco education, prevention and cessation program. Through CDC Cooperative Agreement funds, the program has partnered with the MSDH Office of Preventive Health, Chronic Disease Bureau to establish chronic disease coalitions, which educate communities on cardiovascular disease, diabetes, asthma and tobacco use. The program has furthered its efforts to enhance established coalitions by supporting the MSDH/American Lung Association of Mississippi's district-level asthma coalitions. In addition to coalition-building and enhancement, the program provides funds to MSDH health educators to allow resources and information to be distributed at the grassroots level, and the program works with MSDH district and county offices to promote tobacco cessation services such as the Mississippi Tobacco Quitline. The program also supports state and local networking opportunities through its administrative roles in the Mississippi Tobacco Control Network and the Mississippi Tobacco Disparities Network.

In addition to Cooperative Agreement funds, the program has worked to further develop statewide programs and interventions. In January 2008, the office issued contracts to two entities that have remained at the forefront in tobacco cessation within Mississippi: Information and Quality Healthcare (MS Tobacco Quitline) and University of Mississippi Medical Center ACT Center. In February 2008 and March 2008, the office awarded funds for the development/implementation of the following program components/strategies: community coalitions and targeted interventions; statewide youth tobacco use prevention program; mass media campaign addressing youth tobacco use, cessation and promotion of the MS Tobacco Quitline; and, surveillance and evaluation. As of April 2008, the MSDH Office of Tobacco Control has provided funds to more than 40 community and statewide organizations.

Although it has been three years since Mississippi's coastal counties were devastated by Hurricane Katrina, adequate health care is still a concern for Gulf Coast residents. While Vietnamese patients have decreased, there has been a greater increase in the number of Hispanic patients being seen by the health department(s). The influx of Hispanic patients produced a need for Spanish interpreters, which have been obtained to assist in helping the Hispanic population, especially in Harrison and Jackson counties. Some patients are not able to read their own language, and the addition of interpreter assistance was instrumental in helping meet the needs of the Hispanic populace. Due to lack of health insurance, or knowledge of the health system, Hispanic women often present late in their pregnancy, which increases risks related to prenatal care. Once the newborn is delivered, mothers and their newborns continue to be served through WIC, Immunizations, and Family Planning clinics. However, in addition to partnering with other providers to improve the provision of services to the MCH population, the MSDH currently provides an array of health education programs on a statewide basis through district and local county health departments. Health education is being provided to residents in the areas on poison

prevention, child safety, immunization, infection control, nutrition, childhood obesity, fire safety, oral hygiene, and dental screenings. Many of these educational services are provided with the assistance of partners in communities, schools, and faith-based groups targeting youth and adolescents.

In addition to concerns about adequate access to health care, coastal residents currently living in FEMA trailers are also concerned over the fact that many of FEMA's nearly 36,000 manufactured homes nationwide have high levels of formaldehyde, a preservative that can pose health risks from high-level exposure to it. So far, according to an article printed April, 2008 in an AARP Bulletin, there have only been reported complaints of watery eyes, constant asthma flare-ups, sinus congestion, and trouble breathing. The article further stated that FEMA officials now say they will relocate the residents to other housing.
//2009//

B. Agency Capacity

The MSDH is the state agency responsible for administering the Maternal and Child Health (MCH) Block Grant. MCH Block Grant funds are allocated in the central office to the Offices of Women's Health and Child and Adolescent Health. The Children's Medical Program (CMP), the program of services for Children with Special Health Care Needs (CSHCN), is located organizationally in the Office of Child and Adolescent Health. All are located organizationally within Health Services (HS). (see organization chart at www.msdh.state.ms.us). These two HS Offices (Women's Health and Child and Adolescent Health) provide services for the three major populations targeted by the MCH Block Grant, which are women and infants, children and adolescents, and children with special health care needs.

The MSDH operates a statewide network of local health departments and specialty clinics which serve the MCH population. Although the MSDH provides services to all 82 counties, only 81 counties have county health departments. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

County level efforts are coordinated through nine public health districts. The District Chief Nurse oversees all public health nursing activities in the district and supervises the Maternal-Child Health/Family Planning Coordinator.

Child/Adolescent Health Services

Children's Medical Program

The Children's Medical Program provides medical and/or surgical care to children with chronic or disabling conditions. Program services are available to state residents through 20 years of age who meet eligibility criteria. Conditions covered by the Children's Medical Program include major orthopedic, neurological, and cardiac diagnoses, and chronic conditions such as cystic fibrosis, sickle cell anemia, and hemophilia. The program provides community-based specialty care through 10 clinic sites in which 39 specialty clinic sessions are held throughout the State, including a multi-disciplinary clinic centrally located in Jackson at the Blake Clinic for Children in the Jackson Medical Mall.

The CMP has a very strong link with the county health department system. Genetics/CMP Coordinators are utilized to provide community based CMP application sites, screening and referral services, as well as a base of operations for central office staff when clinics are

conducted at the community level. The CMP has developed partnerships with the University of Southern Mississippi Institute for Disability Studies (IDS), Cerebral Palsy Foundation, Cystic Fibrosis and Hemophilia parent support groups, Division of Medicaid, the University of Mississippi Medical Center, and the Choctaw Indian Health Services to ensure that all support services are coordinated for the patients when and where appropriate.

The CMP utilizes the CMP Advisory Committee to communicate with and receive feedback from health care providers and consumers. The Advisory Committee includes specialty and sub-specialty physicians (pediatricians, pediatric orthopedic surgeons, pediatric cardiologists, etc.), dentists, physical therapists and other health care providers, and parents of CMP patients. Through this effort, providers are advised of program efforts to increase awareness efforts about program services and the efforts to assist CMP patients in finding a medical home. CMP also receives input from the CMP Parent Advisory Committee composed of parents of CSHCN served by the program.

/2009/ CMP has partnered with the University of Southern Mississippi Institute for Disability Studies (IDS) to utilize a Parent Consultant in a dual role. She serves a Parent Consultant and as the Family to Family Health Information and Education Center Coordinator. At CMP clinics, she provides support services to families. Through her experiences with CMP as a parent, she has a unique perspective on the services CMP provides to its patients. She is relied upon to share her experience and perspective in assisting CMP in providing quality service and in policy decision making. She serves in an advisory capacity with CMP's Advisory Committees. She has a pivotal role in the development of Family to Family Health Information and Education Center which will enhance CMP's efforts to involve families of CSHCN as partners in decision making at all levels. CMP has also partnered with IDS to conduct a telephone survey of families of children with special health care needs to assess the needs of families based on the six core MCHB outcomes. /2009//

Adolescent Health Services

/2009/ Adolescent health information and services are provided through many existing programs within the Mississippi State Department of Health service delivery system. Services include, but are not limited to: comprehensive health screenings and referrals, oral health screenings and referrals, abstinence education, nutritional assessment and counseling, genetic counseling, tobacco prevention, health promotion, safety and prevention education, social services, mental health referrals, immunizations, sexually transmitted disease education and prevention and HIV awareness, reproductive health, domestic violence and rape prevention and crisis intervention, and habilitative services for adolescents with special health care needs.

The Mississippi State Department of Health, Adolescent Health Services Program has established collaborations with many partnering agencies and organizations to fulfill its mission to respond to the many issues impacting children, adolescents and young adults. Several critical initiatives include collaborating with: (a) Mississippi Department of Education to strengthen communications and collaboration between State Departments of Education and Health to support and improve HIV, STD, and Unintended and Teen Pregnancy prevention for school-aged youth and to improve school health and public health education policies and programs; (b) Mississippi Department of Mental Health to address an interagency system of care approach to deliver accessible and appropriate wrap-around community-based level services and treatment to children, adolescents and families with serious emotional, mental health disorders, substance abuse disorders and/or with juvenile justice system relations; (c) Mississippi Department of Human Services to deliver a wide range of community social services for vulnerable children, youth and their families in order to prevent and/or reduce service dependency, teen

pregnancy, neglect and abuse and inappropriate institutionalization; (d) Mississippi Alliance for School Health to improve the health of school-aged children and youth through the promotion of coordinated school health services; and (e) Mississippi Department of Employment Security to deliver basic and appropriate health services to youth in order to prevent and reduce school dropout and youth delinquency rates.

The Adolescent Health Coordinator serves on numerous task forces and committees to raise awareness, educate, and plan interventions regarding critical health-risk behaviors and issues confronting children, adolescents, and young adults such as alcohol and drug abuse, bullying, violence and crime, obesity, injury and safety, teen suicide, school dropout prevention, juvenile delinquency, peer pressure and stress, transition, sexual health, unintended and teen pregnancy and parenting among adolescents.

Future health initiatives include establishing additional statewide, regional and community-based partnerships and trainings with middle and high schools, colleges and universities, national and state youth development organizations, such as United Way of America, 100 Black Men, Boys and Girls Club of America, Big Brother, Big Sister of America, Boy and Girl Scouts of America, Children's Defense Fund, Students Against Destructive Decisions (SADD), faith and community-based organizations, and youth-centered advocacy organizations and alliances to achieve the Healthy People 2010 objectives related to the adolescent health. //2009//

Genetic Services

//2009/ The Genetics Services Program provides comprehensive services statewide for a broad range of genetic related disorders. Priority is given to prevention measures to minimize the effects of these disorders through early detection and timely medical evaluation, diagnosis, and treatment. Newborn screening is mandated by law in Mississippi. In 2003, the MSDH expanded the screening panel to include the American College of Medical Genetics (ACMG) and March of Dimes (MOD) universal panel along with other disorders/diseases recommended by the MS Genetics Advisory Committee. The program provides newborn screening for phenylketonuria, hypothyroidism, hemoglobinopathies, galactosemia, congenital adrenal hyperplasia, biotinidase deficiency, cystic fibrosis, medium-chain acyl-CoA dehydrogenase deficiency, and 32 other disorders to identify these problems early and allow for immediate intervention to prevent irreversible physical conditions, developmental disabilities or death. Professional and patient education is provided on a yearly basis to ensure that information is readily available to the population at risk, as well as to hospitals, physicians and other health care providers.

The newborn screening program provided screening for over 99 percent of all newborns in the state during 2007. In 2007, there were 2,071 patient follow up visits due to inadequate specimen collection, rejection of the specimen by the lab, or inconclusive test results. Follow-up counseling, referral for medical evaluation, and treatment were provided by the program for 100 percent of babies detected with heritable genetic disease/disorder through the screening program.

The CMP/Genetics Coordinator team consists of a nurse and/or social worker and clerk in each of the nine public health districts. The team works with county and central office health department staff to assure adequate follow-up, care coordination, and continuity of care for patients and their families.

Clinical services are provided primarily through referrals to the University of Mississippi Medical Center, Mississippi's only tertiary care center. Genetics satellite clinics are also routinely conducted in six public health districts in the state. These satellite clinics make

genetic services more accessible for patients and families. The Genetics Services program will continue to increase awareness and education among community providers regarding newborn screening and reporting to the birth defects registry. The program staff will provide on-going education to providers on the follow-up of genetic disorders. //2009//

Early Intervention

First Steps is Mississippi's early intervention system for infants and toddlers with developmental delays and disabilities and their families. The MSDH is the lead agency that ensures an effective and appropriate implementation of IDEA, Part C. Other agencies such as the Mississippi Departments of Mental Health (MDMH), Education, Division of Medicaid, and Human Services collaborate with the MSDH and assist with the direct provision of early intervention services, referrals of potentially eligible infants and toddlers, and funding of the delivery of early intervention services.

Early intervention is implemented through an interagency system of comprehensive developmental services for eligible infants and toddlers. The statewide system seeks to minimize the impact of a disabling condition on an infant or toddler and his or her family by identifying and utilizing, to the maximum extent possible, community based resources. The process of identification of an eligible infant to the provision of services and transition of the toddler into an appropriate educational setting is well orchestrated in keeping with the regulations of the Individuals with Disabilities Education Act (IDEA) Part C.

A child with a developmental delay of 25% in any one developmental domain could be eligible for early intervention services. Infants and toddlers with conditions known to cause developmental delays are automatically eligible for services. These include genetic disorders (such as Down Syndrome), sensory impairments (hearing and vision impairments), and other diagnosed conditions (such as autism or cerebral palsy). Additionally, a qualified provider through informed clinical opinion can establish eligibility for a child. Under IDEA's child find component, the identification, location, and evaluation of infants and toddlers birth to age 3 is a shared responsibility of the MSDH under Part C and the Mississippi Department of Education (MDE) under Part B of the Act.

In 2005, the United States Department of Education/Office of Special Education Programs implemented an accountability system for states participating in Part C. A six-year plan with baselines, targets, activities, and timelines for fourteen indicators was developed by each state's program. The State Performance Plan and Annual Performance Reports must be made publicly available. They are posted on the First Steps home page of the MSDH website.

//2009/ The Early Intervention program's data system, known as the First Steps Information System (FSIS), has undergone recent changes to enhance the program's capability to collect and analyze data needed for the federal reporting requirements. Data are used for monitoring and managing the program statewide and at the local level. As a direct result of changes to FSIS and referral procedures, the referral rate increased by 23% in a two-year period.

Early Hearing Detection and Intervention

Early Hearing Detection and Intervention in Mississippi (EHDI-M) functions as part of the First Steps Program. EHDI-M is the Mississippi State Department of Health's designated program authorized to establish an early identification system for early hearing loss. The EHDI-M implements a statewide family-centered comprehensive delivery system of developmentally appropriate services for infants and toddlers with hearing impairments, coordinated within the child's medical home. Universal newborn hearing screening is being implemented in all hospitals delivering greater than 100 infants per year. Aggressive

follow-up is provided for infants referred from hospital screens to ensure the completion of diagnostic processes and timely referrals into the early intervention system.

Hearing Resource Consultants (HRC's) are contracted by the EHDI program to offer unbiased information regarding intervention choices to families. HRC's link families to support systems and to the Early Intervention system. They participate in the Early Intervention evaluation and Individual Family Service Plan development.

Oral Health

The MCH Block Grant provides funding for a dental sealant program in nine counties in Public Health District III and two counties in District V. The FY 2005 MCH Needs Assessment showed that 12% of third-grade children had dental sealants in District III compared with 26% of children statewide. During the 2007-2008 school year, 1,620 dental sealants were placed on the permanent first molar teeth of 474 children in these counties. But tooth decay remains a serious problem in all 82 counties and additional MCHB funding is needed to expand the program. In FY 2007, a CDC-funded weekly school fluoride mouth rinse program served about 26,746 children in grades 1 thru 5 who live in non-fluoridated areas. CDC-funding is also used to employ 5.5 FTE dental hygienists who provide oral health education, perform oral health screening, and obtain oral health surveillance data. In April 2007, the Mississippi State Board of Dental Examiners adopted a resolution to permit the hygienists in the employ of the Board of Health to apply preventive fluoride varnish as part of oral health screening and education. During the 2007-2008 school year, we provided fluoride varnish to children ages 3 to 5 in a sample of 150 classrooms that participated in an oral health survey at 22 Head Start programs.

The MCH Block Grant provides salary support for a full-time dental director who determines oral health needs, develops policies, and coordinates programs and resources for population-based services. The FY 2005 MCH Needs Assessment showed that 70% of Mississippi's school-age children experienced tooth decay and two in five children have untreated dental decay. In 2006, a Governor's Oral Health Task Force approved a five-year (2006-2010) state oral health plan.

Two oral health questions were included in the agency's WIC Certification to identify source of dental care and to identify pregnant women with symptoms of an oral infection. Data from 26,672 women showed that a higher proportion of blacks (58.8%) reported no source of dental care compared to whites (38.1%) who utilized the WIC service.

Children diagnosed with cleft lip and/or palate or a craniofacial syndrome are eligible for coverage of procedures involving the oral cavity and related affected structures through the Children's Medical Program. In CY 2007, there were 270 CMP patients with the primary diagnosis of cleft lip/palate.

Immunization Program

The Bureau of Immunization provides and supports services designed to ultimately eliminate morbidity and mortality due to childhood vaccine-preventable diseases, such as diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Haemophilus influenzae-type b, hepatitis A, hepatitis B, Rotavirus, and chickenpox. The bureau also provides services to prevent morbidity and mortality related to influenza and pneumonia. Services include vaccine administration, monitoring of immunization levels, disease surveillance and outbreak control, information and education, and enforcement of immunization laws.

The Immunization Program assures that adequate supplies of vaccine are available for MSDH health departments and Vaccines for Children (VFC) Providers. The program

annually monitors both public and private schools and licensed child care facilities for compliance with immunization law and regulations. The program conducts an annual survey to determine the immunization status of children at 24 months of age, and several other surveys to determine the immunization status of other population groups. Additionally, staff develops education materials and provides training to immunization providers in the public and private sector; facilitates a statewide immunization coalition; and assists in the development of a statewide immunization registry.

School Nurse Program

For the period defined as the 2007-2008 school year, the Department of Education reports 419 school nurses statewide. 94% of these nurses are Registered Nurses (RN), and 6% are Licensed Practical Nurses (LPN). An LPN must be supervised by an RN to meet Mississippi School Nurse Procedures and Standards of Care guidelines. In addition, there are 2 Nurse Practitioners, and 10 Certified Nurse Assistants.

Overall, the average across the state was 2.7 school nurses per district. The Department of Education estimates a nurse to student ration of 1:1174 - a number well above the National School Nurse Association's recommendation of 1:750 for general student population or 1:225 when students with special health care needs are mainstreamed with other students.

Women's Health Services

The MSDH Women's Health programs provide women with or assure access to comprehensive health services that affect positive outcomes, including early cancer detection, domestic violence prevention and intervention, family planning, and maternity services.

Breast and Cervical Cancer

The Breast and Cervical Cancer Early Detection Program works to reduce high morbidity and mortality caused by breast and cervical cancer in Mississippi. The target population for the program is uninsured, underinsured, and minority women. Women 50 to 64 years of age are the target group for mammography screening, and women 45 to 64 years are the target for cervical cancer screening.

Domestic Violence, Rape Prevention and Crisis Intervention

The MSDH provides funding to 14 domestic violence shelter programs and nine Rape Crisis Center Programs. When requested, the MSDH provides brochures, pamphlets and educational materials on a statewide basis to the general public and other organizations.

Domestic violence shelters strive to meet the individual needs of every victim entering a shelter as a result of domestic violence. Program staff seeks to empower and enable through teaching life skills that promote non-violent responses which lead to a more peaceful life. Services include but are not limited to: temporary, safe housing; education regarding domestic violence; child care; transportation; job skills training; assistance in locating permanent housing; medical assistance; financial assistance; group and individual counseling; court advocacy; and transitional or second stage housing.

The sexual assault/rape crisis centers provide primary prevention and education activities, preventive services, as well as direct crisis intervention services to victims of rape and other forms of sexual assault. Primary prevention focuses on education to eliminate

violence from sexual assault before it occurs. Although preventing the act from occurring is the desired outcome, prevention is not always an option. Centers spend a great amount of time providing direct service to victims of sexual assault including: court advocacy; transportation; confidential counseling; family intervention and follow-up services.

The new focus for rape crisis centers is primary prevention and education activities (preventing the act of violence before it occurs). These educational activities will focus on men and boys in an effort to change their beliefs and attitudes and increase respect for themselves, women and girls. The perception is that this approach will help to end or prevent the cycle of sexual violence against women.

//2009/ During FY 2007, a total of 2,134 (1,005 women and 1,129 children) received shelter services in Mississippi as a result of domestic and/or family violence. The number of sexual assault cases reported to rape crisis centers in Mississippi totaled 1,620 (146 men, 841 women and 633 children). //2009//

Family Planning Program

The Family Planning Program promotes awareness and assures access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives. More than 60,793 Mississippians received comprehensive family planning services in CY 2007, and approximately 18,027 of those were age 19 years or younger.

The target populations are Teenage Females 19 and women ages 20-44 at or below 150 percent of poverty level. A fee system with a sliding scale is used. Under this scale, clients with an income at or below 100 percent poverty level are not charged for services. Reimbursement is sought for Medicaid eligible clients.

The family planning program:

1. Medical and non-medical counseling about methods of contraception,
2. Medical examination and provision of contraceptive method,
3. Pregnancy testing and counseling and
4. STD/HIV Testing & Counseling

The family planning program also provides blood pressure screening, clinical breast exams, cervical cancer screening, follow-up of abnormal Pap smears and treatment, treatment for sexually transmitted diseases, preconception care, sterilization, and infertility services. Access to other MSDH services such as WIC, immunizations, prenatal care, child health, and children's medical services is provided to family planning clients and their families as needed.

The Family Planning Program Demonstration Waiver was requested from Medicaid in 1999, approved in December 2002, and implemented statewide in October 2003. The waiver was designed to increase the number of women served and the length of time services would be available to them. An evaluation of the program expanded the Family Planning baseline data by examining inter-pregnancy intervals (IP) in the repeat birth population. The project is in the process of being evaluated by Health System through the Division of Medicaid with the inclusion of the Mississippi State Department of Health.

The Family Planning Waiver Program represents a collaborative effort between the Division of Medicaid and the Mississippi State Department of Health to increase the availability of family planning services to all women of childbearing age (13-44) with incomes at or below 185% of the federal poverty level who would not otherwise qualify for Medicaid. During Calendar Year 2006 a total of 44,918 beneficiaries enrolled in the Family Planning Waiver Program with 123 private providers that provide services to some of these beneficiaries.

Maternity

MSDH Maternity Services Program aims to reduce low-birth weight, infant and maternal mortality, and morbidity in Mississippi by providing comprehensive, risk-appropriate prenatal and postpartum care through county health departments.

During CY 2007, approximately 19 percent of the women who gave birth in Mississippi received their prenatal care in county health departments. Public health nurses, nurse practitioners, physicians, nutritionists, and social workers provide this cost-effective, comprehensive primary, as well as, preventive care. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a critical component of the maternity care effort.

A part-time, board-certified obstetrician/gynecologist continues to provide consultation statewide for the maternity and family planning programs. The public health team at the district and county level evaluates the maternity patient at each visit, using protocols which reflect national standards of care for maternity patients. Special emphasis is placed on the identification of high-risk factors and ensuring appropriate care to reduce or prevent problems. This includes arranging for delivery by an obstetrician at hospitals that provide the necessary specialized care for the mother and her baby.

Perinatal High Risk Management/Infant Services System

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) provides a multidisciplinary team approach to high-risk mothers and infants. Targeted case management, combined with the team approach, establishes better treatment of the whole patient, improves the patient's access to available resources, provides for early detection of risk factors, allows for coordinated care, and decreases the incidence of low birth weight and preterm delivery. These enhanced services include nursing, nutrition, and social work. This team of professionals provides risk screening assessments, counseling, health education, home visiting, and monthly case management.

PHRM services were provided to health department postpartum women who were not Medicaid eligible due to their socioeconomic status. In some districts, public health nurses visit postpartum women prior to their discharge from the hospital. In Fiscal Year 2007, the PHRM/ISS program provided services to 29,116 mothers and infants.

Perinatal Regionalization

Regionalization of perinatal services is an effective strategy for decreasing neonatal and infant mortality and morbidity, with pronounced effects on mortality among Very Low Birth weight (VLBW) infants (<1,500 grams). Perinatal regionalization is a system of care that involves obstetric and pediatric providers, hospitals, public health, and includes outreach education, consultation, transport services, and back-transport for graduates from the Neonatal Intensive Care Unit (NICU).

Closing the Gap on Infant Mortality: African American-Focused Risk Reduction

/2009/ During this fiscal year, Closing the Gap (CTG) completed a three-year program funded by the Health Resources and Services Administration through the Bureau of Maternal and Child Health. The purpose of CTG was to reduce significant disparity in African American infant mortality related to low birthweight, prematurity, and sudden

infant death syndrome (SIDS). The target areas included five counties in the Mississippi Delta (Bolivar, Coahoma, Leflore, Sunflower, and Washington) and three counties in the Jackson Metropolitan area (Hinds, Madison, and Rankin). The CTG pilot program sought to reduce infant mortality through community outreach, professional education, research, and surveillance.

Internal Infant Mortality Task Force

In addition to the CTG program, other infant mortality activities have been initiated. In August 2007, the new State Health Officer called for the assembly of an internal infant mortality task force. This task force was charged with identifying immediate or near future interventions that could be implemented right away to begin reducing Mississippi infant mortality. Task Force participants represented all nine public health districts and were a dynamic multidisciplinary team representing administrators, data analysts, community health educators, directors, epidemiologists, various nursing positions, nutritionists, physicians, and social services.

The Internal Infant Mortality Task Force developed the following recommendations for addressing infant mortality in Mississippi and agreed that if sufficient support was available, the recommendations listed below could be implemented on a statewide level.

- 1. Expedite Medicaid application process by placing Medicaid eligibility workers in Local Health Clinics to facilitate earlier entry into prenatal care**
- 2. Conduct statewide Needs Assessment of available health department services and staffing capabilities to support those services (i.e., prenatal care, PHRM/ISS, mortality reviews, post partum home visit other than PHRM, hospital visiting), along with further analysis of infant mortality data**
- 3. Expand staffing to support delivery of infant mortality related services**
- 4. Provide staff education and development activities**
- 5. Provide education and outreach at professional and community levels**

Some of these recommendations were immediately initiated. For example, A CDC epidemiology team worked with MSDH Health Services to conduct in depth analysis of infant birth linked with death files. And as of February 28th, 2008, the number of days per month that a Medicaid eligibility worker was present within a local health department increased by 212%.

Delta Infant Mortality Elimination (DIME) Project

The Delta Infant Mortality Elimination (DIME) project's primary focus is to reduce infant mortality in the Mississippi Delta. The DIME project targets gaps in women's and infants' health services in the 18 counties of the Delta Health Alliance initiative. DIME is a multidimensional, multicollaborative effort including the MSDH, the University of Mississippi School of Medicine, the University of Mississippi School of Nursing, and the Jackson State University College of Public Service.

The DIME project proposes to accomplish its goal of decreasing infant mortality in the Mississippi Delta by: 1) Filling gaps in healthcare services for women and infants; 2) Increasing efficiency and utilization of available healthcare services for women and infants; and 3) Enhancing knowledge and skills of healthcare consumers and providers in the Delta.

The DIME project will strategically assemble partners to increase the number of providers in the Delta, enhance case management and follow up services, initiate post-partum home visitation activities, and increase access to women's healthcare and chronic disease management. An additional DIME component will be coordinated infant death review conferences among health department and local providers to gain insight on opportunities to improve outcomes for infants and families of the Mississippi Delta. Outreach and educational services will be provided at individual, community, and professional education levels. //2009//

Pregnancy Risk Assessment Monitoring System (PRAMS)

//2009/ MS PRAMS is part of the Centers for Disease Control and Prevention (CDC) initiative to reduce infant mortality and low birth weight deliveries in Mississippi. It is an ongoing, population-based, state-specific source of information on selected maternal behaviors and experiences that occur before and during pregnancy and during a child's early infancy.

Since the start of data collection, PRAMS continues to successfully survey mothers throughout the state of Mississippi. PRAMS surveys approximately 176 mothers a month. PRAMS received its first 2007 data batch in June of the same year. The state's response rate is required to be 70 percent of the total sample size as the epidemiologically valid threshold.

All PRAMS reports and raw data for 2004 and 2006 births have been submitted to CDC. The data collection for 2005 was halted due to Hurricane Katrina. The data analyses for 2004 will be published in a fact sheet by summer 2008. The 2006 data collection ended in May of 2007 and is currently being analyzed.

Phase five (5) of the PRAMS survey began January 14, 2004 and will end December 2008. The MSDH's PRAMS staff submitted a poster presentation entitled "2003 PRAMS Data Reporting versus Birth Record Reporting: A Statewide Comparison of Three Variables Using Cronbach's Statistics" at the 2006 Annual Maternal and Child Health Epidemiology Conference in Atlanta, Georgia.

PRAMS staff collaborated with the Dental and STD/HIV programs to ask state specific questions of concern to add to the Phase six (6) survey which will begin in January 2009. In addition, the PRAMS Steering Committee provided input at their February 28, 2008 meeting regarding the selection of specific standard questions that will be added to the new PRAMS survey. The new Phase six (6) survey questions are currently being reviewed by CDC staff, and will be sent back for final approval by the MS Prams Program staff. //2009//

Office of Tobacco Control

//2009/ The mission of the MSDH Office of Tobacco Control is to promote and protect the health of all Mississippians by reducing tobacco-related morbidity and mortality. The program accomplishes this mission by utilizing a systemic approach to tobacco prevention and control. Program components include: state and community interventions; health communication interventions; tobacco cessation interventions; and, surveillance and evaluation. Each program component is developed and implemented based on evidence-based strategies and the recommendations outline in CDC Best Practices -- 2007.

Since its inception in July 2007, the MSDH Office of Tobacco Control has worked diligently to develop the statewide and comprehensive tobacco education, prevention and cessation

program. Through CDC Cooperative Agreement funds, the program has partnered with the MSDH Office of Preventive Health, Chronic Disease Bureau to establish chronic disease coalitions, which educate communities on cardiovascular disease, diabetes, asthma and tobacco use. The program has furthered its efforts to enhance established coalitions by supporting the MSDH/American Lung Association of Mississippi's district-level asthma coalitions.

Office of Preventive Health

The Office of Preventive Health's mission is to educate, prevent and control chronic diseases and injury by promoting optimal health through advocating for community health awareness, policy development, coordinated school health, faith-based, and worksite wellness initiatives. The Office of Preventive Health (OPH) also collaborates with public, private, and voluntary organizations; establishes and participates in coalitions, task forces and partnerships; and obtains funding for planning and program development. Programs within the Office of Preventive Health that are designed to improve the health of Mississippians are referenced in the programs below:

Cardiovascular Health Program priorities are to: control high blood pressure, educate on signs and symptoms, improve emergency response, eliminate health disparities, develop culturally-competent strategies for priority populations, and develop population-based strategies.

Comprehensive Cancer Control Program priorities are to: establish a statewide system for comprehensive cancer control in MS, develop a coordinated response to the excessive cancer burden in MS using data and input from interested citizens, to identify and prioritize the implementation of the state CCC plan.

Diabetes Prevention Program priorities are to: identify and monitor the burden of diabetes, develop new approaches, implement specific measures, and coordinate and integrate efforts to reduce the economic and social consequences of diabetes.

Community Health Program priorities are to: promote population based strategies to impact policy and environmental changes that will positively affect the risk factors of chronic disease.

Injury/Violence Prevention priorities are to: promote bicycle/pedestrian safety awareness, provide bicycle/pedestrian training to key stakeholders, reduce the incidence of death and injuries attributed to fires in high risk communities, enhance infrastructure for injury prevention and control in Mississippi, and promote injury prevention policy. //2009//

Sudden Infant Death Syndrome (SIDS)

The purpose of the Mississippi Department of Health's Sudden Infant Death Syndrome (SIDS) program is to provide a statewide system for the identification of SIDS deaths, and to offer counseling and referral services as indicated for families with sudden unexplained infant deaths. The program also provides assistance in the campaign to educate the general public on SIDS risk reduction.

In 2006, 68 infants died from Sudden Infant Death Syndrome (SIDS). This is a decrease from the 91 infants who died from SIDS in 2005. In CY 2006-2007, SIDS trainings were conducted at childcare facilities in Hinds County utilizing a resource kit for reducing the risk of SIDS developed by the National Institutes of Health (NIH). MSDH also provided SIDS health education materials at SIDS trainings sponsored by the Nation Institute of Child Health and Human Development

(NICHD). The program mails out monthly "What you Need to Know About SIDS" brochures to hospitals statewide. From January-June 2008, the program has provided 7,000 brochures to hospitals and at community health fairs, and has provided trainings at a total of 15 childcare facilities in Warren, Claiborne, and Hinds counties. The program has also developed and provided SIDS display boards to social workers in all nine health districts to use at various outreach activities.

C. Organizational Structure

//2009/ In December, 2007, the newly established 11 member Board of Health selected interim State Health Officer, Dr. F. E. Thompson, Jr. as the new state health officer for the State of Mississippi. Prior to serving as the interim state health officer, Dr. Thompson was Mississippi's State Health Officer from 1993-2002.

Also, Dr. Mary Currier, who was serving as interim State Epidemiologist, was re-selected as Mississippi's State Epidemiologist. Dr. Currier served as Mississippi's State Epidemiologist from 1993 to 2004. Having Dr. Currier as our State Epidemiologist is a giant stride toward rebuilding the epidemiological capacity of the MSDH, which is critical to protecting the public's health.

Health Services directly supports the MSDH mission to protect and promote the health of Mississippians through a variety of programs designed to prevent disease, maintain health, and promote wellness for Mississippians of all ages. Health Services has two primary areas of focus. Those are Health Maintenance and Health Promotion. The primary goal of services offered through Health Maintenance is reducing Mississippi infant mortality. Health Maintenance strives to improve healthcare services for women and infants, increase efficiency and utilization of available services, and enhance knowledge and skills of both consumers and providers of healthcare in Mississippi. Health Promotion encourages achievement of optimal health and physical well-being while seeking to minimize risks for chronic disease and injuries. Health Promotion programs and information benefit Mississippians who want to improve and secure their health. Together, the two areas provide a comprehensive approach to improving health outcomes, which in turn leads to reduced morbidity and mortality among Mississippians. //2009//

BIOGRAPHICAL SKETCHES

Daniel R. Bender, MHS, currently serves as the Director of Health Services. Mr. Bender was the Director of the Genetics Program from 1983 to 2000, where he worked toward the passage of laws mandating newborn screening for PKU, T4 (TSH), Hgb and Galactosemia. Mr. Bender started nine satellite genetic clinics in the state and started the first genetics database in Mississippi. He also developed the Mississippi Birth Defects registry. Mr. Bender's medical experiences include registered Emergency Medical Technician for Baldwin Ambulance and Director of Rankin County Emergency Medical Services. His education includes a Bachelor of Science Degree in Special Education and Master's Degree in Health Science. Mr. Bender has made many presentations which include Health Care for the Poor, the National Neonatal Screening Symposium, and the American Public Health Association.

LeDon Langston, MD, is a Board Certified OB/GYN physician currently serving as medical consultant to the Office of Women's Health in Health Services of the MSDH. Recently retired from 25 years of private practice at Southwest Mississippi Regional Medical Center in McComb, Mississippi, he joined the MSDH in February, 2001. He brings with him experience of 6000 deliveries and 3000 gynecological surgeries and hopes to serve as a bridge between private and public health practices. Dr. Langston is a former flight surgeon in the United States Air Force. He is a former member of the Mississippi Medicaid Medical Advisory Committee; President of the Mississippi OB/GYN UMMC Society; and the Medical Policy Advisory Committee for Blue

Cross/Blue Shield of Mississippi. His present interests include the Teen Pregnancy Prevention and Breast and Cervical Cancer Programs.

Lynn Walker, M.D. recently replaced Dr. Carey as the Pediatric Consultant to the Mississippi Department of Health. Dr. Walker is a board certified pediatric pulmonologist serving as the pediatric clinician in the Office of Health Services in the MS Department of Health. She has twenty years of experience in general pediatrics and pediatric pulmonology, especially in the care of children with chronic illness and special health care needs. Dr. Walker joined the department in September, 2006 and hopes to be a link between the community health care providers, tertiary care providers and the Department of Health. Special interests include newborn screening and care of children with special health care needs.

Louisa Young Denson MS, MPPA, is currently the Director of the Office of Women's Health for the Title V program within the Mississippi State Department of Health. Ms. Denson has served in various capacities in public health. Previously, she served as the Director of Disparity Elimination, Director of Minority Affairs, Office Systems Advisor for all clerical staff with the agency, Immunization Representative for 11 counties in District V, Hinds County Office Manager (which consisted of 11 clinics), Director of the Mary C. Jones Clinic, Public Health Advisor for the Sexually Transmitted Disease Program and a clerk in Vital Records and Statistics. Ms. Denson has a Master's in Public Policy and Administration, Bachelor's degree in Social Work, and is a licensed social worker. She has also completed the Certified Public Managers Program with the State Personnel Board.

Geneva Cannon RN-C, MHS, is Director of the Office of Child and Adolescent Health. Ms. Cannon has over twenty years of experience as a pediatric nurse in critical care, public health, and administration. She was employed with the MSDH in the late 1980's and early 1990's as a nurse with the Genetics Program and later as a nurse consultant with the Office of Child and Adolescent Health. Her career also includes working as Director of Licensure and Practice with the Mississippi Board of Nursing. Prior to her current position, she worked as the Program Coordinator in the planning and implementation of the separate insurance plan for the state's Children's Health Insurance Program.

Lawrence H. Clark is the Director of the Children's Medical Program (CMP), Mississippi's Title V Children with Special Health Care Needs (CSHCN) program. He has over 25 years of supervisory and management experience. He has worked with the Allstate Insurance Company's Regional Office in Jackson, Mississippi, and their corporate headquarters in Chicago, Illinois. He has 13 years of managerial experience with the Mississippi Development Authority, formerly known as the Mississippi Department of Economic and Community Development. Before joining the MSDH staff, he was employed with the Mississippi Department of Education, Office of Special Education where he managed several statewide initiatives.

Kathy Gibson-Burk is the Director of the Office of WIC with the MSDH. She came to the Department of Health in 1994 as the District Social Work Supervisor for the West Central Public Health District V. In 1997 she was promoted to the State Social Services Director; and in 1999 she received another promotion as the Deputy Field Services Director. She has over 22 years of service and management experience in state government, having worked 13 years with the Mississippi Department of Human Services. She earned a Bachelor's of Social Work degree from Mississippi University for Women, and a Master's of Social Work degree from the University of Southern Mississippi. She also received the Certificate of Achievement from the Tulane School of Public Health and Tropical Medicine for completion of the South Central Public Health Leadership Institute and is a graduate of the Certified Public Manager's Program through the Mississippi State Personnel Board.

Juanita Graham, MSN, RN is the Health Services Chief Nurse. Juanita serves as a nurse consultant to the five offices of Health Services including WIC, Women's Health, Child & Adolescent Health, Preventive Health, and the Office of Health Data & Research. Juanita

participates in a variety of activities including grant writing, continuing education for nurses, logic modeling, and research. She holds both Bachelor's and Master's degrees in Nursing Science from the University of Mississippi. She teaches and develops online courses for several nursing and healthcare administration programs and holds a number of adjunct faculty appointments. Juanita is a member of the American Public Health Association, an officer and state delegate for the Mississippi Nurses Association, and a chapter board member and national delegate for the Sigma Theta Tau International Nursing Honor Society. She has given several state and national presentations on a variety of topics ranging from logic modeling to infant mortality.

Benny Farmer became the financial director of Health Services on May 1, 2003. He has considerable experience with grants and budgeting due to working in the MSDH Bureau of Finance and Accounts for sixteen years, first as an accountant in various areas, and then as director of the Division of Budgeting/Purchasing/Grants. He holds a Bachelor's degree in accounting from the University of Southern Mississippi.

Virginia L. Green, MD, began working with Children's Medical Program (CMP), Mississippi's Title V CSHCN program, in 1986, as Pediatric Consultant. Other pediatric experience includes: private practice in Montgomery, AL, 1980-1983; pediatrician for District V, Mississippi Department of Health, 1983-1986; pediatrician and Assistant Professor of Pediatrics, Department of Pediatric Gastroenterology, University of MS Medical Center (UMC), 1991 -1993. She also served as a review pediatrician for Mississippi Disability Determination Services (DDS), reviewing childhood cases for eligibility for Supplemental Security Income (SSI) and Medicaid, 1991 -1993. In 1994, she returned to CMP and recently replaced Dr. Marilyn D. Graves as the Program's Medical Director. She has served on several committees relating to children with special health care needs and continues to serve on the UMC Visiting Teaching Faculty and on the Board of Directors for the Spina Bifida Association of MS.

Ulysses Conley, B.S., MPPA, CPM, currently serves as the principal grant writer for Mississippi's Maternal and Child Health Block Grant. He was employed by the Mississippi State Department of Health (MSDH) in October, 1991, as a Senior Analyst with the Office of Policy and Planning. In February, 1996, he joined Health Services as a Principal Analyst/Grant writer for the state's Title V program.

//2009/ Larry L. Smith, MS, PhD, is a research biostatistician currently assigned to the Office of Health Data and Research of the Mississippi State Department of Health. In addition to providing support to various programs within the MCH Title V program, he is a data/analyst for the Mississippi State Department of Health Pregnancy Risk Assessment Monitoring System (PRAMS) and Women, Infants, Children (WIC) program. Dr. Smith's research interests include health survey data analysis and the influence of behavioral stressors on maternal child health outcomes. He has published in peer-reviewed journals. He has a Master of Science degree in Engineering Science with environmental concentration from the University of Mississippi in addition to a Master of Science and Doctor of Philosophy in Preventive Medicine/Epidemiology from the University of Mississippi Medical Center in Jackson, MS. //2009//

Lei Zhang, MS, MBA, PhD, is the director of the Office of Health Data & Research . He is the principal investigator of the Mississippi Asthma Program and the Mississippi Pregnancy Risk Assessment and Monitoring System (PRAMS). In addition, he oversees all aspects of data collection and data analysis within Health Services. Dr. Zhang's research interests include health survey data analysis and spatial investigation using GIS. He has published several articles in peer-reviewed journals. In addition, he has given numerous presentations in national and local conferences. Currently he is a member of both the American Statistical Association and the American Public Health Association.

Dr. Nicholas Mosca is State Dental Director for the Mississippi Department of Health and Clinical Professor of Pediatric and Public Health Dentistry at the University of Mississippi Medical Center

School of Dentistry. A 1987 graduate of Loyola University School of Dentistry, Dr. Mosca completed a two-year General Practice Residency at Charity Hospital Center in New Orleans. From 1989 to 1999, he served as director of the Hospital Dental Clinic at the University of Mississippi Medical Center and later served as clinic coordinator for the Jackson Medical Mall Outpatient Dental Clinic. Dr. Mosca is a fellow of the American College of Dentists and the Rho Sigma Chapter of Omicron Kappa Upsilon Honorary Dental Society.

In 1996, Dr. Mosca completed the Harry W. Bruce Jr. Legislative Fellowship at the American Dental Education Association (ADEA). In 2005, he completed a Department of Health and Human Services Primary Care Health Policy Fellowship. From 2004 to 2007, he served as a member of the National Oral Health Advocacy Committee for ADEA and the American Association of Dental Research. From 2005 to 2007, he served as co-chair of the Oral Health Policy Committee for the American Association of Public Health Dentistry. Presently, Dr. Mosca serves as secretary on the Executive Committee of the Association of State and Territorial Dental Directors, an affiliate of the Association of State and Territorial Health Officers.

//2009/ Donna Speed, MS, RD, LD serves as the Nutrition Services Director and coordinator for the Fruits & Veggies-More Matters program for the state. She has 30 years of experience, much of it working with the public and community in the area of disease prevention and wellness. Donna works with the WIC program and the Department of Education to promote a healthier lifestyle for women, infants, and children. She has served as an advisor to the Office of Healthy Schools during the time that legislation was passed for healthier vending guidelines, for nutrition education, and physical activity in the schools in Mississippi. She is a frequent speaker for professional and community events. She serves as the education/nutrition chairman for Mississippi Chronic Illness Coalition, the Mississippi Comprehensive Cancer Control Program, Mississippi Action for Healthy Kids, the School Nutrition Action Plan, Mississippi Alliance for School Health, Lead Prevention and Elimination Program and is on several committees with the National Partnerships of Fruits & Veggies-More Matters Coordinators. Her interests include infant and pediatric nutrition and promoting a healthier lifestyle for the adult population.

Terry Beck, the Interim State Public Health Social Work Director, has some forty years of public health experience at all levels of practice. He holds the Master of Social Work Degree and is credentialed at the Licensed, Certified Social Work level (LCSW). The Social Work Director provides professional social services perspective and consultation to the director of Health Services regarding policy development, standard setting, and the establishment of service priorities in addition to oversight, consultation and professional supervision to nine social services regional directors and three state level social work consultants. //2009//

Laws and Authorizations:

A number of state laws guides Mississippi's public health system and provides authorization for certain programs and policies. These laws are added as an attachment to this file for review.

An attachment is included in this section.

D. Other MCH Capacity

At the state level, HS administers programs that provide services to the MCH/CSHCN population. Within HS there are three Offices that serve this population. They are listed below with the Central Office FTE of each:

Office of WIC 12

Office of Women's Health 22

Office of Child/Adolescent Health, including CSHCN
and First Step Early Intervention System (FSEIS) 72

Each office, through the MCH Block Grant, supports services to women and infants, children and adolescents and CSHCN through local county health departments and speciality clinics. The MSDH provides case management, childhood immunizations, well-child assessments, limited sick-child care, and tracking of infants and other high-risk children. Services are targeted towards women and children whose family incomes are at or below 185 percent of the federal poverty level. The MSDH provides services to more than 120,000 children annually. Adjunct services such as the First Steps Early Intervention System (FSEIS), Genetic Screening, WIC, and the Children's Medical Program are important components of the comprehensive Child/Adolescent Health Program. Services are provided through a multi-disciplinary team approach including physicians, nurses, nutritionists, and social workers, and provide early identification of potentially disabling conditions and linkages with providers necessary for effective treatment and management. The MSDH provides services to women and infants through its family planning, maternity, and Perinatal High Risk Management/Infant Services System (PHRM/ISS) programs.

Children and adolescents are targeted for periodic health assessments and other services appropriate for their age and health status. Those services may include, but are not limited to:

- (a) immunizations;
- (b) genetic screening and counseling;
- (c) routine and periodic screening, diagnosis and treatment for EPSDT eligible infants and children;
- (d) well-child and sick-child care;
- (e) vision and hearing screening;
- (f) WIC services;
- (g) counseling regarding: reproductive health issues, alcohol, tobacco, and substance abuse, and sexually transmitted diseases;
- (h) comprehensive developmental services from child birth to age 3;
- (i) dissemination of information on the benefits of protective dental sealants to families of children receiving health department services; and,
- (j) referral and case management for treatment of conditions where services are not readily available; and,
- (k) PHRM/ISS

Children and adolescents, including CSHCN, receive direct health care services such as interventions for high risk individuals, case management, care coordination, primary and preventive care, health education and counseling.

The CMP has developed very effective lines of communication with the UMMC, the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis Foundation, and the local chapter of the Hemophilia Foundation to make sure that all support services are coordinated for the patients where and when appropriate.

The CMP also maintains a major link with health care providers through the CMP Advisory Council, which includes physicians, parents, hospital representatives, anesthesiologists, physical therapists, social workers and other health care providers. Through these resources, providers are advised of the expanded effort to provide services to disabled children under sixteen (16) who receive SSI benefits under Title XVI. The Children's Medical Program has led the way to coordinate communication between CMP, Social Security, and the State Disability Determination Office.

The CMP works to develop and strengthen lines of communication between all state agencies that provide assistance to CSHCN and to the blind and disabled population under sixteen (16)

years of age. This includes invitations to CMP Advisory Council meetings, both parent and professional.

The Title V agency maintains a toll-free telephone line in the Office of Women's Health. The line provides assistance to clients seeking information about MCH services, family planning, Medicaid, and other services. This valuable tool encourages early entry into prenatal care and further links the private and public sectors. Information about the line is publicized through a newsletter of the Mississippi Chapter of the American Academy of Pediatrics, brochures, posters, and a Teen Help Card.

Toll-free numbers in the agency which are directly related to services for the MCH/CSHCN population include a Genetics/Early Intervention line, an HIV/AIDS line, and a CMP line.

E. State Agency Coordination

There are various organizational relationships that exist between the MSDH and other human service agencies that work to enhance the capacity of the Title V program. Examples of MSDH's coordination efforts with other human service agencies are as follows:

Alcohol and Drug Prevention Programs

The Born Free project, which originated with the MSDH, networks available community resources for the provision of services to substance-involved pregnant women and their infants. Other agencies involved in the Born Free network include: (a) the University of Mississippi Medical Center; (b) Marian Hill Chemical Dependency Treatment Center; (c) New Life for Women (housing); (d) Catholic Charities (provides direct primary treatment services and transitional program services); (e) community health centers; (f) Jackson Recovery Center; (g) state mental health centers and state hospital; (h) parole officers and the court system; and, (i) sexual assault and domestic violence shelters and other treatment centers. Born Free is now administered by Catholic Charities.

The Mississippi State Department of Health Adolescent Health Coordinator actively serves on the Mississippi Department of Mental Health Alcohol and Drug Abuse Advisory Council in order to advise and support prevention and treatment programs aimed at reducing alcohol and drug abuse among adolescents and young adults. The Council promotes and assists the Bureau of Alcohol and Drug Abuse with developing effective youth prevention programs; providing input on the development of the annual State Plan for Alcohol and Drug Abuse Services; participating in the Department of Mental Health's peer review process; and promoting the further development of alcohol and drug treatment programs at the community level.

March of Dimes

The MSDH partners with the March of Dimes to increase the awareness of folic acid as it relates to birth defects. The March of Dimes launched a campaign to raise awareness of the growing problem of prematurity and to decrease the rate of preterm births. Premature infants are more likely to be born with low birthweight and suffer mild to severe disabilities and/or death. Prematurity is the leading cause of infant death before the first month of life.

Mental Health

The Mississippi State Department of Health collaborates with the Mississippi Department of Mental Health, Division of Children and Youth Services to provide a comprehensive community-based mental health service system for children and adolescents. The Division serves as the lead agency responsible at the state level to improve the availability of and accessibility to appropriate,

community-based service. A collaborative team of the Mississippi Department of Mental Health Comprehensive Mental Health Centers, the State Level Case Review Team, several local Multidisciplinary Assessment and Planning (MAP) Teams, and other child-serving agencies and task forces assist children, youth and family access the system of care.

The State Level Case Review Team operates through an interagency authorization agreement to review cases of children and youth up to age 21 with serious emotional and behavioral problems and or serious mental illness for whom adequate treatment and or placement cannot be found at the county or local level, and for whom any single state agency has been unable to secure necessary services through its own resources. Before cases are referred to the State Level Case Review Team, all cases concerning children and youth (age 5 to 21) who have a serious emotional and/or behavioral disorder or serious mental illness; and who are at immediate risk for an appropriate 24 hour institutional placement due to lack of access to or availability of needed services and supports in the home and community are reviewed by the Local-Level Multidisciplinary Assessment and Planning (MAP) Team. After having exhausted all available services and resources in the local community and/or in the state, cases are then referred to the State Level Case Review Team.

First Steps Early Intervention System

The FSEIS is structurally located within the Office of Child and Adolescent Health, and has established an Interagency Coordinating Council to bring together the state departments of Mental Health, Education, and Human Services; the Division of Medicaid; universities, providers of services, and others to develop a comprehensive system of family-centered, community-based, culturally-competent services. Local interagency councils support the planning, development and implementation of the system at the community level.

Mississippi Statewide Immunization Program

The MSDH's Statewide Immunization Program is primarily funded by the Centers for Disease Control and Prevention, but MCH funds are used to support some staff in local health department clinics. A statewide coalition has been established, which is composed of health care professionals (organizations and individuals), immunization providers, community-based organizations, social/civic groups, lay people, and others with an interest in improving the immunization status of Mississippi's children. This broad-based group provides the framework for promoting the implementation of the immunization monitoring and tracking system in non-health department clinics.

Department of Human Services (DHS)

DHS provides services that include case management, child care for the developmentally disabled, services for the chronic mentally ill, abstinence education, and treatment for alcohol and chemically dependent adolescents.

DHS Office of Children and Youth uses funds for day care, while the Division of Aging and Adult Services uses Social Services Block Grant (SSBG) funds for home health aides, ombudsmen services, transportation for elderly, case management for adults, adult day care, home delivered meals for adults, and respite care. The MSDH no longer receives SSBG funds from the DHS to assist in its efforts to provide needed contraceptive services to teens, however, a representative of the MSDH is a member of the DHS Out-of-Wedlock Task Force.

DHS administers the federal Child Care Development Block Grant (CCDBG) which has two basic component areas. The provision of actual child care services comprises 75 percent of the budget. The Quality Child Care Development portion of the budget provides funds for training of child care providers, improvements to day care centers, and media centers. Some CCDBG funds are

provided to the MSDH for child care facilities licensure.

Division of Medicaid

The Division of Medicaid is a key player in the reimbursement for services to patients seen in Mississippi State Department of Health (MSDH) clinics. In addition to a cooperative agreement, which allows billing for special services provided to Perinatal High Risk Management/Infant Services System (PHRM/ISS) and other non-high risk patients, the MSDH assists Medicaid in assessing pregnant women and children for Medicaid and CHIP eligibility using MSDH staff and out-stationed eligibility workers. Medicaid staff and MSDH staff meet quarterly to discuss PHRM/ISS progress and concerns.

The Mississippi State Department of Health Office of Child and Adolescent Health collaborates with Mississippi Division of Medicaid to support the MYPAC (Mississippi Youth Programs Around-the Clock) , a home and community-based Medicaid waiver program that provides an array of services for youth with severe emotional disorders. The program provides alternate services to traditional Psychiatric Residential Treatment Facilities (PRTF) services.

Community Health Centers/Primary Health Care Association

A primary care cooperative agreement with the Bureau of Primary Health Care has been administered by the MSDH since 1985. The cooperative agreement provides a mechanism for joint perinatal planning and provider education between the state MCH program and the 21 community health centers (CHCs). Perinatal providers are placed in communities of greatest need through a joint decision-making process of the Mississippi Primary Health Care Association (MPHCA) and the MSDH Primary Care Development Program, making access to care available to many pregnant women and their infants. The Office of Rural Health (ORH) works closely with Primary Care Development to promote the recruitment and placement of providers in rural areas.

The MSDH, through its Office of Rural Health, administers the Medicare Rural Hospital Flexibility (FLEX) Grant, which funds the Critical Access Hospital program. This program is designed to foster the growth of collaborative rural health delivery systems across the continuum of care at the community level with appropriate external relationships for referral and support. This should result in improved access to care, economic performance and viability of rural hospitals, and ultimately, health status of the community. The Office of Rural Health contracts with the Mississippi Hospital Association to provide staff support and programmatic assistance for the FLEX program.

During the 1999 Legislative Session, House Bill 403 was passed that provided funding to the MSDH to increase access to preventive and primary care services for uninsured or medically indigent patients, and to create new services or augment existing services provided to uninsured or medically indigent patients. Services include, but are not limited to, primary care medical and preventive services, dental services, optometric services, in-house laboratory services, diagnostic services, pharmacy services, nutritional services, and social services. The MSDH serves as the conduit for this funding and contracts with Mississippi Qualified Health Centers to provide this increased access to care.

The MSDH HIV/AIDS Program maintains contractual agreements with a number of community agencies. The Jackson/Hinds Community Health Center provides AIDS education and information services to their clients in Hinds County and the Jackson public school system. Another agreement with the Aaron Henry Health Center in Clarksdale provides AIDS education and information to residents of Quitman, Tallahatchie, Tunica and Coahoma counties.

The Family Planning Program maintains six contracts with community health centers and four contracts with universities and/or colleges for the provision of contraceptive supplies and educational materials. These contracts have been formulated with the Aaron Henry Health

Center, Arenia Mallory Health Center, G.A. Carmichael Health Center, Northeast Mississippi Health Care, Inc., Southwest Health Agency for Rural People, Access Family Health Services, Jackson State University, Alcorn State University, Tougaloo College, and Coahoma Community College.

The Breast and Cervical Cancer Screening and Early Detection program provides contracts to community health centers, health departments, private providers, and hospitals to conduct screening services, diagnostic services, referrals and case management. The target populations for the program are uninsured, underinsured, and minority women. Women 50 years of age and older are the target group for mammography screening, and women 45 years and older are the target group for cervical cancer screening.

The Bureau of Immunization located in the Office of Communicable Disease, provides vaccine to private physicians and community health centers that are enrolled as Vaccine for Children providers.

The Office of WIC has a contractual relationship with 19 community health centers for the purpose of certification of women, infants, and children for provision of WIC food and/or formula through distribution centers located throughout the state.

Those community health centers that provide EPSDT services are also subject to the Division of Medicaid requirement for periodic lead screening. As the MSDH expands its statewide program of lead screening and follow-up to improve access to this service for potentially vulnerable populations, the cooperation of community health centers continues to be critical to its success in implementing community based interventions. The Mississippi State Department of Health received a CDC children lead prevention grant to implement lead prevention education and screening activities in targeted areas of the state.

Children's Medical Program (CMP)

CMP, the state CSHCN program, maintains an Advisory Council whose members include medical and other service providers and parents of CSHCN. Medical service providers of the Advisory Council include private physicians, a dentist, orthotics/prosthetics provider, and staff physicians of the University of Mississippi Medical Center, the only state funded medical teaching and tertiary care facility. A representative from the MSDH also serves on the State Developmental Disabilities Council. CMP partners with the Mississippi Disability Determination Service providing for the exchange of respective program eligibility criteria in cross referral of CSHCN for services.

The Children's Medical Program now maintains a Parent Advisory Committee composed of parents of CSHCN who are covered by the program. Parents provide input regarding the services that their children receive from the CSHCN program.

Maternal Death Review

In the past, the Mississippi State Medical Association's Committee on Maternal and Child Care reviewed all cases involving maternal deaths in the state. All maternal death certificates and matching birth certificates (if there was a live birth) or fetal death certificates were sent to the director of the Office of Women's Health. District and county health department staff were requested to gather information regarding prenatal care, labor and delivery, postpartum care and any other information surrounding the death. This information was used for both the in-house review and for the review by the Mississippi State Medical Association's Committee on Maternal and Child Care. The death certificates were revised in 1998 and a block added to check if the decedent had been pregnant within the last 90 days.

Dietetic Education

/2009/ The Nutrition Services program serves in an advisory capacity to programs and services. The primary focus is to encourage a healthier lifestyle, by means of improved nutrition and increased physical activity, throughout the agency and state. To reach this goal, two programs are being utilized to fight obesity. Bodyworks, a program for 9-13 year old girls and caregivers has resulted in over 130 trainers in the state completing the "Train-the-Trainer" course, preparing them to teach the 10-week course. Nutrition Services also has been instrumental in promoting changes in regulations for child care facilities. Some of the changes that have occurred are stricter meal guidelines, encouraging physical activity for children, and restricting the use of and products in vending. To also encourage healthier lifestyles in the preschool child and their parent, the department, along with Childcare Licensure, has launched a training program, "Color Me Healthy". This statewide program is for teachers in the preschool setting and targets incorporating food variety and physical activity using all five senses.

Our Fruits & Veggies-More Matters program reached over 24,000 individuals in 2007. We recognize the importance of eating fruits and vegetables for a healthier lifestyle. Nutrition Services provided pamphlets, recipes, and posters in the clinics for educating our clients on the use of and importance of including a variety of fruits and vegetables in the diet. The Fruits & Veggies-More Matters program has been incorporated in several Head Start programs to encourage the young child to try new foods. Nutrition Services also works with the Child Nutrition Program in the Department of Education to promote Fruits & Veggies-More Matters at school events and education/health fairs.

Nutrition Services also works with universities and colleges in precepting and training dietetic students. Dietetic students are assigned preceptors for community nutrition in the clinics. Students are assigned to educate clients through individual counseling, WIC certification, and group classes. The Department also hosts a "Genetics 101" conference for all students and professors annually. During the conference, students are introduced to the genetic and metabolic diseases that affect many of our children. Topics also include the processes to assist our children and their parents with dietary, emotional, and financial needs.

Education is a primary goal of Nutrition Services. Pamphlets, handouts, posters, cooking demonstrations, and taste testings are utilized to promote a healthier lifestyle. The Department participated in over 30 screenings/health fairs during 2007. Community and professional education through media, lectures, "lunch-n-learn" series, workshops, and health fairs/screenings is encouraged throughout the agency and state. Resources are distributed to clinics and other providers when funding permits.

Social Work Services

Mississippi has a well established public health social work program whose major focus is promoting services for mothers, infants and children to age twenty-one and for children with special health care needs. MSDH employs a state director of public health social work who reports to the director of the office of Health Services, home to Mississippi's Title V program. The major characteristic of public health social work is an epidemiological approach to identifying social problems affecting the health status and social functioning of the MCH population. Emphasis is placed on intervention at the primary prevention level. Social workers assist patients in using the health care system. //2009//

Oral Health

/2009/ The MCH Block Grant provides salary support for a full-time dental director who determines oral health needs, develops policies, and coordinates programs and resources for population-based services. The FY 2005 MCH Needs Assessment showed that 70% of Mississippi's school-age children experienced tooth decay and two in five children have untreated dental decay. In 2006, a Governor's Oral Health Task Force approved a five-year

(2006-2010) state oral health plan.

Community Water Fluoridation (Population-based Services)

Since July 2003, a private foundation has provided funding to equip and install water fluoridation programs. With this funding, 61 water systems have been recruited to begin fluoridation programs to benefit 290,646 people and 30 systems have been activated to serve 145,609 people. In June 2008, the proportion of MS population on fluoridated public water was slightly over 53%.

School-based Oral Health Programs (Population-based Services)

The MCHBG provides funding for a dental sealant program in nine counties in Public Health District III and two counties in District V. The FY 2005 MCH Needs Assessment showed that 12% of third-grade children had dental sealants in District III compared with 26% of children statewide. During the 2007-2008 school year, 1,620 dental sealants were placed on the permanent first molar teeth of 474 children in these counties. But tooth decay remains a serious problem in all 82 counties and additional MCHB funding is needed to expand the program. In FY 2007, a CDC-funded weekly school fluoride mouth rinse program served about 26,746 children in grades 1 thru 5 who live in non-fluoridated areas. CDC-funding is also used to employ 5.5 FTE dental hygienists who provide oral health education, perform oral health screening, and obtain oral health surveillance data. In April 2007, the Mississippi State Board of Dental Examiners adopted a resolution to permit the hygienists in the employ of the Board of Health to apply preventive fluoride varnish as part of oral health screening and education. During the 2007-2008 school year, we provided fluoride varnish to children ages 3 to 5 in a sample of 150 classrooms that participated in an oral health survey at 22 Head Start programs.

Oral Health Assessment in WIC Certification (Enabling Services)

Two oral health questions were included in the agency's WIC Certification to identify source of dental care and to identify pregnant women with symptoms of an oral infection. Data from 26,672 women showed that a higher proportion of blacks (58.8%) reported no source of dental care compared to whites (38.1%) who utilized the WIC service.

Children's Medical Program Dental Corrections (Direct Health Care)

Children diagnosed with cleft lip and/or palate or a craniofacial syndrome are eligible for coverage of procedures involving the oral cavity and related affected structures through the Children's Medical Program. In 2003, there were 381 CMP patients with the primary diagnosis of cleft lip/palate.

MSDH Mobile Dental Clinic (Direct Health Care)

In January 2007, the Sullivan-Schein Corporation donated a 51-foot mobile-dental-clinic equipped with two dental operatories, digital radiography, and electronic records for use to provide direct health care services. In February 2008, we collaborated with the University of Mississippi School of Dentistry to provide free dental care to about 50 people in the City of Clarksdale in the MS Delta. We seek additional funding to use this state-of-the-art mobile clinic to provide dental services in rural underserved communities. //2009//

Rural Health Program

The MCH program works collaboratively with the Office of Rural Health (ORH) in resolving access to care issues. This program is administered by the MSDH Office of Health Policy and Planning. This program has been funded through a Federal Office of Rural Health Policy grant since August, 1991. There are four mandated functions under the grant: (1) to establish and maintain a clearinghouse of rural health issues, trends, and innovative approaches to health care delivery in rural areas; (2) to coordinate activities carried out in the state that relate to rural health care in order to avoid redundancy; (3) to identify federal and state programs for rural health and provide technical assistance to public or nonprofit entities regarding participation in the programs and; (4) an option to provide technical assistance to rural hospitals and communities on

recruitment and retention of health care professionals.

The Centers for Disease Control and Prevention and Health Resources and Services Administration provide funding for most services implemented through Health Services. Health Services houses the MCH and CSHCN programs and is reliant on federal funds. Less than 2% of total funding to Health Services is provided by the State of Mississippi. Therefore, many MCH programs funded through Title V work in cooperation with national resources such as CDC and other HRSA/MCHB programs. Program staff are constantly in touch with project directors at the national level to ensure that needed services are provided to the MCH population.

F. Health Systems Capacity Indicators

Introduction

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	254.2	286.6	305.0	60.6	65.7
Numerator	2542	5869	6246	1021	1038
Denominator	100000	204815	204815	168525	157883
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

The denominator used to calculate this rate is adjusted from the actual 2007 statewide 0-4 population estimate (219,282) to account for missing data due to non-reporting hospitals. The estimated denominator is calculated based on the percentage of hospital beds in the state accounted for in the reported data. As of June 11, 2008, hospitals reporting data used in this calculation account for 72% of all acute hospital beds in Mississippi. Therefore, the 0-4 population estimate was adjusted by 72% ($219,282 \times .72 = 157,883$).

This rate may appear significantly different than estimates in prior years. Prior estimates were based on data from the tri-county Jackson metropolitan area only. The MSDH's asthma surveillance system has since expanded to collect statewide data. Due to incomplete data collection as of June 11, 2008, the denominator is adjusted by hospital bed coverage, as described in #1, to increase the validity of the estimate.

This is provisional data. Due to significant geographic variations in asthma hospitalizations, the data from hospitals that have not reported as of the June 11, 2008 estimate may significantly change the rate.

2003 through 2006 rates were estimated based on 2003 provisional data for three Mississippi counties (Hinds, Rankin, and Madison). This data included emergency department and outpatient visits in addition to inpatient hospitalizations, and the population denominators were estimated. The rates reported for 2003 through 2006 are inflated due to these errors. As of 2007

these errors have been corrected. Data for 63 of the 82 Mississippi counties have been collected and analyzed using actual population denominators adjusted to reflect the population accounted for by the data. The 2007 provisional rate reflects the updated data collection and analysis procedures. The 2003 through 2006 rates for the 63 counties using the corrected collection and analysis procedures are as follows:

2003: 52.4 per 10,000 (981/187174)

2004: 53.8 per 10,000 (951/208556)

2005: 50.89 per 10,000 (918/209511)

2006: 60.6 per 10,000 (1021/168525)*

*2006 is provisional due to ongoing data collection.

Notes - 2006

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2004: 53.8 per 10,000 (951/208556)

2005: 50.89 per 10,000 (918/209511)

2006: 60.6 per 10,000 (1021/168525)*

*2006 is provisional due to ongoing data collection.

Narrative:

The Mississippi Department of Health has completed a five-year State Asthma Plan and established nine regional asthma coalitions and an Asthma Coalition of Mississippi. Mississippi continues to enhance its asthma surveillance system, and has recently completed a five-year surveillance report.

2001-2004 indicator data were computed per 100,000 children; however, the Centers for Disease Control and Prevention (CDC) and other state asthma programs compute the hospitalization rate per 10,000. 2006 and 2007 estimates are provisional due to ongoing data collection.

Asthma is not a reportable disease in Mississippi, however the Asthma Program, funded through the CDC, is working with individual hospitals to obtain hospital discharge data on a regular basis. Currently, the Asthma Program is receiving data from over 80% of Mississippi hospitals.

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	60.9	68.6	71.4	66.9	77.7
Numerator	48990	54829	28286	54356	53655
Denominator	80456	79869	39618	81284	69077
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

Both numerator and denominator represent unduplicated totals.

Narrative:

According to the latest data (CY 2007) from the Mississippi Division of Medicaid, of the 69,077 Medicaid enrollees whose age is less than one, 77.7% (53655) received a screening service.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	75.5	76.3	76.3	81.1	88.5
Numerator	542	546	546	60	23
Denominator	718	716	716	74	26
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

SCHIP data reported by Blue Cross Blue Shield of Mississippi. HEDIS criteria requires that the denominator be limited to children turning 15 months old during the measurement year and having been continuously enrolled from 31 days of age, thus there was a small number of MS CHIP children who met this criteria.

Notes - 2006

According to data from the Division of Medicaid, the numbers reported in this measure are "Well child visits during the first 15 months of life", as reported on the CHIP Annual Report FFY 2006. A periodic screening is for Medicaid beneficiaries only, and the majority of Medicaid enrolled infants under one (1) year receive screenings as a result of the EPSDT program.

Notes - 2005

Due to difficulties in obtaining SCHIP data for 2005, 2004 estimates are used.

Narrative:

According to CY 2006 data from the Mississippi Division of Medicaid, 81% of the children enrolled in SCHIP who were less than one year of age at some point during the year, had a visit to a health care professional (physician, nurse practitioner, etc.) before one year of age.

There continues to be a need for data linkage with the Mississippi Division of Medicaid, coordinator for the State Children's Health Insurance Program (SCHIP), for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	86.3	84.1	82.2	83.6	84.4
Numerator	36363	35831	34643	38337	38683
Denominator	42136	42595	42120	45833	45833
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

Narrative:

According to 2007 provisional data 84.4 percent of women (15 through 44) with a live birth during the reporting year had observed expected prenatal visits greater than or equal to 80 percent of the Kotelchuck Index.

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	92.6	96.7	94.7	81.3	80.5
Numerator	363503	382511	347715	327214	317487
Denominator	392720	395621	367091	402241	394306
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

Narrative:

Data from the Mississippi Division of Medicaid revealed that during CY 2007, there were 394,306 children 1 to 21 years of age who were potentially eligible for Medicaid. Of that number, 317,487 (80.5%) received a service paid by the Medicaid Program.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	41.7	43.6	88.4	37.9	46.0
Numerator	34409	36421	69233	34715	36073
Denominator	82555	83629	78320	91548	78378
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 - 2006

According to data from the Division of Medicaid, the numerator is based on paid claims to dental providers who performed a dental service. The number does not include oral health screening services.

Narrative:

According to CY 2007 data from the Division of Medicaid, 78,378 children age 6 through 9 were eligible for EPSDT services. Of that number, 46 percent (36,073) received dental services.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	100.0	100.0	0.7	3.6	3.4
Numerator	18366	18784	127	688	662
Denominator	18366	18784	19084	19250	19328
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 - 2006

Data reported during 2005 and 2006, unlike previously reported data, is based on the actual percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. Previous yearly percentages reported were based on the percentage of SSI beneficiaries less than 16 having access to CSHCN program services due to a collaborative effort between Medicaid, the Social Security Administration, and other third party payors to ensure access to needed services for children with special health care needs. It is important to note that the state's CSHCN program does not provide direct services for children with emotional, behavioral, and mental health needs. However, children with needs for these services are referred to the State's Mental Health network of providers.

Notes - 2005

Data reported during 2005 and 2006, unlike previously reported data, is based on the actual percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. Previous yearly percentages reported were based on the percentage of SSI beneficiaries less than 16 having access to CSHCN program services due to a collaborative effort between Medicaid, the Social Security Administration, and other third party payors to ensure access to needed services for children with special health care needs.

Narrative:

The Children's Medical Program (CMP) staff maintains an ongoing relationship with the Social Security Administration and the State Disability Determination Services to facilitate the referral process to CMP for children and families potentially eligible for the program. The CMP collaborates with Medicaid, Social Security Administration and other third party payors to ensure access to needed services for children with special health care needs.

Each SSI beneficiary is made aware of CMP, eligibility criteria, and covered services. All beneficiaries are encouraged to apply for CMP services. However, all SSI beneficiaries may not directly receive rehabilitative services through the CSHCN program due to differences in eligibility criteria for program enrollment.

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	other	65	35	12.4

Notes - 2009

No linked data file exists at this time. Data are calculated based on a combination of sources which include Vital Statistics and Medicaid sources.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

Narrative:

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of live births.

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	other	63	37	10.1

Notes - 2009

No linked data file exists at this time. Data are calculated based on a combination of sources which include Vital Statistics and Medicaid sources.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

Narrative:

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the

Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of live births.

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	other	49	51	84.9

Notes - 2009

No linked data file exists at this time. Data are calculated based on a combination of sources which include Vital Statistics and Medicaid sources.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

Narrative:

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of pregnant women.

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	other	51	49	84.4

Notes - 2009

No linked data file exists at this time. Data are calculated based on a combination of sources which include Vital Statistics and Medicaid sources.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

Narrative:

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of pregnant women.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	200

Narrative:

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among all infants (age 0 to 1).

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2007	133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2007	200 200

Narrative:

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among all children (age 1 to 19).

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

INDICATOR #06 The percent of poverty level for eligibility in the State's	YEAR	PERCENT OF POVERTY LEVEL
--	-------------	---------------------------------

Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		Medicaid
Pregnant Women	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	200

Narrative:

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of pregnant women.

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

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	2	Yes

Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

Although a well coordinated network of services is being provided on a statewide basis by the MSDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI program is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files; and to conduct statewide need assessments when needed. The establishment of an improved data collection system will be used to aide the MSDH in the sharing of quality data to assist health partners and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

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

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Pediatric Nutrition Surveillance System (PedNSS)	2	Yes
WIC Program Data	3	Yes
PRAMS	3	Yes

Notes - 2009

Narrative:

Although the Mississippi State Department of Health does have direct access to the state YRBS database for analysis, the need exists for data linkage among the various data sources within and available to the MSDH. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Tobacco and the YRBS, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi.

IV. Priorities, Performance and Program Activities

A. Background and Overview

In an effort to carry out the core functions of public health, the MSDH relies on the work of public health team members across the state to assist every community in the state to achieve the best possible health status for its citizens. The MSDH accomplishes this through the agency's goals of:

(1) Assessing health status indicators of the state's population to document each community's health needs and conduct epidemiological and other studies of specific health problems; (2) Developing, promoting, and supporting public policy and strategies that protect the state's citizens from unsanitary conditions related to the environment and that emphasize healthy lifestyles and the prevention of morbidity and mortality associated with disease and illness; and (3) Assuring access to essential health services.

The MSDH's Health Services (HS) department, through the Office of Women's Health and the Office of Child/Adolescent Health Services, administers programs that provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs (CSHCN). Clinical and support services are provided to the target populations through local county health departments and speciality clinics. Services include prenatal and postnatal care, case management for high risk pregnant and postpartum women and infants, well child and sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

The MSDH Child Health and Prenatal programs serve all women, infants, and children but target services to women, infants, and children at or below 185 percent of poverty. Services are preventive in nature; however, treatment is often included for those whose need is greatest. Using a multi-disciplinary team approach, including medical, nursing, nutrition and social work, the Child Health Program provides childhood immunizations, well child assessments, limited sick child care, and tracking of infants and other high risk children. Services provided are basically preventive and designed for early identification of health concerns. Case management services are provided to high risk pregnant and postpartum women and infants by nurses, social workers and nutritionists. Services are provided in clinics and in the clients' homes.

In areas where the MSDH is not the primary provider of care, the MSDH contracts and/or collaborates with private providers to care for the MCH and CSHCN population. Some of these providers conduct regular and/or screening clinics in health department facilities. Others are contracted for consultation and referrals. The MSDH provides support services such as case management, nutrition and psychosocial counseling, education and nursing.

In some areas of the state, prenatal patients are seen in health department clinics until delivery and then return to MSDH for postpartum and family planning services after delivery. High risk patients are sometimes co-managed by the health department and the private provider.

In other parts of the state, the health department has contractual agreements with private providers whereby the MSDH manages the patient until a certain stage of gestation and then transfers the patient to the private provider for the remainder of her care. There are several areas of the state where, when a patient's pregnancy is confirmed, she goes immediately into the private sector or to a community health center or rural health clinic for care.

/2009/ The number of maternity clients seeking prenatal care at county health departments has started to increase within the past few years. During FY 2005, a total of 7,997 clients received prenatal care at county health departments. By FY 2007, the number of clients

receiving maternity services from county health departments had risen to a total of 8,356. During CY 2007, 18 percent of the women who gave birth in Mississippi received their prenatal care in county health departments. //2009//

The MSDH, in administering the Title V programs, has taken steps to integrate the private medical community into the system through contractual arrangements whereby local physicians provide limited clinical coverage at local health departments. These physicians enhance the continuum of care by becoming the client's provider of after-hours and weekend care when necessary and many times provide a medical home for families as the family's economic status improves.

B. State Priorities

STATE PRIORITIES

Mississippi's health priorities from the 2006 Needs Assessment are enumerated below:

1. Increase EPSDT/preventive health services for children on Medicaid and SCHIP.
2. Decrease smoking among pregnant women.
3. Decrease cigarette smoking among sixth through twelfth graders.
4. Reduce repeat teen pregnancies for adolescents less than 18 years old.
5. Address child/adolescent obesity/overweight issues.
6. Increase oral health care and preventive services for children.
7. Reduce child/adolescent unintentional injuries.
8. Decrease unhealthy behaviors, specifically alcohol and drug use and risky sexual behavior, for teenagers sixth through twelfth grades.
9. Maintain case management follow-up services for children with genetic disorders identified through MSDH newborn screening.
10. Continue to improve and maintain developed data collection capacity for Title V population

These state priorities were derived from the needs assessment process in 2004 and 2005. Priorities were determined based on the needs of the MCH population in relation to current MCH Block Grant state and national measures. The priorities are designed to complement national performance measures without duplicating efforts that are currently being used to address performance measures. Each priority, however, does relate in some way to the state and national performance measures as well as Healthy People 2010 goals. Eight state performance measures were derived from these priorities and are detailed on subsequent forms in this grant application/report. Below are summaries of each priority and why it was chosen.

EPSDT/Preventive Health Services: This priority was carried over from the previous cycle and enhanced. Little more than one-half of Medicaid eligibles receive preventive health screenings. One may reasonably assume a comparable percentage for SCHIP eligibles. Therefore, SCHIP was added to this priority and to the state performance measure that corresponds with this

priority.

Smoking Among Pregnant Women: During the previous cycle, smoking among pregnant teenagers was selected as a priority to focus efforts on a specific age group of pregnant women. When revisited, it was agreed that this priority should be expanded to include all pregnant women. As data reflect, women who smoke during pregnancy are more likely to be low socioeconomic status, minorities, and deemed high risk. Smoking in itself makes pregnant women high risk due to the effects of smoking on unborn babies. In Mississippi, approximately 25% of pregnant women smoke. This statistic makes the size, seriousness, and scope of the issue appropriate for selection as a top priority.

Cigarette Smoking Among Sixth through Twelfth Graders: Cigarette smoking among youth continues to be a public health problem in Mississippi. Progress has been made to address youth smoking in Mississippi. However, according to 2007 YRBSS, the percent of children who report having smoked in the last 30 days or having ever smoked is well above the national average. Therefore, this priority was selected to remain in the top ten priorities. In the past, due to only having weighted data for ninth through twelfth graders, sixth through eighth graders were not included. Due to improved data resources, the priority will be enhanced to include sixth through twelfth graders, increasing the global scope of the priority.

Repeat Teen Pregnancy: Teen pregnancy remains a problem in Mississippi. Currently, over 40 per 1,000 births are to adolescent mothers. The rate of repeat teen pregnancies continues to be of special concern. Since a national performance measure to address teen pregnancy for 15-17 year olds exists, the workgroup desired to address the issue of repeat teen pregnancy. Repeat teen pregnancies remain around 140 or more per 1,000 live births to teens. This statistic accounts for approximately 25% of all teen births, above the national average according to Child Trends- Research Brief (2007). Although it has declined in recent years, the rate is still a major concern due to implications for repeat teenage births. Adolescent mothers are at risk for LBW and preterm births, and a host of other health problems. This priority will remain in the top priorities for 2006-2010 so that more can be done to address this issue.

The Mississippi State Department of Health Office of Child and Adolescent Health continues to assist Mississippi Department of Human Services Abstinence Education Program with the development and planning of the 2008 "Just Wait" Teen Abstinence Summit. This year's abstinence educational awareness summit attracted approximately 6,000 middle and high school students from across the Mississippi.

Childhood Obesity: Overweight or obese children, poor nutrition and physical inactivity have drawn public attention in recent years. Mississippi's children are becoming increasingly overweight, as is the adult population. Mississippi ranks among the most obese states in the U.S. According to 2007 YRBSS data, over 17.9% of youth self report as being overweight and another 17.9% as at risk for becoming overweight. With physical education at an all time low and education funding woes, little seems to be in progress to influence this growing problem. Childhood obesity must be made priority so that multi-agency combined efforts may collaborate to eliminate child obesity.

Unintentional Injuries in Children: Mississippi holds one of the highest rates of childhood unintentional injuries and deaths. Most childhood deaths and injuries occur before age 14 with the highest risk ages being 0-5 years. Adolescent injuries comprise the second highest risk group. According to CY 2006 data from MSDH Vital Statistics shows that 32.1 per 100,000 deaths will occur in children between ages one and 14 years. According to the 2008 Kids Count Data Book, 69 per 100,000 teenagers aged 15-19 die as a result of homicide, suicide, and accidents. This statistic is well above the national average of 50 per 100,000 deaths. These statistics support selection of this issue to be addressed during the next cycle.

Using technical assistance, networking initiatives and partnerships to plan programs and

coordinate efforts, the Mississippi State Department of Health works with Mississippi Office of Public Safety to reduce the incidence of alcohol-related fatal and injury traffic crashes among the adolescent driver population. Teens on the Move, a statewide awareness and educational youth conference is planned and implemented by Mississippi Office of Public Safety. The program seeks to reduce needless deaths and injuries associated with motor vehicle crashes; promotes healthy lifestyles among adolescents; encourages student leadership in alcohol and drug prevention and highway safety; provides a platform for motivating schools to continue providing guidance in highway safety programs and alcohol and drug prevention. The conference targets students in grades 5 to 12 who participate in Students Against Destructive Decisions (SADD) or other clubs choosing to be alcohol and drug-free and respect highway safety laws. SADD provides students with intervention and prevention tools to deal with issues of underage drinking, drunk driving, drug abuse and other destructive decisions in Mississippi.

Unhealthy Behaviors in Adolescents Sixth through Twelfth Grades: The Youth Risk Behavior Surveillance System shows that the state's data on teenagers in Mississippi consistently ranks above national averages for unhealthy behaviors. As an MCH program, the MSDH will address unhealthy behaviors in hopes of lowering those averages to meet or fall below national averages in order to improve health status. STD rates for teenage males, drug and alcohol use, and injuries are a public health problem. Through the needs assessment, Mississippi has chosen to address unhealthy behaviors through other state performance measures, such as repeat teen pregnancy, obesity, and cigarette smoking.

Case Management Follow-up for Children with Genetic Disorders: The state leads in newborn screening and identification of genetic disorders and birth defects. Mississippi screens for over 40 genetic disorders and MSDH follows identified cases through case management services. During the past five years, the MSDH worked diligently to capture all families who had a newborn with a genetic disorder and offered case management, education, and support. Case management efforts are reaching close to 100% of families having a newborn identified through the newborn screening program. This priority will remain a top priority to support continued success within the program.

Data Collection Capacity: During the 2000 needs assessment cycle, a separate entity for data collection and capacity was a fairly new concept. A CDC assignee had been struggling to develop MCH data capacity. The workgroup determined the best way to address such an issue was to make it a top priority. Over the next five years a great amount of growth and strengthening occurred. Much has been done to address the issue of data capacity and infrastructure. However, data collection capacity should remain a top priority for this needs assessment cycle, but not as a state performance measure.

Summary: The Title V MCH Needs Assessment process consisted of several methodological principals to ensure the ongoing nature of the process and incorporate results and activities with other portions of the grant application and annual report. National and state performance measures were examined. Overall MCH health status was considered. Capacity indicators were used to develop the state's top ten priorities and develop new state performance measures based on needs assessment evidence. Steps involved the collaboration of a workgroup, conducting special analyses, analyzing health status and existing data, identifying current activities to address needs, and finally, assigning top priorities along with developing with a plan to address the priorities and monitor progress over the next five years.

To assess communities and MCH needs statewide, similar qualitative and quantitative methods were used. Surveys developed by ad hoc committees were based on surveys used during the 2000 Needs Assessment. The committees essentially built upon strengths of existing surveys and enhanced questions to meet the changing Mississippi climate. Other similarities consisted of the convening of the needs assessment workgroup and conferences to present data findings. The state's capacity to meet the needs identified by the 2005 needs assessment is adequate and provides room for growth and further capacity development.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	99.8	99.6	99.7	100	100
Annual Indicator	99.9	99.4	100.0	100.0	100.0
Numerator	41295	41219	100	136	120
Denominator	41316	41488	100	136	120
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
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

Denominator and numerator is based on the numbers of positive screens and the number receiving follow-up services.

Notes - 2006

Denominator and numerator is based on the numbers of positive screens and the number receiving follow-up services.

Notes - 2005

Data in the past had been entered by number of total screenings conducted over the number of total births, However, it was determined that MS needed to enter the number of follow ups to positive/presumptive positive screens over the total number of positive/presumptive positive screens. Therefore the numbers this year are different from other years.

a. Last Year's Accomplishments

Last year, 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 was 100 percent.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide screening of all births occurring in the state and follow-up on all inconclusive, abnormal, and presumptive positive results			X	
2. . Provide family counseling and arrange for repeat screens for all babies with inconclusive and abnormal results, and arrange		X		

for diagnostic evaluations for all babies with presumptive positive results				
3. . Identify all confirmed cases of genetic disorders detected through the screening process		X		
4. Assure that children diagnosed with genetic disorders have a local medical home and are under the care of a specialty provider as indicated		X		
5. Continue to assist in coordinating the case management of affected children with local health departments, specialty providers and primary care providers		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During CY 2007, one hundred-twenty (120) newborns were confirmed with a genetic disease/disorder through the newborn screening program. Follow-up, counseling and referral for medical evaluation and treatment were provided for 120 or (100%) of babies detected with a genetic disorder. This was accomplished through the support of the CMP/Genetics Coordinator teams. The teams in public health districts coordinate with county staff to follow up on presumptive positive screens. The coordination of newborn screening, follow-up, facilitation of diagnosis management, evaluation and education are essential public health activities which have contributed to the success of this population-based screening program.

The program's current activities include continuing education on the importance of newborn screening to health care providers, parents, the public, and public health staff.

c. Plan for the Coming Year

Mississippi's plan for the coming year is to continue screening newborns and provide follow-up, counseling and referrals, and facilitate medical evaluation and treatment to families with babies born with genetic disorders. In addition to implementing activities necessary to maintain the percent of newborns screened and confirmed, staff will continue to educate health care providers and parents on the importance of timely screening and follow-up. Efforts will also continue to identify community resources and local services for families.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	44.5	47.5	50.5	53.5	56.5
Annual Indicator	41.5	41.5	41.5	41.5	60.4
Numerator	147	147	147	147	442
Denominator	354	354	354	354	732
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
	2008	2009	2010	2011	2012
Annual Performance Objective	62.5	63	63.5	64	64.5

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

During the enrollment process all applicants are requested to identify their medical home. If they indicate they do not have one, they are instructed on the need for a medical home. Then they are referred to a physician in their community.

Notes - 2005

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

a. Last Year's Accomplishments

Program and policy input from CSHCN families included representation on advisory committees where individuals provided input and/or feedback. The Parent Advisory committee met four times during the year. Parents of CSHCN were also members of the Children's Medical Program Advisory Committee and provided program input along with physicians and other CMP professional and non-professional providers. The Children's Medical Program's parent consultant worked closely with the parent and youth advisory committees and served as an important link between the CMP and the committees.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. . Maintain family participation through the program advisory committee		X		
2. Maintain CMP Parent Advisory Council		X		
3. Include patient and family subcommittee input in the MCH Block Grant Needs Assessment				X
4. Continue contractual agreements with community based organizations that serve CSHCN to provide support services for families				X
5. Utilize a Family Satisfaction Survey tool to obtain information from families regarding the services they receive				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN families continue to participate in program and policy development through their participation as members of the Children's Medical Program (CMP) Advisory Committees throughout the state. Program and policy input from CSHCN families includes representation on advisory committees where individuals provide input and or feedback that is both solicited and

unsolicited. CMP is currently in the process of establishing a Family to Family Health Information and Education Center (F2FC) in collaboration with the University of Southern Mississippi Institute of Disabilities Studies (IDS). The F2FC will facilitate the involvement of families of children with special health care needs as partners in program and policy development at all levels.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to enhance, as well as continue to assure family participation in program policy activities in the State's CSHCN Program. The MSDH's Children's Medical Program (CMP) will continue to work to maintain family participation through the program advisory committee. The Parent Consultant and CMP/Genetics Coordinator teams will work to establish regional family support groups.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	46.2	48.2	50.2	52.2	54.2
Annual Indicator	44.2	44.2	44.2	44.2	45.0
Numerator	312	312	312	312	340
Denominator	706	706	706	706	756
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
	2008	2009	2010	2011	2012
Annual Performance Objective	45.8	46.2	47	47.5	48.2

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

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

a. Last Year's Accomplishments

Last year, data collected by the most recent SLAITS Survey shows that 44.2 percent of Children with Special Health Care Needs (CSHCN) in Mississippi had a medical home. CMP assessed medical home status of all enrollees at the time of application processing, as well as during visits at the specialty clinics. Ninety-three percent (93%) of the children enrolled in CMP were reported as having a medical home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess medical home status at all clinic encounters and make referrals as needed				X
2. Collaborate with primary care physician groups to increase the availability of medical homes				X
3. Continue to coordinate with the University Medical Center to provide care coordination				X
4. Develop CMP case management positions (as funds allow) to provide care coordination services				X
5. Utilize district CMP/Genetics Coordinators to assist in care coordination at the community level				X
6. Continue to provide continuing education opportunities for primary care providers on topics related to CSHCN				X
7. Participate in training for primary care providers on the medical home concept of CSHCN (conferences, continuing education activities, etc.)				X
8.				
9.				
10.				

b. Current Activities

Current data collected by the most recent SLAITS Survey shows that 45 percent of Children With Special Health Care Needs (CSHCN) in the Children's Medical program have a medical home. The Children's Medical Program (CMP) will continue to assess medical home status of all enrollees at the time of application processing and during visits to specialty clinics.

c. Plan for the Coming Year

The MSDH's Children's Medical Program (CMP) will continue to partner with the community based organization, Living Independence for Everyone of Mississippi (LIFE), to implement transition activities. LIFE has several activities directly related to program efforts in developing access of CSHCN to medical homes. CMP will support the Family to Family Health Information and Education Center's efforts to provide educational training opportunities and develop and disseminate information for families and providers related to medical homes.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	54.7	57.7	60.7	63.7	66.7
Annual Indicator	51.7	51.7	51.7	51.7	58.8
Numerator	370	370	370	370	436
Denominator	715	715	715	715	742
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

	2008	2009	2010	2011	2012
Annual Performance Objective	62.5	64.8	66.9	68.4	70.2

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

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

a. Last Year's Accomplishments

Last year in Mississippi, the percent of children with special health care needs age 0 to 18 whose families had adequate private and/or public insurance to pay for the services they needed was 51.7 percent. Overall, Mississippi rates are at or above national averages for most categories and questions asked in the SLAITS survey.

According to the 2001 State and Local Area Integrated Telephone Survey (SLAITS) interviews conducted in Mississippi, 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 was 51.7 percent. Overall, Mississippi rates were at or above national averages for most categories and questions asked. The survey questions did not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include insurance information on CMP applications		X		
2. Verify insurance status at all patient encounters and make referrals to other sources		X		
3. Maintain CMP data system to capture pertinent information				X
4. Continue to work with Medicaid insurers and advocacy groups to promote adequate health coverage for CSHCN				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, the percent of children with special health care needs age 0 to 18 whose families had adequate private and/or public insurance to pay for the services they needed is 58.8 percent.

c. Plan for the Coming Year

Data for this measure will continue to be generated from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, and CSHCN effect on family.

CMP will continue to assess health coverage status of all enrollees and assist families in applying for Medicaid and other available benefits. CMP serves as a payer of last resort for needed services.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	70.9	72.9	74.9	76.9	78.9
Annual Indicator	68.8	68.8	68.8	68.8	90.9
Numerator	245	245	245	245	676
Denominator	356	356	356	356	744
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
	2008	2009	2010	2011	2012
Annual Performance Objective	91	92	92.5	93	93.5

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

LIFE is dedicated to the empowerment of people with significant disabilities to be as independent as and fully involved in their communities as they can be. Life coordinates the provision of devices, equipment, aids, modifications or other services and forms of support. LIFE provides advocacy support, peer counseling. They provide services to over 350 CSHCN and their families in addition to adults.

Notes - 2005

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

a. Last Year's Accomplishments

Last year's percentage of children with special health care needs age 0 to 18 whose families reported that community-based service systems were organized so they could use them easily was at 68.8 percent. Overall, Mississippi rates were at or above national averages for most categories and questions asked in the SLAITS survey. The survey questions did not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide and coordinate 10 community-based CSHCN subspecialty medical clinic sites throughout the state to improve access				X
2. Continue to collaborate with families and providers to work through barriers impacting continuity of care				X
3. Maintain a collaborative relationship with community health centers to provide other needed services				X
4. Facilitate communication between specialty and primary care providers through care coordination initiatives				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, 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 is 90.9, which is a significant increase over last year's survey report. The CMP however, is collaborating with the Family to Family Health Information and Education Center to assist families in identifying community resources. CMP contracts with Living Independence for Everyone (LIFE) to assist families in navigating through the health delivery system, as well as identifying other community resources. The CMP/Genetic Coordinating teams continue to provide a significant link between families and providers at the community level. The team effort put forth by these entities help ensure families are receiving community based services.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this national measure is to continue its efforts to provide quality services that are accessible to Mississippians who need these services. (Until further notification, data for this measure will be generated from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, and CSHCN effect on family.)

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	9.8	13.5	13.8	17.8	21.8
Annual Indicator	10.6	10.6	10.6	10.6	30.9
Numerator	10	10	10	10	104
Denominator	94	94	94	94	337
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
	2008	2009	2010	2011	2012
Annual Performance Objective	31	32.5	34	35.8	37.5

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.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

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

a. Last Year's Accomplishments

Last year, 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 was 10.6. In an effort to improve this percentage, CMP held special transition clinics every month at the multispecialty clinic site in Jackson, MS (Blake Clinic) for selected children and families with special needs. Clinics were staffed with multiple disciplines and referrals are made as needed.

Technical assistance was provided by the Healthy and Ready to Work National Resource Center, which reviewed the transition services currently provided by CMP and made recommendations on methods to improve services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with agencies and organizations working with adolescents on transition issues		X		
2. Enhance the life-skills clinic for the transition of CSHCN to		X		

adulthood				
3. Ensure that transition services are discussed with patients at appropriate age levels		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

According to current data generated from the State and Local Area Integrated Telephone Survey (SLAITS) interviews, 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 is 30.9

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to continue to support the Children's Medical Program's (CMP) partnership with Living Independence for Everyone of Mississippi in an effort to help prepare CSHCN for transition into adulthood. Among services necessary to transition to adulthood will be transition to community life, employment and independent living skills, and individualized education plan support activities. CMP will continue to partner with LIFE to provide necessary training and support to transition children and youth to adult healthcare settings. Family to Family Health Information and Education Center will enhance CMP's efforts to make available training resources and facilitate community participation for CSHCN transitioning to all aspects of adult life. CMP will continue to explore the addition of transition clinics and services to other regional sites around the state.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	88	89	90	89	89.5
Annual Indicator	84.1	85.8	87.6	83.3	80.5
Numerator	756	780	859	750	779
Denominator	899	909	981	900	968
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
	2008	2009	2010	2011	2012
Annual Performance Objective	83.5	84.2	86.3	87.4	85.2

Notes - 2007

Mississippi's Immunization rate (4:3:1:3:3) for children 19-35 months of age has declined over the past few years mainly due to children missing the 4th dose of DTaP. Tracking and follow-up is needed to make sure the MSDH does not miss opportunities to vaccinate. Additional reminder recall systems are being reviewed to be put in place to let parents become aware that shots are due.

Data reported was pulled from the Mississippi Immunization Annual Two Year Old Survey of children who completed 4:3:1:3:3 series by 27 months of age.

Notes - 2005

Percentages, numerators and denominators are derived from a yearly survey conducted by the MSDH Immunization department. MSDH surveyed 981. Out of that we were able to locate and review 859 immunization records. 87.6% of those children were complete at 2 yrs of age. By sampling the immunization records of 19-35 month olds, the MDH is able to generate immunization rates consistently.

a. Last Year's Accomplishments

According to last year's 2006 immunization survey of children at 27 months of age, 83.3 percent completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to conduct annual immunization surveys to obtain statistical estimates of immunization rate				X
2. Continue to emphasize, through the Statewide Immunization Coalition, immunizations' significance				X
3. Continue to work with the Mississippi Chapter of the American Academy of Pediatrics (AAP)				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

According to the 2007 immunization survey of children at 27 months of age, 80.5 percent completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B.

c. Plan for the Coming Year

The MSDH's plan for this measure is to continue to emphasize the significance of completing immunizations by two years of age. Also, professional and public education will continue to be a

part of the state effort to increase immunization awareness.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	38.2	36.7	35.3	32.5	31.1
Annual Indicator	35.4	33.9	33.1	39.7	32.4
Numerator	2217	2126	2107	2601	2125
Denominator	62706	62661	63715	65576	65576
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
	2008	2009	2010	2011	2012
Annual Performance Objective	32	31.8	30.5	30.1	29.7

a. Last Year's Accomplishments

The birth rate (per 1,000) last year for teenagers age 15 through 17 years was 39.7 per 1,000 live births, which represents a slight increase from CY 2005 rate of 33.1 per 1,000 live births. During FY 2006, approximately 75,600 students attended 1,926 presentations about general and reproductive health. All nine public health districts were active in making presentations to schools.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support Statewide Abstinence Education Program				X
2. Meet with ministers and church organizations to solicit help in addressing teen pregnancy				X
3. Increase collaboration between adolescent pregnancy prevention programs that focus on minorities				X
4. Collaborate with community health centers in all medically underserved counties				X
5. During postpartum home visits, counsel teens regarding availability of family planning services		X		
6. Work with school nurses on counseling teens regarding risky behaviors and goal setting		X		
7. Counsel children ages 9-18 regarding postponing sex, reproductive health, and contraception		X		
8. Develop partnerships between the State OB/GYN medical consultants and other providers				X
9.				
10.				

b. Current Activities

The 2007 provisional birth rate (per 1,000) for teenagers age 15 through 17 years is 32.4 per 1,000 live births, which represents a slight decrease from the 2006 rate of 39.7 per 1,000 live births. During 2007, approximately 75,000 students attended 2000 presentations about general and reproductive health. All nine public health districts were active in making presentations to schools.

The Adolescent Health Coordinator collaborates with internal and external partners to address teen pregnancy and adolescent sexual and reproductive health issues. The Mississippi State Department of Health Office of Child and Adolescent Services Program works closely with the Division of Family Planning to implement strategies, policies and services that reduce the rate of repeat births to adolescent mothers less than 17 years old; to reduce the rate of adolescents at-risk of early sexual initiation, teen pregnancy and teen parenthood; and to increase the rate of adolescents receiving comprehensive sexual health education in middle and high schools.

Mississippi State Department of Health Division of Family Planning Program has contracted with eleven (11) delegate agencies that are comprised of community health and university student health centers and job corps sites to provide clinical health education and preventive services, counseling and information, and reproductive health methods to adolescents outside of the public health catchment areas.

c. Plan for the Coming Year

Mississippi's plan for the coming year is to continue implementing activities aimed at reducing the birth rate for teenagers age 15 through 17 years of age, as well as maintaining collaborative efforts among public health districts and community health centers in all medically underserved counties regarding the provision of free contraceptives to teens. Through the EPSDT and Abstinence Programs, children and adolescents 9-18 years of age will continue to be counseled regarding postponing sex. Although the Abstinence Programs are no longer under the oversight of the health department, partnerships with those who operate the programs will continue to benefit the MCH population in Mississippi.

The adolescent coordinator has begun focusing on teen issues such as births to teenagers. Through collaborative efforts, the state adolescent coordinator will promote healthy behaviors for all teens in Mississippi.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	17	25	30	30	30
Annual Indicator	17	17	17	7.4	7.5
Numerator				2819	2800
Denominator				38041	37277
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
	2008	2009	2010	2011	2012
Annual Performance Objective	8	8.5	9	9.5	10

Notes - 2006

Weighted percentage = 25.6% of third grade children have received preventive dental sealants. (95% CI -- 24.3%-26.8%)

Notes - 2005

Current data are unavailable; 17 percent represents an estimate based on data from a previous survey.

a. Last Year's Accomplishments

Last year, the MSDH Dental program worked to develop a non-profit statewide oral health coalition to achieve the goals and objectives listed in Mississippi's oral health plan. The Dental Program also worked to develop community-based direct oral health care services using a 51-foot mobile-dental-clinic with community partners.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop partnerships between the State OB/GYN medical consultants and other providers				X
2. Develop a statewide oral health coalition.				X
3. Develop a school-based dental sealant program.			X	
4. Propose a fluoride varnish program			X	
5. Work to implement oral health questions in WIC Certification.		X		
6. Initiate oral health education and promotion		X		
7. Develop outreach program for recently acquired mobile dental clinic.	X			
8. Conduct Dental corrections for eligible children in CMP	X			
9.				
10.				

b. Current Activities

By June 30, 2007, 52.5 percent of Mississippi's population on public water systems received optimally fluoridated water, an increase of over 176,000 people. Participation reports showed that 26,746 children at 153 elementary schools received school fluoride mouthrinse during the 2007 school year. However, 58 participating schools did not return their participation records. Through the school-based preventive dental sealants program, 1,073 students at 32 schools received sealants and 3,883 sealants were applied to permanent first molar teeth during the 2007 school year. This decrease in the percentage of sealants placed is a consequence of decreased funding for oral health through the MCHBG. An additional 93 students were screened but were not eligible to receive dental sealants. In November 2007, a statewide oral health coalition was incorporated as the Mississippi Oral Health Community Alliance (MOHCA) by the Secretary of State.

c. Plan for the Coming Year

The Office of Oral Health will publish the results of the Head Start survey, and utilize new FY 09 funding from the Bower Foundation for Mississippi's community water fluoridation program. The Office of Oral Health will also use a dental group provider number made possible by the Mississippi Division of Medicaid, which will allow the Office to submit claims for preventive dental procedures performed by our hygiene staff. In addition to the provider number, the Division of Medicaid also opened procedure code D1206 for fluoride varnish application to moderate or high risk children with an allowable claim of \$19.20. The Office of Dental Health obtained memoranda

of agreement with Head Start programs to perform screening and fluoride varnish application, and will identify dental partners for referral to treatment.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	8.4	8.2	8.2	7.9	7.7
Annual Indicator	8.8	7.9	9.1	8.1	7.9
Numerator	56	49	56	47	46
Denominator	633103	621884	618595	582226	582226
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
	2008	2009	2010	2011	2012
Annual Performance Objective	7.5	7.2	7	6.5	6.1

a. Last Year's Accomplishments

The death rate last year of children aged 1-14 by motor vehicle crashes (per 100,000) was 8.1, which represented a slight decrease from the 2005 rate of 9.1.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Safe Kids of Mississippi Coalition to initiate the passage of legislation				X
2. Partner with local health departments to provide child safety seats to residents of the state				X
3. Develop and implement an initiative to educate and provide information to parents on the proper use of child safety seats		X		
4. Utilize educational videos and informational TIPP sheets developed by the Ford Motor Company		X		
5. Maintain MDH participation with the Mississippi Association of Highway Safety Coalition				X
6. Work with school nurses and other school personnel to promote safety education related to motor vehicle crashes				X
7. Identify opportunities for collaboration to enhance safety awareness efforts and interventions				X
8.				
9.				
10.				

b. Current Activities

Currently, 2007 provisional data estimates that the death rate of children aged 1-14 by motor vehicle crashes (per 100,000) is approximately 7.9, which represents a decrease from the 2006 rate of 8.1. The MSDH has several preventive health activities aimed at reducing the death rate by motor vehicle crashes through collaborative efforts and promotions.

c. Plan for the Coming Year

Mississippi's plan for the coming year is to continue its collaboration with agencies and community-based organizations to develop initiatives to decrease death to children age 1-14 caused by motor vehicle crashes, and to improve communication and collaborative activities with the Emergency Medical Services for Children Department on education and awareness efforts throughout the state. Continue discussions with the Children's Safety Network National Injury and Violence Prevention Resource Center on ways to integrate MCH program activities and education regarding safety issues.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				16.3	16.5
Annual Indicator			16.2	12	18
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?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	18.5	18.6	18.9	19.1	19.5

Notes - 2007

According to the latest data available from Ross Mother Survey (2006), 18 percent of mothers surveyed breastfed their infants at 6 months of age.

Notes - 2006

According to the latest data available from Ross Mother Survey, 12 percent of mothers surveyed breastfed their infants at 6 months of age.

Notes - 2005

Data recorded from the latest Ross Mothers Survey report in November, 2005. Currently, this measure has been changed to request breastfeeding data at 6 months instead of at hospital discharge requested by the previous measure. Thus, data from the latest Ross Mothers Survey revealed that 16.2 percent of mothers in Mississippi breastfed their infants at 6 months.

a. Last Year's Accomplishments

Last year, data from the Ross Mothers Survey revealed that 12 percent of Mississippi mothers breastfeed their infants at 6 months of age.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Certify and promote MDH clinics as breastfeeding-friendly facilities		X		
2. Continue the nationally recognized peer counselor breastfeeding program through the MDH		X		
3. Continue the implementation of USDA National Breastfeeding Promotion Campaign		X		
4. Distribute a promotional video to assist WIC clients, physician clinics and hospitals		X		
5. Provide technical training opportunities for health care providers on breastfeeding promotion				X
6. Conduct outreach activities with worksites employing large numbers of women in the childbearing age range		X		
7. Increase collaboration among MDH agency programs and private providers				X
8. Continue to partner with the March of Dimes to encourage providers to apply for funding to provide patient education				X
9.				
10.				

b. Current Activities

Data from the latest Ross Mothers Survey revealed that 18 percent of mothers in Mississippi breastfed their infants at 6 months.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this national measure is to continue implementing initiatives to improve the incidence and duration of breastfeeding among women in Mississippi. These initiatives will include activities such as certifying and promoting MSDH clinics as breastfeeding-friendly facilities, and distributing promotional videos to assist WIC clients, physician clinics and hospitals with ways to address breastfeeding barriers.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	99	99.3	99.5	99.6	99.7

Annual Indicator	96.4	96.7	98.5	98.6	97.1
Numerator	40778	40921	40453	44238	44191
Denominator	42321	42321	41062	44863	45511
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
	2008	2009	2010	2011	2012
Annual Performance Objective	99.7	99.8	99.8	98.8	98.8

Notes - 2007

Mississippi's birth cohort was not used here, but the number 45,511 was used which represents the total births in Mississippi for 2006 minus the children born outside of the state and not screened in Mississippi.

Notes - 2006

2006 data for this measure are currently unavailable. However, data for this measure was calculated using a simple linear regression formula.

a. Last Year's Accomplishments

During Calendar Year (CY) 2006 44,234 (98.6%) infants received hearing screening prior to hospital discharge. Extensive training was conducted at all screening facilities to ensure competence of hospital staff in effectively completing the screening procedures and providing timely referral for infants not passing the screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical support to hospitals with regard to the screening process and upgrading equipment		X		
2. Receive and review written, electronic and faxed reports from birthing hospitals and /or facilities				X
3. Review screening reports for risk factors				X
4. Monitor referral of infants to diagnostic centers for confirmation of hearing loss		X		
5. Provide literature to hospitals for distribution to parents regarding pass/refer status, follow-up recommendations, and parent support		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, 2007 provisional data estimates that 44,191 (97.1%) infants were screened prior to hospital discharge. Extensive training continues to be conducted at all screening facilities to ensure competence of hospital staff in effectively completing the screening procedures and providing timely referral for infants not passing the screening.

c. Plan for the Coming Year

Plans for the coming year relevant to this national measure include the continued upgrading of screening equipment that will improve the accuracy and completeness in the reporting of screening results. Also, the MDH plans to continue efforts to assure the implementation of universal screening at all hospitals for early detection of hearing impairments in newborns. MSDH owns 5 portable Automated Auditory Brainstem Response (AABR) units to be used by hearing resource consultants who are licensed audiologists. They will screen children not screened in the hospital or lost to follow-up between first and second screens.

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	11.5	14.5	10.5	10.4	10.3
Annual Indicator	12	10.8	10.8	13	12.6
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	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	12	11.5	11.1	10.9	10.2

Notes - 2007

Source: Medicaid Facts; January 2007
National Association of Children's Hospitals.

Notes - 2006

Data for this measure were taken from the Mississippi Profile Fact Sheet reported in the Kaiser Family Foundation 2005 report.

Notes - 2005

Data for this measure were taken from the Mississippi Profile Fact Sheet reported in the Children's Defense Fund's latest report.

a. Last Year's Accomplishments

Last year's data to determine the number of children in Mississippi without health insurance was extracted from reports posted by the Children's Defense Fund.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with Medicaid to address issues and barriers to applying and receiving for Medicaid and SCHIP				X
2. Facilitate dialogue with stakeholders to work with Insurance		X		

companies to improve access to health coverage for children				
3. Assess health coverage status at every opportunity and provide assistance to families in the completion of applications		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, data used to determine the number of children in Mississippi without health insurance was extracted from data published in the Kaiser State Health Facts (2004-2005)

c. Plan for the Coming Year

Mississippi's plan for the coming year relative to this measure is to collaborate with state agencies, advocacy groups, and other projects to identify uninsured children and increase awareness of available health coverage options.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				33.5	33.2
Annual Indicator			33.7	32.5	33.0
Numerator			13626	11892	6719
Denominator			40391	36643	20376
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
	2008	2009	2010	2011	2012
Annual Performance Objective	32	31	30	29	29.5

a. Last Year's Accomplishments

Last year, according to WIC data collection system, 32.5 percent of children ages 2-5 receiving WIC services had a Body Mass Index (BMI) at or above the 85 percentile.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Conduct nutrition education and encourage WIC clients to make appropriate food choices and exercise				X
2. Tailor food packages to suit family needs			X	
3. Recommend and promote health lifestyle changes			X	
4. Continue to implement the Value Enhanced Nutrition Assessment			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, WIC data collection system revealed that there are 33.0 percent of children ages 2-5 receiving WIC services with a Body Mass Index (BMI) at or above the 85 percentile.

In efforts to address childhood obesity, the MSDH WIC program has implemented a policy for children age 2-5 referred to as "VENA" or Value Enhanced Nutrition Assessment. Children 2-5 with a Body Mass Index greater than the 95 percentile are required to be placed on skim milk. Mississippi is the first state to implement this policy. The WIC program is also conducting nutrition education classes that encourage WIC clients to make appropriate food choices and exercise.

c. Plan for the Coming Year

During the coming year, the MSDH WIC program will continue to implement VENA and promote nutrition education classes that encourage WIC clients to make appropriate food choices and exercise.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				21.7	21.5
Annual Indicator			21.9	14.6	14.0
Numerator			318	147	204
Denominator			1453	1009	1453
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

	2008	2009	2010	2011	2012
Annual Performance Objective	13.5	13.5	13.2	13	12.5

Notes - 2007

Source: Estimates for PRAMS 2007 Analysis.

Notes - 2006

Source: PRAMS 2006 Analysis.

Notes - 2005

The most recent data for this measure is 2003. Data for 2004 are pending.

a. Last Year's Accomplishments

The MSDH provided funds and resources to the agency's health educators to increase awareness of tobacco cessation services among pregnant women. The MSDH also provided funds for and promoted the services of the Mississippi Tobacco Quitline, a free-of-charge, telephone-based cessation counseling service that implements special counseling protocol for women who are pregnant, and the ACT Center for Tobacco Education, Treatment and Research, a free-of-charge, face-to-face counseling service available at hospitals throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with nurses and health educators to increase health education		X		
2. Work with nurses and health educators to increase health education		X		
3. Provide training about smoking cessation and pregnancy to nurses, nutritionists, and social workers		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MSDH provides funds and resources to the agency's health educators to increase awareness of tobacco cessation services among pregnant women. The MSDH also provides funds for and promotes the services of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Education, Treatment and Research. In addition, the MSDH provides funds to organizations who serve this special population to provide tobacco prevention education and promote cessation services.

c. Plan for the Coming Year

The MSDH will continue to provide funds and resources to the agency's health educators to increase awareness of tobacco cessation services among pregnant women. The MSDH will also provide funds for and promote the services of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Education, Treatment and Research. The ACT Center will also conduct cessation intervention trainings for MSDH health care providers in each public health district. In addition, the MSDH will provide funds to organizations who serve this special population to provide tobacco prevention education and promote cessation services.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	7.6	9.2	7.9	7.9	7.7
Annual Indicator	6.0	8.8	8.8	5.9	7.2
Numerator	13	19	19	13	16
Denominator	216778	216248	216518	220823	220833
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
	2008	2009	2010	2011	2012
Annual Performance Objective	7	6.9	6.4	6.1	5.9

a. Last Year's Accomplishments

During 2006, the suicide death rate in Mississippi (per 100,000) among youths 15-19 was 5.9. This represents decrease from the CY 2005 rate of 8.8. Public health and school nurses were available to provide counseling and referral services to youth identified to be at risk by acting as a school and community resource for health education.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop strategies for utilization of school health nurses as a school and community resource for health education and to assist in bridging the communication gaps between adolescents and their families				X
2. Collaborate with the Department of Mental Health to explore initiatives for preventing suicide deaths among youths, such as suicide risk assessments and prevention				X
3. Review records to screen for high risk youth		X		
4. Through suicide prevention networks, provide information on available resources throughout the state		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CY 2007 estimated suicide death rate in Mississippi (per 100,000) among youths 15-19 is 7.2. This represents a slight increase from the CY 2006 rate of 5.9. Public health and school nurses will continue to be available to provide counseling and referral services to youth identified to be at risk by acting as a school and community resource for health education. The Mississippi Department of Mental Health was awarded a grant to implement youth suicide prevention activities for the coastal counties.

Public health and school nurses and social workers continue efforts to provide counseling and referral services to youth identified to be at risk by acting as a school and community resource for health education. In 2006, the Mississippi Department of Mental Health received a grant from the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, to develop and implement suicide prevention and early intervention activities to benefit youth in coastal counties.

c. Plan for the Coming Year

In the coming year, Mississippi State Department of Health, along with other members of the Mississippi Youth Suicide Prevention Council will host a statewide youth suicide prevention and awareness conference. The conference will examine key national and state statistical data; identify warning signs, risks and protective factors of suicide; address issues about the social stigma and shame of suicide, suicide attempts and suicidal ideation; and provide preventive strategies to reduce incidences of adolescent and youth suicide. The targeted audience will consist of school, mental health, public health, social service and juvenile justice professionals; community and faith-based stakeholders; youth suicide prevention advocates; parents; and adolescents and young adults.

The Mississippi State Department of Health will continue its collaboration with key stakeholders of the Mississippi Youth Suicide Advisory Council to develop strategies to address youth suicide in the state. Through increased awareness and understanding of this menacing problem threatening Mississippi's youth, the Mississippi State Department of Health will support the purchase of educational and awareness materials; support professional staff trainings on evidence based screening tools and prevention material related to the assessment, treatment, and management of suicidal youth, including: "SOS" (Signs of Suicide), A.S.I.S.T. (Train-the-Trainer Youth Suicide Model), Trauma-focused Cognitive Behavioral Therapy (Catholic Charities), Jason Foundation and the Youth Suicide Prevention Program's "Gatekeeper" Training Curriculum; and promote and assist with developing youth and young adult suicide prevention awareness programs and campaigns.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	33	33	34	32.7	32.6
Annual Indicator	34.9	31.2	30.5	28.6	31.1
Numerator	336	297	301	310	337
Denominator	963	952	988	1083	1083
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
	2008	2009	2010	2011	2012
Annual Performance Objective	32.5	32.3	32.2	32.1	32.5

a. Last Year's Accomplishments

During CY 2006, 28.6 percent of very low birthweight infants were delivered at tertiary centers. This represents a slight decrease from 30.5 percent reported for CY 2005.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to work with the Mississippi Perinatal Association and the March of Dimes to evaluate the regionalization system in the state				X
2. Evaluate the current system and develop a plan of improvement if needed				X
3. Continue to conduct annual hospital surveys to obtain status of available manpower for multiple medical services, including maternity and newborn		X		
4. Assess facility availability across the state for perinatal practices and statistics for use in state planning		X		
5. Continue to provide financial assistance to the tertiary center for newborn transport		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During 2007, according to provisional data, an estimated 31.1 percent of very low birthweight infants were delivered at tertiary centers. This represents a slight increase from 28.6 percent reported for CY 2006.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this national measure is to increase the percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates by continuing to work with the Mississippi Perinatal Association, the Infant Mortality Task Force, the March of Dimes, and other partners to evaluate the regionalization system in the state.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	84.1	85.1	86	86	86.9
Annual Indicator	84.3	81.8	81.4	81.4	84.9
Numerator	35663	35036	34455	37461	39093
Denominator	42321	42809	42327	46046	46046
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
	2008	2009	2010	2011	2012
Annual Performance Objective	87.7	88.6	89.5	90.1	91.4

a. Last Year's Accomplishments

During CY 2006, 81.4 percent of infants born were to women who had received prenatal care beginning in the first trimester. This represents no change from the 81.4 percent reported for CY 2005.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Medicaid and Department of Human Services to include AFDC checks and Food Stamp mailouts with information on prenatal care, WIC, and family planning	X			
2. Collaborate with Miss. Food Network to distribute information about prenatal care				X
3. Collaborate with the March of Dimes to develop media materials related to early prenatal care				X
4. Collaborate with the Healthy Baby Campaign, a multi-state campaign, to provide coupons for pregnant women who initiate and continue prenatal care				X
5. Collaborate with March of Dimes to implement Stork Nests for clients receiving continuous prenatal care				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During CY 2007, provisional data estimates that approximately 84.9 percent of infants born were to women who had received prenatal care beginning in the first trimester. This estimate represents an increase from 81.4 percent reported for CY 2006.

c. Plan for the Coming Year

Mississippi's plan for this national measure in the coming year is to increase the percent of infants born to pregnant women who received prenatal care beginning in the first trimester by partnering with other agencies and organizations to disseminate information on the importance of prenatal care, WIC, and family planning.

D. State Performance Measures

State Performance Measure 1: *Percent of children on Medicaid and SCHIP who receive EPSDT and preventive health services well child visits.*

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				35	37
Annual Indicator			33.4	27.5	35.3
Numerator			134265	145798	145775
Denominator			401799	530716	412552
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	40	42	45	45	45

a. Last Year's Accomplishments

During CY 2006, of the 530,716 Medicaid eligible children (0-20 years old), 145,798 (27.5%) received screening services. The MSDH continues to work with the Division of Medicaid, Head Start, and other community partners to increase the EPSDT screening participation rate. Arrangements have been made to provide screening in non-traditional settings and after-hours to facilitate access to services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage parents during postpartum home visits to take advantage of EPSDT screenings				X
2. Provide information about EPSDT in WIC Packets		X		
3. Remind parents at immunization visits about the importance of EPSDT and to seek health care		X		
4. Check whether EPSDT screenings are due on children being seen for WIC services and screen if needed				X
5. Develop a plan to provide and ensure EPSDT services to all eligible children in the state				X
6. Conduct mass EPSDT screening in select areas		X		
7. Support funding sources to school nurses to perform EPSDT				X

screening				
8.				
9.				
10.				

b. Current Activities

During CY 2007, of the 412,552 Medicaid eligible children (0-20 years old), 145,775 (35.3) received screening services. The MSDH will continue to work with the Division of Medicaid, Head Start, and other community partners to increase the EPSDT screening participation rate. Arrangements have been made to provide screening in non-traditional settings and after-hours to facilitate access to services.

c. Plan for the Coming Year

The MSDH's plan for the coming year relative to this measure is to continue its efforts to provide increased access to health care for children on Medicaid. The MSDH will continue to encourage parents during prenatal care and postpartum home visits to take advantage of EPSDT screenings. Parents will also be provided information about EPSDT screening at immunization visits and in WIC packets. Mass EPSDT screenings will be conducted in selected areas of the state as well.

State Performance Measure 2: *Current percent of cigarette smoking among adolescents grades 6-12.*

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				21	20.5
Annual Indicator	21.0	21.0	21.0	21.0	19.2
Numerator	597	597	597	597	289
Denominator	2843	2843	2843	2843	1504
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	19	19	18.5	18.5	18

Notes - 2007

YRBS data reported represents students in grades 9-12. Data are not captured for grades 6-12. "Current use" is defined as use of tobacco product on one or more occasions in the past 30 days preceding the survey.

Notes - 2005

Q31 (HS) and Q20 (MS). During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day? MDH did not receive weighted data for 2005, therefore data are from 2003 YRBSS.

a. Last Year's Accomplishments

The MSDH provided funds to statewide tobacco control organizations for the implementation of the following youth tobacco prevention programs: Students Working Against Tobacco (SWAT) for youth in grades 4-6; FREE for youth in grades 7-8; Frontline, a youth advocacy program, for youth in grades 9-12; and, TATU, a tobacco prevention and mentoring program, for youth in

grades 9-12. The youth tobacco prevention programs provided opportunities for students to have an active role in tobacco prevention by joining SWAT/FREE/Frontline/TATU Teams and conducting monthly activities. The youth programs were implemented in such venues as schools, social organizations, faith-based organizations and after school programs. In addition, MSDH conducted a media campaign to educate youth on the dangers of tobacco use and the importance of making positive, healthy lifestyle choices.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Through EPSDT, Family Planning and other adolescent visits, counsel youths about tobacco use		X		
2. Maintain community-based tobacco prevention programs in collaboration with the Partnership				X
3. Maintain use of tobacco prevention curricula in school through the School Health Nurses				X
4. Conduct site visits to at least 15 schools to assess tobacco prevention activities				X
5. Train staff on smoking cessation specifically targeted to adolescents				X
6. Make literature available to communities and schools on smoking cessation		X		
7.				
8.				
9.				
10.				

b. Current Activities

The MSDH provides funds to statewide tobacco control organizations for the implementation of the following youth tobacco prevention programs: Students Working Against Tobacco (SWAT) for youth in grades 4-6; FREE for youth in grades 7-8; Frontline, a youth advocacy program, for youth in grades 9-12; and, TATU, a tobacco prevention and mentoring program, for youth in grades 9-12. The youth tobacco prevention programs provide opportunities for students to have an active role in tobacco prevention by joining SWAT/FREE/Frontline/TATU Teams and conducting monthly activities. The youth programs are implemented in such avenues as schools, social organizations, faith-based organizations and after school programs. In addition, youth advocacy trainings have been conducted for youth involved in the Frontline program. These trainings provide youth with advocacy and leadership skills.

c. Plan for the Coming Year

The MSDH will continue to provide funds to statewide tobacco control/public health organizations for the implementation of the following youth tobacco prevention programs: Reject All Tobacco (RAT) for youth in grades 4-6; FREE for youth in grades 7-12; and, TATU for youth in grades 7-12. In addition, MSDH will provide funds for the implementation of the Face Reality Spit Tobacco Program, a program that will be implemented with middle school and high school sports teams throughout the state. A media campaign will also be conducted to educate youth on the dangers of tobacco, and special youth events (contest, youth summits) will be implemented throughout the year.

State Performance Measure 3: Percent of pregnant women who smoke

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				11.7	11.5
Annual Indicator			11.8	11.8	11.8
Numerator			5067	5067	5067
Denominator			42809	42809	42809
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	11.2	11	10.5	10.5	10.5

Notes - 2007

Data for this measure are the latest weighted PRAMS data available. (2004)

Notes - 2006

Data for this measure are the latest weighted PRAMS data available.

Notes - 2005

This measure changed with the 5 year needs assessment. It was formerly the percent of pregnant teenagers who smoked, but was decided that all women should be targeted. Therefore, data are new beginning with this reporting year.

a. Last Year's Accomplishments

The MSDH provided funds and resources to the agency's health educators to increase awareness of tobacco cessation services among pregnant women. The MSDH also provided funds for and promoted the services of the Mississippi Tobacco Quitline, a free-of-charge, telephone-based cessation counseling service that implements special counseling protocol for women who are pregnant, and the ACT Center for Tobacco Education, Treatment and Research, a free-of-charge, face-to-face counseling service available at hospitals throughout the state.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with nurses and health educators to increase health education		X		
2. Continue to educate pregnant women receiving services on the dangers of prenatal smoking		X		
3. Provide training about smoking cessation and pregnancy to nurses, nutritionists and social workers		X		
4. Refer to PHRM/ISS		X		
5. Refer to Tobacco Quitline Mississippi for information on smoking cessation		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MSDH provides funds and resources to the agency's health educators to increase awareness of tobacco cessation services among pregnant women. The MSDH also provides funds for and promotes the services of the Mississippi Tobacco Quitline and the ACT Center for

Tobacco Education, Treatment and Research. In addition, the MSDH provides funds to organizations who serve this special population to provide tobacco prevention education and promote cessation services.

c. Plan for the Coming Year

The MSDH will continue to provide funds and resources to the agency's health educators to increase awareness of tobacco cessation services among pregnant women. The MSDH will also provide funds for and promote the services of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Education, Treatment and Research. The ACT Center will also conduct cessation intervention trainings for MSDH health care providers in each public health district. In addition, the MSDH will provide funds to organizations who serve this special population to provide tobacco prevention education and promote cessation services.

State Performance Measure 4: *Percent of children with genetic disorders identified through the MSDH newborn screening who receive case management services.*

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	96	97	98	98.5	98.5
Annual Indicator	1.0	1.0	1.0	1.0	1.0
Numerator	3060	2977	100	136	120
Denominator	3117	2992	100	136	120
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

In CY 2006, 100 percent of children with possible genetic disorders received case management services. All newborn screens with inconclusive, abnormal, or presumptive positive test results are reported to genetics field staff for follow-up. Field staff work with local health department nurses to contact the families of these babies by phone or home visits to arrange for counseling and case management. They repeat the screens or collect diagnostic specimens if needed, and arrange for medical evaluation and treatment or other intervention if indicated. Children diagnosed with genetic disorders receive medical care and case management through local physicians, county health departments, the University of Mississippi Medical Center, other treatment centers, and MSDH satellite clinics. Case Management services are limited for some infants with inconclusive results at screening due to the inability to locate families or refusal of service by families.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Report all inconclusive, abnormal, and presumptive positive test results to genetics field staff for counseling, clinic appointments, and follow-up		X		
2. Contact families of babies with inconclusive, abnormal, or presumptive positive test results by phone or home visit, and		X		

arrange for counseling or case management				
3. Repeat newborn screens or collect diagnostic specimens as needed, and arrange for medical evaluation and treatment if indicated		X		
4. Assure that children diagnosed with genetic disorders have a local medical home and are under the care of a physician				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In CY 2007, approximately 100 percent of children with possible genetic disorders received case management services. All newborn screens with inconclusive, abnormal, or presumptive positive test results are reported to genetics field staff for follow-up. Field staff work with local health department nurses to contact the families of these babies by phone or home visits to arrange for counseling and case management. They repeat the screens or collect diagnostic specimens if needed, and arrange for medical evaluation and treatment or other intervention if indicated. Children diagnosed with genetic disorders receive medical care and case management through local physicians, county health departments, the University of Mississippi Medical Center, other treatment centers, and MSDH satellite clinics. Case Management services are limited for some infants with inconclusive results at screening due to the inability to locate families or refusal of service by families.

c. Plan for the Coming Year

Mississippi's plan for this measure is to ensure that children testing positive for genetic disorders receive appropriate case management services. This will be achieved by reporting all positive test results to genetic field staff for clinic appointments and follow-up, and conducting home visits on positive cases for case management.

State Performance Measure 5: *The Rate of Repeat Birth (per 1000) for Adolescents Less Than 18 Years Old*

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	13.1	13.2	12.5	120	116
Annual Indicator	138.8	125.5	127.5	141.3	120.0
Numerator	329	289	292	392	333
Denominator	2371	2303	2290	2774	2774
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	112	108	104	104	104

Notes - 2006

During past years, Mississippi's Annual Performance Objectives were entered as percentages instead of rates. In an effort to correct this error, 2006 and following performance objectives will be listed as rates.

a. Last Year's Accomplishments

During CY 2006, the rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years was 141.3 per 1,000 births to teenagers. The MSDH will continue to sponsor collaborative training such as conferences and male involvement workshops, and support training of MCH/Family Planning nurses to ensure their understanding of the problem of repeat adolescent pregnancies and the benefits of family planning and inter-pregnancy spacing.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to sponsor, through MDHs Family Planning Program, collaborative training				X
2. Continue to support the training of MCH/Family Planning (MCH/FP) Coordinators				X
3. Continue to work with staff to make prevention of repeat adolescent pregnancies a priority				X
4. Encourage health departments to provide enhanced family planning services to adolescents				X
5. Partner with March of Dimes to implement more Project Alpha Projects				X
6. Continue to collaborate with Delta Health Partners (Healthy Start Initiative)				X
7.				
8.				
9.				
10.				

b. Current Activities

During CY 2007, the rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years was 120.0 per 1,000 births to teenagers. The MSDH will continue to sponsor collaborative training such as conferences and male involvement workshops, and support training of MCH/Family Planning nurses to ensure their understanding of the problem of repeat adolescent pregnancies and the benefits of family planning and inter-pregnancy spacing.

c. Plan for the Coming Year

The MSDH will continue to sponsor through it's Family Planning Program, collaborative training such as conferences and male involvement workshops, and work with local health department staff to make prevention of repeat adolescent pregnancy a priority in care plans for teen clients. The MSDH will also continue to partner with the Mississippi Chapter of the March of Dimes to implement at least one Project Alpha Program in the state to increase healthy lifestyle behaviors among adolescent males through education and responsible decision-making.

State Performance Measure 6: Percent of children ages 0-5 on WIC classified as overweight

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				12.8	12.5
Annual Indicator			13.0	12.7	1.9
Numerator			5248	4668	394
Denominator			40391	36643	20376
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	12.2	12	11.8	11.8	11.8

Notes - 2006

Statistics could only be provided for ages 2 through 5. We were not able to find the percentile data tables needed to provide statistics for ages 0 to 23 months. Thus, data are for children 2-5 years and children at or above the 95 th percentile to classify overweight.

Notes - 2005

Because data were only available with a history of 1 year, we were unable to find the percentile data tables needed to provide statistics for ages 0 to 23 months. Thus, statistical data are being provided for this measure using ages 2 through 5 years of age.

a. Last Year's Accomplishments

Last year, 12.7 percent of children ages 2-5 on WIC were classified as overweight. In efforts to address obesity in children ages 2 through 5, the MSDH WIC program encouraged and/or promoted breastfeeding of infants, and implemented a new policy for children age 2-5 referred to as "VENA" or Value Enhanced Nutrition Assessment. Children 2-5 with a Body Mass Index greater than the 95 percentile were required to be placed on skim milk. Mississippi was the first state to implement this policy. The WIC program also conducted nutrition education classes that encouraged WIC clients to make appropriate food choices and exercise.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage and/or promote breastfeeding of infants				
2. Tailor food package to suit family needs				
3. Encourage health lifestyle changes				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

According to WIC data sources, 1.9 percent of children ages 2-5 on WIC were classified as overweight. In efforts to address obesity in children ages 2 through 5, the MSDH WIC program encourages and/or promotes breastfeeding of infants, and is currently implementing a new policy for children age 2-5 referred to as "VENA" or Value Enhanced Nutrition Assessment.

c. Plan for the Coming Year

The MSDH WIC program will continue encouraging breastfeeding of infants and implementing VENA, as well as promoting nutrition education classes that encourage WIC clients to make appropriate food choices and exercise.

State Performance Measure 7: Percent of adolescents in grades 6-12 who are overweight or at risk for becoming overweight

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				26	26
Annual Indicator	27.3	27.3	27.3	27.3	35.8
Numerator	809	809	809	809	1051
Denominator	2961	2961	2961	2961	2936
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	26	25	25	25	25

Notes - 2007

Most recent data are from 2007 YRBSS. The percentage was obtained by adding the percentages of the overweight and at risk of becoming overweight groups.

Notes - 2006

Most recent data are from 2003 YRBSS. MS did not receive weighted data for the 2006 YRBSS.

Notes - 2005

Most recent data are from 2003 YRBSS. MS did not receive weighted data for the 2005 YRBSS.

a. Last Year's Accomplishments

Last year during 2006, approximately 27.3 percent of adolescents in grades 6-12 were classified as overweight or at risk for becoming overweight.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and implement health education programs targeting adolescents in grades 6-12 who are overweight or at risk of becoming overweight				X
2. Identify and recruit contact persons within the public school system to assist the initiation of health education programs targeting overweight of at risk students				X
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

According to the latest available data for this measure, approximately 35.8 percent of adolescents in grades 9-12 were classified as overweight or at risk for becoming overweight. Most recent data are from 2007 YRBSS. MS did not receive weighted data for the 2005 YRBSS.

c. Plan for the Coming Year

In an effort to address childhood obesity, the MSDH will work to develop and implement health education programs in Mississippi targeting adolescents in grades 6-12 who are overweight or at risk of becoming overweight.

State Performance Measure 8: *Percent of Medicaid eligible children ages 1-5 reported to have had at least one preventive dental service*

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				30	30.5
Annual Indicator		29.2	3.0	3.0	26.8
Numerator		33032	3551	4196	38737
Denominator		113311	117827	139273	144787
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	31	31.5	32	32	32

Notes - 2007

The following information was provided by Division of Medicaid, explaining the differences from previous years:

Topical Application of Fluoride became a covered service in January 2007 causing in increase in the number of oral health preventive services received by Medicaid-eligible children ages 1-5, and is reflective in the numerator for 2007 being larger than those in 2004, 2005, and 2006.

Note regarding 2004 data, unable to correct error in 2004 reported information, field is not available for any changes.

Notes - 2006

According to data received from the Division of Medicaid, the numerator for this measure is based on select dental procedure codes for oral health preventive service, and paid claims to dental providers only. The number does not include an oral health preventive service provided by a primary care practitioner.

The following information was provided by Division of Medicaid, explaining the differences from previous years:

Topical Application of Fluoride became a covered service in January 2007 causing in increase in

the number of oral health preventive services received by Medicaid-eligible children ages 1-5, and is reflective in the numerator for 2007 being larger than those in 2004, 2005, and 2006.

Notes - 2005

Data obtained from CMS website, 2003 participation report. Numerator is total eligibles receiving preventive dental services (#12b) and Denominator is total eligibles who should receive at least one initial or periodic screen (#8).

The following information was provided by Division of Medicaid, explaining the differences from previous years:

Topical Application of Fluoride became a covered service in January 2007 causing in increase in the number of oral health preventive services received by Medicaid-eligible children ages 1-5, and is reflective in the numerator for 2007 being larger than those in 2004, 2005, and 2006.

a. Last Year's Accomplishments

Last year, 2.8 percent of Medicaid eligible children ages 1-5 during the past year were reported to have had at least one preventive dental service.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Initiate at least two oral health questions in the WIC certification application			X	
2. Initiate more water flouridation programs in communities			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

According to 2007 data from the Division of Medicaid, approximately 25.4 percent of Medicaid eligible children ages 1-5 during the past year reported to have had at least one preventive dental service.

c. Plan for the Coming Year

The MSDH's Dental Program will continue to engage in the promotion of several activities aimed at improving oral health in Mississippi. In the coming year, the Dental Program will implement the use of oral health risk reduction assessments using MSDH Web and Palm-application software to identify children at-risk for oral disease and provide early intervention; begin implementing state oral health plans (first year activity or a five-year plan) by engaging key state and community partners to form a statewide oral health coalition; and the development of oral health

programming through WIC and Child Health Programs.

E. Health Status Indicators

Health status indicators are used by the MSDH to identify services needed in all 82 counties in Mississippi. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care. County level efforts are coordinated through nine public health districts. The District Chief Nurse oversees all public health nursing activities in the district and supervises the Maternal-Child Health/Family Planning Coordinator.

Although a well coordinated network of services is being provided on a statewide basis by the MSDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Tobacco Survey and the Youth Risk Behavior Survey, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. The MCH Health Services Data Unit's plans are to continue its work with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files; to conduct statewide needs assessments when needed. Progress in accomplishing these objectives has been made, but challenges exist in staffing and compatible data systems. Additional challenges also exist that are due to the MSDH's quest to reconstruct the agency's current data collection systems to establish a more centralized integrated data system for improved data analyses. The establishment of this improved data collection system will be used to aide the MSDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

During FY 2005, the most significant achievement was the successful completion of the Title V Block Grant Needs Assessment. A workgroup of stakeholders was established consisting of office directors and district staff, Medicaid representatives, Human Services, Mississippi Systems of Care, and other social services agency executives. Data collection was initiated at state, district, and community levels. Secondary resources for state level data included vital statistics, national MCH performance and outcome measures, and state performance measures. Other specific topics investigated at the state level included: Perinatal Periods of Risk, Asthma Surveillance and Prevention, Prematurity and Infant Mortality, and the Mississippi National Evaluation of Camp Noah. Ad hoc committees were created to develop two survey tools for primary data collection within districts and communities. Both consumer and community survey tools were descriptive and qualitative in nature. The purpose of the consumer survey was to collect information regarding barriers to care, public health needs, and to determine if needs were being met. The second survey interviewed state MCH professionals to identify special subpopulations within the state to rate barriers of care, and to recruit feedback to help determine the best way to address challenges within communities.

Two conferences were held, the first occurring in August, 2004 to initiate the kick-off of the needs assessment process, to build collaboration among MCH professionals, and to provide health professionals with an opportunity to obtain more information on birth defects and developmental disabilities. The second conference was held in March, 2005 to present and/or report findings associated with the needs assessment to stakeholders, community leaders, and health professionals throughout the state.

Another major achievement during the FY 2005 period was the completion of an analysis of the Children with Special Health Care Needs SLAITS survey specific to Mississippi. A CDC ORISE Fellow assigned to Mississippi conducted analyses related to the CSHCN population. The findings were beneficial not only to the MCH Needs Assessment, but also to the Children's Medical Program (CMP), the state's CSHCN program. The analysis included information suggesting that consistency of health insurance plays a major role in access to care. The analysis also revealed that some CSHCN experience shortages in providers and access to oral health services.

In FY 2006, a year long course on PRAMS data analysis was completed in coordination with CDC and the University of Chicago using 2004 Mississippi PRAMS data. As a result of the data analysis a fact sheet titled "Racial Differences in Maternal Behaviors and Risk Factors Associated with Preterm Delivery in Mississippi" was developed and is now being considered for publication through CDC's MMWR Report.

During FY 2006 Youth Tobacco Survey (YTS) was conducted among Mississippi public high school and middle school students; this information has been analyzed and reports generated along with media releases to the public.

In FY 2007, YRBS data on Mississippi high school students were analyzed and some indicators were used in the preparation of the FY 2008 MCH Block Grant.

FY 2007, data from 2005-6 SLAITS was released in April 2008. We have downloaded the data and studies the variables related to state performance measures.

F. Other Program Activities

Program begins new topical Fluoride Varnish Program to Prevent Dental Decay for At-Risk Children in Head Starts Programs

Mississippi's dental practice act is one of the most restrictive in the U.S.; it requires that auxiliary dental workers can only perform preventive dental procedures when under the direct supervision of a licensed dentist. This rule makes it impossible to conduct school-based procedures without having a dentist physically present with the worker. There is one exception to this rule; dental hygienists who work for the MS Board of Health are permitted to provide dental screening and education under the general supervision of a licensed dentist. During the 2007 MS Legislative Session, we attempted to expand this permission to allow for the application of fluoride varnish by licensed dental hygienists in school-based settings under general supervision.

Fluoride varnish is a lacquer containing fluoride that is painted on teeth to change bacterial activity associated with dental caries. Most fluoride varnish products contain 5 percent sodium fluoride. Fluoride varnish decreases the acidic environment caused by plaque, is not inactivated by plaque, can reverse early decay and may promote the remineralization of tooth enamel as well as decrease tooth sensitivity. Fluoride varnish sets on contact with teeth in the presence of saliva, which gives it some advantage for use in populations where other topical fluorides might be ingested, such as young children in day care settings and persons with neurodevelopmental and intellectual disabilities.

House Bill 930 and Senate Bill 2595 were introduced in the 2007 MS Legislative Session to amend the State Dental Practice Act to allow licensed dental hygienists to perform preventive procedures through organized community outreach under the general supervision of a licensed dentist. Both bills failed but the MS State Board of Dental Examiners agreed to consider the issue. In June 2007, the State Dental Board amended Board Regulation 13 to allow dental hygienists in the employ of the Board of Health to apply fluoride varnish as part of any oral hygiene instruction and screening procedure. We have been working with Head Start programs to develop a clinical oral health survey and fluoride varnish initiative for the 2007-2008 school-year.

G. Technical Assistance

The MSDH is not requesting any technical assistance during this particular grant period. However, many MCH programs seek technical assistance from other sources and other state programs as needed. For example, simply by attending different professional conferences, such as YRBSS training, MSDH staff gains valuable technical skills and are exposed to technical assistance in various MCH situations specific to their programs.

V. Budget Narrative

A. Expenditures

EXPENDITURES

The three components and the anticipated expenditure amounts are described below:

Component A, Services for Pregnant Women and Infants, is budgeted as follows for FY 2009: \$3,161,223 for federal funds (30 percent of the total federal award), \$2,702,753 for non-federal funds (34 percent of total non-federal funds).

Component B, Services for Child and Adolescent Health, is budgeted as follows for FY 2009: \$3,161,223 for federal funds (30 percent of the total federal award), \$2,623,260 for non-federal funds (33 percent of total non-federal funds).

Component C, Services for Children with Special Health Care Needs, is budgeted as follows for FY 2009: \$3,161,223 for federal funds (30 percent of the total federal award), \$2,623,260 for total non-federal funds (33 percent of total non-federal funds).

Administrative Costs are budgeted at \$1,053,740 which is 10 percent of the total federal grant award. This amount will not exceed the allowable 10 percent of the total MCH Block Grant as mandated in OBRA 1989.

Personnel are employed to develop and implement standards of care as well as to directly provide services to clients. Typically, classes of employees include physicians, social workers, nurses, nurse practitioners, nutritionists, health aides and clerical staff. Employees are required to meet the standards for practice as specified by his or her professional organization.

Travel is reimbursed for official duty at the state authorized rate of \$0.505 per mile. Government contract rates for lodging and per diem ceilings for subsistence are also utilized.

Equipment including minor medical and office, may be purchased in order to administer the program. The equipment items are minor parts of the budget. State regulations governing purchase of equipment are strictly followed.

Supplies include the necessary clinical and office materials to operate the programs and to deliver patient care. Supplies are purchased centrally and according to purchasing policy of state government.

Contractual reflects funds budgeted to purchase services from outside providers. Examples would be for high risk medical care for women and CSHCN.

Construction: none

Other includes telephone, copying and postage used on behalf of the block grant program.

B. Budget

BUDGET

The budget for Mississippi's MCH Block Grant application was developed by Health Services in cooperation with the Office of Health Administration, Bureau of Finance and Accounts. The total program for FY 2009 is \$18,486,681 of which \$10,537,408 (57 percent) is Title V and \$7,949,273 (43 percent) is match provided in-kind by the applicant. Sources of match funds are state funds,

Medicaid earnings (as allowed by the MCH Bureau), and other Third Party earnings. Other federal funds available to support the MCH objectives are listed on Form 4.

The MSDH will expend funds for the four types of services (Core Public Health/Infrastructure, Population Based Individual Services, Enabling and Non-Health Support, and Direct Health Care Services). Services will target the three categories including pregnant women and infants, children and adolescents, and Children with Special Health Care Needs, specifically those in families living at or below 185 percent of the federal poverty level. This includes services to be provided or coordinated for individuals, by category of individual served and source of payment or for budgeting/accounting/auditing for each capacity building activity described in the Annual Plan (e.g., public health leadership and education, assessment, policy development, planning, technical assistance, standard setting, quality assurance, and the like).

Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2009 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989 as indicated in the attached chart.

Matching funds for the MCH Block Grant are identified by listing all direct program costs which have been paid from non-federal sources. These expenses include travel, medicine, medical services, clinical, and lab supplies. Funds used to match Medicaid or other grants are deducted. All salary and non-salary charges for the Children with Special Health Care Needs program are identified by budget. The agency time study provides a report of the value of staff time paid from state or county funds. Time coded to Family Health, Family Planning, Maternity, Perinatal High Risk Management and other Maternal and Child Health efforts is used to match the Perinatal Services category. Time coded to Child Health, Dental Health and School Nurse is used to match the Children and Adolescent category.

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.