

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **MS**

APPLICATION YEAR: **2005**

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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.

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 (uconley@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; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Public Input

//2005/ The Mississippi State Department of Health (MSDH) solicits public input by making copies of the Block Grant Application available at each of the nine (9) public health district offices in the state to allow local citizens an opportunity to visit and view this document at their convenience. A copy of the 2005 Block Grant will also be placed on the agency's website (www.msdh.state.ms.us) to be viewed by citizens who have access to computers.

Public input will continue to be solicited through key parent and family support groups who are affiliated with programs funded by the grant. //2005//

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. 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. 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 have been brought in to work for the poultry, forestry, and construction industries in the state. /2004/ According to 2000 Census data, Hispanics comprise 1.4% of the state's population. Mississippi is, and has been for many years, one of the poorest states in the nation. Seventeen percent of the population was below the federal poverty level (FPL) in 1999. According to 2000 Census data, approximately 16.7 percent of Mississippi's children under 18 live in poverty, compared to 18.9% in 1999. //2004//

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.

/2005/ According to the "Mississippi Economic Review and Outlook," December 2003 Report, employment growth in the state is slowing.

However, with the passing of legislation granting the expansion of the new Nissan plant, an additional 1,000 workers were added to the estimated 4,000 workers slated to be employed at the facility, adding over 2 percent to the current 153,000 persons in durable manufacturing.

Nevertheless, Mississippi has suffered a severe drop in the number of manufacturing jobs; between 1995 and 2003, 23 percent of these jobs were lost. By comparison, for the United States (U.S.) as a whole, the drop was 11 percent. This drop was matched by a global decline of 11 percent.

Overall, a 4.0 percent drop in manufacturing employment is estimated for 2003. But there are signs of an upturn nationally, with manufacturing orders running 2 percent ahead of 2002 and industrial production increasing in the fall.

One positive development in manufacturing in the state is the \$1.4 billion Nissan auto plant, which is now operational. The plant will employ over 5,000 and produce 400,000 automobiles per year at a maximum capacity. Executives claim that this may occur as early as mid-2004. The opening of the plant and the subsequent small manufacturing rally is expected to increase the growth rate of employment in manufacturing, contributing to an average annual increase of 0.1 percent in the sector for the 2003-2008 period. //2005//

/2004/ The communications sector had a very respectable growth rate of employment of 4.9%, but manufacturing employment continued to falter in the first three quarters of 2001. Services showed a mixed picture, with a 6.3% increase in jobs in amusement but less than 3.0% growth in health services. Overall, services employment increased 1.1 percent.

The gaming industry continues to do well. Gaming revenues were up 10% on the Coast and 4.6% in the River counties of Mississippi as of summer 2000. State tax revenues from gaming, July through October, were growing at a rate of 9.5%.//2004//

/2005/ In FY 2003, which ended in July, revenues from state gaming taxes increased only 0.8 percent, in sharp contrast with the average annual increase of 7.6 percent from FY 1997 to FY

2002. Gaming employment was down 3.0 percent. The slowdown in tourism since 2001 also continues to affect hotels and accommodations.

While the economic outlook for Mississippi has become more positive in recent years, the state remains one of the poorest in the nation. Compared with the nation as a whole, a greater percentage of children in Mississippi are born out of wedlock and live in one-parent families. According to the 2004 Kids Count Data Book, Mississippi ranks 49th of the 50 states in births to females ages 15-17.

The 2002 immunization rate for two-year old children is one of the highest among the states at 87.5 percent, and is continually improving because of the development of a statewide immunization registry and outreach campaign. Other measures of child health and well-being are less encouraging. /2005/ According to the recently released 2004 Kids Count Data Book, Mississippi has improved in six out of 10 measures that reflect child well-being between 1996 and 2001. Mississippi saw improvements in child well-being in the following areas: infant mortality rate by five percent; child death rate by 13 percent; teen birth rate by 24 percent; percent of children living in families where no parent has full-time, year-round employment by six percent; percent of children in poverty by 19 percent. According to this same source, Mississippi had one of the highest percentages of low birth-weight babies in 2001, the highest infant mortality and child death rates, and ranks number 48 in teen deaths by accidents, homicide, and suicide. Overall, Mississippi was ranked last among the states in a composite rating of 10 selected measures of child well-being. //2005//

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. /2004/ Economic factors continue to influence the Title V delivery system. Since the demise of Medicaid's mandatory managed care program (HealthMACS), an increase in the number of maternity patients seeking prenatal care at county health departments has not occurred; however, the number of maternity patients receiving Perinatal High Risk Management services has begun to increase. Local health departments also expect an increase in Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening and well-child services as well.//2004//

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.

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 Bureau of Women's Health and the Bureau of Child and Adolescent Health. The Children's Medical Program (CMP), the program of services for CSHCN, is located organizationally in the Bureau of Child and Adolescent Health. All are located organizationally within the Office of Health Services (OHS), one of eleven offices covering the programmatic and oversight areas within the health department (see organization chart at (www.msdh.state.ms.us)). These two OHS bureaus (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.

Children/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. 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 19 clinics throughout the State, including a multi-disciplinary clinic centrally located in Jackson at Blake Clinic for Children. /2003/ In FY 2001, the program spent over 3.6 million dollars on diagnostic and treatment services for Mississippi CSHCN. /2004/ According to the MSDH 2002 Annual Report, in FY 2002, the program spent over 3.9 million dollars on diagnostic and treatment services for Mississippi CSHCN. //2004//

The CMP has a very strong link with the county health department system. This system is 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 based level. The CMP has developed very effective lines of communication with the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis and Hemophilia parents groups, Division of Medicaid, the University of Mississippi Medical Center, and the Choctaw Indian Health Services to make sure that all support services are coordinated for the patients when and where appropriate.

The CMP utilizes the CMP Advisory Council to communicate with and receive feedback from health care providers and consumers. The Advisory Council 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 such as the expanded effort to provide services to disabled children under sixteen years of age who receive SSI benefits under Title XVI, and the coordinated 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.

Genetic Services

The Genetics Program has developed comprehensive genetics services statewide including screening, diagnosis, counseling, and follow-up of a broad range of genetic related disorders. Seven genetics satellite clinics and five sickle cell satellite clinics are strategically located in the state, making genetics services more accessible for patients and families.

/2004/ Effective June, 2003, an additional 35 genetic disorders will be added to mandated newborn screening. This expansion in newborn screening will be one of the most comprehensive in the United States. //2004//

/2005/ The Genetics Services Program provides comprehensive services statewide for a broad range of genetic related disorders. Newborn screening is mandated by law and provides testing for PKU, hypothyroidism, galactosemia, and hemoglobinopathies. In March, 2002, congenital adrenal hyperplasia (CAD) was added. In June, 2003, newborn screening was again expanded to include cystic fibrosis, biotinidase deficiency, medium-chain acyl-CoA dehydrogenase deficiency (MCAD) and 32 additional disorders detectable through tandem mass spectrometry. Mississippi now screens for a total of 40 genetic disorders and has one of the most comprehensive newborn screening programs in the nation.

In 2003, the Mississippi State Department of Health began adding field staff to provide a Genetics Services team that will consist of a nurse, social worker, and clerk in each of the nine public health districts. The genetics team works with county health department staff to assure adequate follow-up, case management, and continuity of care for genetic patients.

Clinical services are provided primarily through referrals to the University of Mississippi Medical Center, Mississippi's only tertiary center. Genetic satellite clinics are also routinely conducted in six public health districts in the state. Sickle cell satellite clinics are conducted in seven strategic locations throughout the state. These satellite clinics make genetic services more accessible for patients and families. //2005//

Early Intervention

First Steps Early Intervention Program (FSEIP) is Mississippi's early intervention system for infants and toddlers with special developmental needs and their families. First Steps 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.

/2005/ First Steps is the name for the multi-agency system of comprehensive early intervention services. 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, 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.

To be eligible for early intervention services through First Steps, a child must have a developmental delay of 25% or 1.5 standard deviations in any one developmental domain. Infants and toddlers with conditions known to cause developmental delays are automatically eligible for services. 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.

The MSDH and the MDE have identified barriers to effective local coordination of activities with regard to mandatory activities under the Individuals with Disabilities Education Act (IDEA) Part C regarding child find and transition. A stakeholders group has been conceived to address these issues. It is expected that the work of the stakeholders will result in policy changes at the state level that will allow for exchange of electronic data, modification of existing MDE policies, development of effective performance measures for MSDH and MDE activities, and improved identification of children who are potentially eligible for Part C and B services.

For the first time, First Steps conducted a statewide family satisfaction survey to determine the level of satisfaction among people receiving First Steps services. The survey was mailed to more than 3,500 families who experienced First Steps services from 2000 through 2003. By the date selected as the deadline for receiving responses, over 20% of the surveys had been returned. The analysis of these data revealed that 86% of those responding to the survey were satisfied with the services they received. //2005//

Early Hearing Detection and Intervention

//2005/ Early Hearing Detection and Intervention in Mississippi (EHDI-M) functions as part of the First Steps Infant and Toddler Early Intervention Program. EHDI-M is the Mississippi State Department of Health's designated program authorized to establish an early identification system and implement 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 has been 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. //2005//

Oral Health

School Mouth Rinse Program

//2005/ The School Fluoride Mouth Rinse Program is a voluntary program in which elementary school children rinse weekly with 0.2 percent sodium fluoride solution. In 2003, over 20,000 children at 49 schools participated. Fluoride mouth rinse activities are supervised by school staff.

Community Water Fluoridation- Fluoridation of community water systems continues to be the most cost effective public health measure in decay prevention. Mississippi has approximately 40 percent of its total population receiving optimally fluoridated drinking water that serves over one million people. MSDH has a public/private partnership to make grants to public water systems to pay for new fluoridation programs.

School-based Dental Sealant Program

In 2000, Public Health District III had ten percent sealant utilization, the lowest in the state. A school-based dental sealant program was initiated to provide preventive dental sealants to second grade children in public schools. From 2001-2003, over 3,700 dental sealants were placed. //2005//

Immunization Program

The purpose of the MSDH Statewide Immunization Program is to improve the delivery of vaccination and other preventive services to infants, children and/or adolescents in Mississippi. The school- based

immunization program makes available immunizations for sixth grade students not previously vaccinated with a booster dose of tetanus and diphtheria vaccine, a second dose of measles, mumps, rubella vaccine, the hepatitis B vaccine series and, if indicated, the varicella vaccine.

Abstinence Education Program

/2004/ The Abstinence Program currently has 21 programs and has provided abstinence education to over 63,000 students.

The state OB/GYN Medical Consultant developed a teen pregnancy prevention presentation and presented it to 15 hospital medical committees and several schools.

During 2003, presentations were presented to 15 hospital medical and nursing staffs, medical societies, and middle and high schools. Presentations were also presented at other organizations such as the Mississippi State Nursing Association Convention, the Mississippi Association of Public Health Districts, and the Action for Healthy Kids Coalition. //2004//

/2005/ The purpose of the Abstinence Education Program is to promote abstinence from sexual activity through education, mentoring, counseling, and adult supervision. Special emphasis is placed on adolescents 10 through 19 years of age who are most likely to experience untimely and unplanned pregnancies. Funding through the Title V Abstinence Only Education Grant supports community, school, and faith-based organizations in teaching social, psychological, and health benefits of abstaining from sexual activity outside of marriage.

A total of 21 abstinence education programs located in 17 counties throughout the state received financial support through Abstinence Only Education Grant funds during FY 2003. In FY 2004, a total of 24 abstinence education programs were funded.

Organizations can apply for and receive funding annually for a maximum of five years. They are encouraged to establish partnerships, collaborations, and other funding sources to enable them to continue their abstinence education programs after that time. Organizations are then eligible to re-apply for competitive funding after two years. //2005//

Health Promotion and Education

The Division of Health Promotion and Education provides and supports services aimed at school health, community health, and worksite programs to improve the health of Mississippians. Health educators work with community groups, schools, and clinics to implement health promotion programs.

School Nurse Program

/2005/ Since October, 2003, approximately 364 school nurses in Mississippi public schools promoted and protected the health status of adolescents and staff through health services and health education. Of the 364 school nurses in public schools, the MSDH only provides oversight for the 51 tobacco nurses. Public school districts provide oversight for the remaining school nurses.

Fifty-one (51) school districts have nurses that are supported by tobacco settlement dollars to reduce and/or prevent the use of tobacco products and other risky behaviors among youth. Twenty four (24) nurses are supported through a private foundation to conduct EPSDT in school-based health clinics. //2005//

Women's Health Services

The MSDH Women's Health programs provide women with and/or ensure 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

/2004/ The MSDH provides funding to 13 domestic violence shelter programs and nine Rape Crisis Center Programs. When requested, the MSDH provides brochures, pamphlets and educational materials on a statewide and local level.

Domestic violence shelters strive to meet the individual needs of every victim entering a shelter as a result of domestic violence. Program staff seek 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 rape crisis centers provide preventive services as well as direct crisis intervention services to victims of rape and other forms of sexual assault. Prevention services focus on education to decrease the number of sexual assaults that occur. Although it 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. For federal fiscal year 2002, a total of 1,294 sexual assault cases were reported to Rape Crisis Centers in the State of Mississippi. //2004//

/2005/ During fiscal year 2003, a total of 1,128 women and 1,195 children received shelter services in Mississippi as a result of family violence. For federal fiscal year 2003, a total of 1,251 sexual assault cases were reported to rape crisis centers in the State of Mississippi. Currently, the MSDH provides funding to 13 domestic violence shelters programs and nine rape crisis center programs. //2005//

Family Planning

The Family Planning Program promotes awareness of and ensures access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives. /2004/ More than 100,000 Mississippians received comprehensive family planning services in CY 2002, and some 30,000 of those were age 19 years or younger. //2004//

The target populations are teenagers and men and women 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 provides:

1. Medical and non-medical counseling about methods of contraception,
2. Medical examination and provision of contraceptive method, and
3. Pregnancy testing and 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, preconceptional 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.

/2003/ The Family Planning (FP) program requested a Medicaid waiver in 1999 to the state's Medicaid program, which would increase the number of women served and the length of time services would be available to them. An evaluation of the program before the waiver could be implemented was needed to provide more baseline information on the program. The evaluation would expand the FP baseline data by examining inter-pregnancy intervals (IP) in the repeat birth population. In order to establish a comparison group for Family Planning, other MSDH programs were included in the evaluation.

/2004/ The waiver was submitted to the Centers for Medicare and Medicaid Services (CMMS) in October 2001 and approved in December 2002. Implementation is expected to take place during the last quarter of 2003. //2004//

/2005/ Approximately 100,000 Mississippians received comprehensive family services during CY 2003, and some 28,000 of those were age 19 years or younger. The target populations are sexually active teenagers and men and women 20-44 years of age with incomes at or below 150% of the federal poverty level.

The Mississippi Medicaid Family Planning Demonstration Waiver Program was implemented October 1, 2003, and has been approved to operate for five years. This 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. //2005//

Maternity

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

/2004/ Approximately 28 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 preventive care. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a critical component of the maternity care effort.

/2005/ Approximately 23 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 preventive care. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a critical component of the maternity care effort. //2005//

A part-time, board-certified obstetrician/gynecologist will continue 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. //2004//

Prenatal Smoking in Mississippi

/2003/ Drs. Zotti, Replogle and Sappenfield conducted a study examining trends in prenatal smoking and the effects of such smoking on birthweight, preterm delivery, and infant mortality in Mississippi. The study was a retrospective cohort analysis of 120,429 singleton births in 1995-1997. They found that even though prenatal smoking was decreasing overall, it was increasing among young pregnant women aged 15-19 years. The primary effect of prenatal smoking was to lower birthweight; correspondingly, the principal effect of smoking on infant death appeared to be the decreasing of birthweight. In addition, infants of mothers who smoked during pregnancy were two and one-half times as likely to die from SIDS as were infants whose mothers did not smoke.

/2004/ The report from this study was published in the Journal of the Mississippi State Medical Association. The Mississippi State Department of Health continues to monitor prenatal smoking among teenage women. //2004//

Perinatal High Risk Management/Infant Services System

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) provides a multi-disciplinary team approach to high-risk mothers and infants. Targeted case management, combined with the team approach, can better treat the whole patient, improve the patient's access to available resources, provide for early detection of risk factors, allow for coordinated care, and decrease the incidence of low birthweight 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.

Medicaid eligible postpartum women who were not eligible for traditional PHRM because they were not high risk, are eligible for postpartum PHRM due to their socio-economic status. In some districts, public health nurses visit postpartum women prior to their discharge from the hospital. /2004/ In fiscal year 2002, the PHRM/ISS program provided services to 38,940 mothers and infants. //2004//

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 Birthweight (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).

Study of Perinatal Regionalization

/2004/ A study about perinatal regionalization was conducted among 1,874 very low birthweight infants born in-state and in-hospital to Mississippi residents from 1979 - 1999. The purposes of the study were to (1) determine the proportion of these infants that were born in each level hospital and (2) assess the effects of hospital level on neonatal mortality while controlling for maternal risk factors. Hospitals were categorized as level A to level D, with level A hospitals having the highest level of perinatal services. The findings were:

1. 40% of Very Low Birthweight infants born of Mississippi residents who delivered in-state were born in a level A hospital
2. As hospital levels decreased, mortality significantly increased (when controlling for <1,000 gram infants.) Exception: Large volume level B hospitals
3. Among infants <1,000 grams, mortality incrementally increased as the hospital level decreased

These findings were presented in January 2003 to the original steering committee associated with this study and to the Mississippi Perinatal Association during March 2003. The Mississippi State Department of Health is in the process of developing a plan to address perinatal regionalization issues. //2004//

Fetal and Infant Mortality Review (FIMR)/Maternal and Infant Mortality Surveillance System /2003/ In 1997, Mississippi was a recipient of a three year SPRANS (Special Projects of Regional and National Significance) grant to conduct fetal and infant mortality death reviews in six counties in Public Health District I. Fetal and Infant Mortality Review (FIMR) is a community owned, action-oriented process that results in improved service systems and resources for women, infants and families. The FIMR process brings a community team together to examine confidential, de-identified cases of infant deaths. The purpose of these reviews is to understand how a wide array of local, social, economic, public health, educational, environmental and safety issues related to the tragedy of the loss. The funding for FIMR ended September 30, 2001.

/2004/ The MSDH is in the process of developing a statewide Maternal and Infant Mortality Surveillance System (MIMS), in which maternal and infant death data will be collected and reviewed. The MIMS process will bring a statewide team together to examine confidential, de-identified cases of infant deaths. The purpose of these reviews is to understand how a wide array of local, social, economic, public health, educational, environmental and safety issues related to the tragedy of the loss. The procedures for this system are currently being written. The plan is to phase in data collection during 2003-2004, beginning with Public Health District V. //2004//

Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is part of the Centers for Disease Control and Prevention (CDC) initiative to reduce infant mortality and low birthweight. 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.

/2004/ Since the start of data collection, PRAMS continues to successfully survey mothers throughout the state of Mississippi. PRAMS surveys approximately 283 mothers a month. Currently, PRAMS has expired ten batches with two remaining active. Only localized analysis of these data will be conducted during the first year.

PRAMS has a steering committee of forty-three members who have various areas of expertise necessary to assist in specific areas of data analysis (e.g., family planning, policy, prenatal care, specific topics-smoking, injury, nutrition, etc.). The committee includes such organizations as Mississippi State Department of Health, Mississippi State Department of Human Services, Jackson Public Schools, Mississippi Chapter of Nursing Association, Perinatal Association, Jackson State University, University Medical Center, Alcorn State University, Blue Cross and Blue Shield, MetLife Insurance Agency, Early Intervention and Genetic and Special Supplemental Food Program for Women, Infants, and Children. //2004//

/2005/ Currently, PRAMS surveys approximately 250 mothers a month and has expired twenty-one batches with five remaining active. The 2003 birth response rate for PRAMS is greater than 70 percent. //2005//

Sudden Infant Death Syndrome (SIDS)

/2003/ SIDS is defined as the sudden death of an infant under one year of age which remains unexplained after a thorough investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical records (Willinger, et al., 1991). Each county health department is encouraged to identify a SIDS contact person whom the coroner can notify of an infant death caused by SIDS. County health department staff initiates contact with the family (phone, mail, home visit) to offer support, counseling, and referral to indicated services.

/2004/ The purpose of the Mississippi State 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 CY 2000 and 2001, SIDS remained the third leading cause of infant deaths in the state. Currently, the Mississippi State Department of Health, in a partnership with the Mississippi SIDS Coalition, is developing local coalitions in the nine public health districts to assist in SIDS risk reduction efforts. //2004//

/2005/ During CY 2001 and 2002, SIDS remained the third leading cause of infant deaths in the state. Data are not yet available for FY 2003. The Mississippi State Department of Health, partnering with the Mississippi SIDS Coalition, continues to develop local coalitions in the nine public health districts to assist in SIDS risk reduction efforts.

A SIDS database was developed in 2003 to effectively compile data on SIDS in Mississippi and to allow analysis of SIDS reports in an effort to identify trends and implement intervention strategies. //2005//

Osteoporosis Screening and Awareness

The Mississippi Legislature recognized the seriousness of osteoporosis, a silent disease discovered frequently when an unexpected fracture of a hip, the spine, or a wrist occurs. The passage of House Bill 1339 provided that the Mississippi State Department of Health establish, maintain, and promote an osteoporosis prevention and treatment education program; to provide for the components of the program; and for related purposes.

/2004/ In Calendar Year (CY) 2002, MSDH screened (using the Luna PIXI Densitometer) 1,239 women and men. Of the 1,239 persons screened, 87 were found to be osteoporotic (osteoporosis), 274 osteopenic (low bone mass) and 852 normal (there were 26 records with missing information). //2004//

/2005/ Using the Luna PIXI Densitometer, the MSDH screened 2,676 women and men. Of the 2,676 persons screened, 106 were found to be osteoporotic (osteoporosis), 726 osteopenic (low bone mass) and 1,698 normal (there were 146 records that were unable to be read).//2005//

Supplemental Nutrition Program for Women Infants and Children (WIC)

WIC is an incentive for early entrance into the expanded maternal and child health delivery system and is an important component of a comprehensive preventive health service. Infants and children are eligible if they show signs of poor growth, anemia, obesity, chronic illness, or nutrition-related diseases. Pregnant and postpartum women are considered at risk if they are younger than 18 or older than 35, have a poor obstetrical history, are anemic, or gain weight at an undesirable rate.

/2004/ Operating in all 82 counties, the Mississippi WIC bureau distributed 1,209,938 monthly food packages during FY 2002: 30 percent (374,961) were for infants, 24% (285,055) were for women and

46% (552,679) were for children. ***//2005/ The WIC bureau distributed 1,235,424 food packages During FY 2003: 30 percent (370,500) were for infants, 23% (286,764) were for women and 47% (578,160) were for children. //2005//***

C. ORGANIZATIONAL STRUCTURE

//2004/ In October, 2002, Dr. Brian W. Amy, MD, MHA, MPH, assumed the leadership role as the MSDH's new State Health Officer. Dr. Amy has created structural changes that should enhance MCH programs and policies. MSDH has also experienced many personnel changes in office and bureau directors.

The OHS is one of the eleven offices within the MSDH, and is responsible for all Maternal and Child Health (MCH) functions. The OHS administers programs that provide services to the Maternal and Child Health/CSHCN population. Each Bureau within the OHS, through the MCH Block Grant, supports services to women and infants, children and adolescents and CSHCN through local county health departments and specialty clinics (see organization chart on Agency Website (www.msdh.state.ms.us) *//2004//*

//2005/ Beginning July 2004, the OHS will also include Health Promotion and selected epidemiologic surveillance systems related to chronic disease and asthma. In anticipation of the expansion, OHS leadership has conducted two meetings. During the first meeting, programmatic activities were discussed with OHS staff leaders. For the second meeting, Dr. Donna Peterson from the University of Alabama at Birmingham facilitated strategic planning. The OHS created its vision "Leading and Empowering People for Healthier Lives" and identified strategic goals. Future strategic planning activities are slated to occur. //2005//

BIOGRAPHICAL SKETCHES

//2004/ Daniel R. Bender, MHS, formerly the Director of the Bureau of Child Health, currently serves as the Director of the Office 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. *//2004//*

LeDon Langston, MD is a Board Certified OB/GYN physician currently serving as medical consultant to the Bureau of Women's Health in the Office of 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.

Marianne E. Zotti, DrPH, RN, MCH Epidemiologist for CDC was a faculty member and administrator in the university setting for eight years prior to working for CDC. In addition to teaching academic courses, she planned and taught in conferences, conducted research on health outcomes and prenatal care among high risk women, conducted community needs assessments and published in several refereed journals. In her CDC role, she often serves as a small group facilitator at the CityMatCH data use training activities. Dr. Zotti's role consists of directing the MCH Data Unit,

coordinating and training staff, conducting needs assessments, monitoring the quality of data, conducting epidemiologic analyses on selected topics, participating in surveillance, and assisting with the creation of infrastructure for data collection and management.

/2004/ Floyd Carey, MD is a Board Certified Pediatrician currently serving as the medical consultant for the Bureau of Child Health within the Office of Personal Health Services of the Mississippi State Department of Health. Dr. Carey recently retired from private practice at Southwest Mississippi Regional Medical Center in McComb, Mississippi. He joined the Mississippi State Department of Health in February, 2002. Among his varied projects, he has been actively involved in changes in genetic screening. //2004//

/2004/ Louisa Young Denson MS, MPPA, is currently the Director of Women's Health for the Title V program within the Mississippi State Department of Health. Ms. Denson has served in various capacities of 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 (Magna Cum Laude), Bachelor's degree in Social Work (Cum Laude) from Jackson State University, and is a licensed social worker. She has also completed the Certified Public Managers Program with the State Personnel Board. //2004//

/2004/ Geneva Cannon RN-C, MHS, is Director of the Bureau 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 Bureau 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 states's Children's Health Insurance Program. //2004//

/2005/ Lawrence H. Clark is the new Director of the Children's Medical Program (CMP), Mississippi's Title V Children with Special Health Care Needs (CSHCN) program. He replaces the previous director, (Mike Gallarno) and has over 25 years of supervisory and management experience. He has worked with the Allstate Insurance Company's Regional Office in their corporate headquarters in Jackson, Mississippi. During his employment with Allstate, he managed several major programs including employee interstate moves and transfers. 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.//2005//

/2004/ Kathy Gibson-Burk is the Director of the WIC program 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 for 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. //2004//

/2004/ Benny Farmer became the financial director of the Office 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. //2004//

//2005/ 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 State 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 healthcare needs and continues to serve on the UMC Visiting Teaching Faculty and on the Board of Directors for the Spina Bifida Association of MS. //2005//

//2005/ Ulysses Conley, B.S., MPPA, currently serves as the principal grantwriter for Mississippi's Maternal and Child Health Block Grant. He was employed by the Mississippi State Department Health (MSDH) in October, 1991, as a Senior Analyst with the Office of Policy and Planning. In February, 1996, he was then employed by the MSDH's Office of Health Services as a Principal Analyst/Grantwriter for the state's Title V program in February, 1996.//2005//

Laws and Authorizations:

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

D. OTHER MCH CAPACITY

D. Other (MCH)Capacity

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

Bureau of WIC 43

Bureau of Women's Health 22

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

Each bureau, 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 to 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 provides early identification of potentially crippling 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 to children 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.
- (k) PHRM/ISS

Children with Special Health Care Needs, children, and adolescents receive direct personal health care services defined 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 who 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 installed a toll-free telephone line in cooperation with the bureaus of WIC and Women's Health. The line provides assistance to clients seeking information about MCH services, family planning, Medicaid, WIC, 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 which work to enhance the capacity of the Title V program. Examples of MSDH's

coordination efforts with other human service agencies are as follows:

Substance abuse 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.

March of Dimes.

//2004/. 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. The MSDH partners with the March of Dimes to increase the awareness of folic acid as it relates to birth defects. //2004//

Mental Health.

The MSDH county health departments make referrals to community mental health centers for families who have experienced Sudden Infant Death Syndrome (SIDS) and other infant deaths if requested by the family. Also, the MSDH has a representative who participates on the State Developmental Disabilities Council. The First Steps Early Intervention System (FSEIS) has recently contracted with the Bureau of Mental Retardation in the DMH. Each of the five regional retardation centers submitted a proposal to expand their capacity to serve infants and toddlers and their families in natural environments, thus moving away from the traditional facility-based service delivery model to a family-centered natural environment. These contracts expand the MSDH capacity to deliver services in some extremely rural and impoverished areas of the state. A representative from the Department of Mental Health serves as an ex-officio member of the Infant Mortality Task Force.

First Steps Early Intervention System (FSEIS).

The FSEIS, which is structurally located within the Bureau of Child and Adolescent Health, has established an Interagency Coordinating Council which brings together the State Departments of Mental Health, Education and Human Services, universities, parents of children with special needs, 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 that 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 currently receives SSBG funds from the DHS to assist in its efforts to provide needed contraceptive services to teens, and a representative of the MSDH is a member of the DHS Out-of-Wedlock Task Force. A representative from DHS is an ex-officio member of the Infant Mortality Task Force and the Pregnancy Risk Assessment and Monitoring System (PRAMS) Advisory Committee.

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 MSDH clinics. In addition to a cooperative agreement, which allows billing for specific services provided to 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 outstationed eligibility workers and a two-part eligibility form with 185 percent of poverty as a threshold, thereby preventing untimely delay for clients who need Medicaid coverage. Medicaid staff and MSDH staff meet quarterly to discuss PHRM/ISS progress and concerns.

Presumptive Eligibility

During the 2001 Legislative Session, the Mississippi Legislature passed a bill which gave the Division of Medicaid authority to implement presumptive eligibility. Presumptive eligibility (PE) means short-term Medicaid coverage for children up to 19 years of age and pregnant women for up to 60 days maximum. Those covered are children up to 19 years of age who are at 200% of the poverty level and pregnant women at 185% of the poverty level.

//2004/ Unfortunately, during 2002 the Mississippi Legislature rescinded the funding and presumptive eligibility was never implemented. //2004//

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.

//2004/ 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.

The Mississippi Primary Health Care Association is the lead agency for the Mississippi Access to Rural Care (MARC) program, funded by the Robert Wood Johnson's Southern Rural Access Program. The program supports work to increase the supply of primary care providers in underserved areas, strengthen the health care infrastructure and build capacity at the state and community level to address healthcare problems. To achieve these goals MARC is focusing on rural health leadership development; recruitment and retention of primary healthcare providers; rural health network development; and revolving loan fund development. The MSDH has a contractual arrangement with

the Primary Health Care Association to provide staff support for the recruitment and retention efforts. In addition, the MSDH holds a seat on the MARC Board of Directors. //2004//

During the 1999 Legislative Session, House Bill 403 was passed that provided funding to the MSDH for the purpose of contracting with Mississippi Qualified Health Centers (MQHC). These funds are used 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 Mississippi Primary Health Care Association (MPHCA) is one of the 24 primary care associations funded by the Health Resources and Services Administration (HRSA) to implement a Medicaid/CHIP Outstation Demonstration Pilot. This Medicaid Demonstration Pilot has expanded on the foundation laid by the regional and national project TEAM (The Early Access Model for Integrated Health Care). The Medicaid/CHIP Demonstration has built these existing partnerships by including partners in "Train the Trainer" sessions on the Medicaid/CHIP application process and how to complete the one-page Medicaid/CHIP application.

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 contracts with community health centers, health departments, private providers, and hospitals to provide 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 Division of Immunization located in the Office of Epidemiology, provides vaccine to private physicians and community health centers that are enrolled as Vaccine for Children providers.

The Bureau 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.

Marion County Health Department in Public Health District VIII and the Lawrence County Health Department in Public Health District VII work cooperatively with local community health center staff, whereby community health center staff provide PHRM/ISS services to maternity patients receiving prenatal care at the county health departments.

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.

A representative from the MPHCA serves as an ex-officio member of the Infant Mortality Task Force.

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 maintains a Memorandum of Understanding 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 received 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 death cases 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 Bureau 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.

//2004/ The MSDH is currently in the process of developing the Statewide Maternal and Infant Mortality Surveillance System (described earlier). Reviews of maternal deaths will be conducted under the auspices of the MSDH, but with the collaboration of UMMC and the Mississippi State Medical Association. //2004//

Infant Mortality Task Force.

The MSDH provides staff to the Infant Mortality Task Force, whose purpose is to foster the reduction of infant mortality and morbidity in Mississippi and to improve the health status of mothers and infants. The Task Force is composed of eleven (11) voting members, one ex-officio or non-voting member from DHS, MSDH, Department of Education, Division of Medicaid, the University of Mississippi Medical Center (UMMC), and the Mississippi Primary Health Care Association, plus the chairman of the Senate Public Health and Welfare Committee and one member of the said committee to be designated by the chair.

According to its statutory authority, the Task Force shall:

1. Serve an advocacy and public awareness role with the general public regarding maternal and infant health issues;
2. Conduct studies on maternal and infant health and related issues;
3. Recommend to the Governor and the legislature appropriate policies to reduce Mississippi's infant mortality and morbidity rates and to improve the status of maternal and infant health; and
4. Report annually to the Governor and the Legislature regarding the progress made toward the goals and the actions taken with regard to recommendations previously made.

//2004/ During this fiscal year, the Infant Mortality Task Force went through a period of transition. Several membership changes occurred as a result of terms expiring and new appointments being made. The Infant Mortality Task Force is currently reorganizing due to the loss of its executive director and the restructuring of Mississippi's Congressional Districts. As directed by the Legislature, the Infant Mortality Task Force will continue to work closely with the Department of Health, the Department of

Mental Health, the Department of Human Services and the Division of Medicaid in the development of its recommendations fostering the reduction of infant mortality and morbidity in Mississippi. //2004//

Dietetic Education.

The CSHCN program nutrition staff are working with university affiliated nutrition education programs in the state to develop and implement community-based experiences for senior or graduate nutrition/dietetic students. These experiences are designed to prepare the students to work with special needs populations and to be significant contributors to the interdisciplinary teams that assist families with their child's care.

Oral Health Policy Task Force

/2004/ In October 2001, Mississippi's Governor Musgrove hosted six states in Jackson for a third National Governors Association (NGA) Policy Academy on "Improving Oral Health Care for Children." The meeting focused on developing an action plan to address oral health care needs in children and building alliances between the public and private sectors to implement the plan. The work done over the course of the Policy Academy meeting provided some vision for how policymakers should address poor oral health. For example, dental sealants were identified as a need during the Policy Academy, and as a result, the MSDH developed a collaborative pilot project between the School of Dentistry at the University Medical Center and the Delta Hills Public Health District. The policy team also identified the need for a full-time Public Health Dentist in the state, and this position was created and filled in 2002.

The Oral Health Task Force has developed strategies to improve oral health care, and they are as follows:

1. Establish effective oral health infrastructure to assure that every child enjoys optimal oral health.
2. Ensure available, accessible, affordable and timely access to dental care.
3. Implement and assure effective oral health programs that prevent disease and improve oral health.
4. Ensure adequate funding for programs that assure good oral health for children. //2004//

/2005/ The Oral Health Task Force has met approximately six times since established. The goal of this task force is to develop a Statewide Oral Health Plan, and to conduct regional public health meetings to present and/or share data with health care providers. //2005//

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 Protection. 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.

F. HEALTH SYSTEMS CAPACITY INDICATORS

F. Health Systems Capacity Indicators

#01- The rate of children hospitalized for asthma (10,000 children less than five years of age)

/2004/ The MSDH Child Health Bureau contracted for the Canton Asthma Project to be conducted by the Mississippi Asthma Collaborative and American Lung Association of Mississippi. Fifty students were initially enrolled in the study during the fall of 2002 with 43 of the students completing the study. The children were randomized to either receive their asthma medicines under directly observed

therapy while at school or have the same medicine administered by their parents at home. The results of the study have now been statistically analyzed and do not show any marked difference between the two groups except that two emergency room visits were required by the group treated at home but none required by the group that received their therapy at school.

The investigator did not necessarily expect there to be any statistical difference between these groups with the relatively small number of children participating. In addition, it must be kept in mind that the children studied are a well controlled group that have had long-term follow-up by Dr. Bacon's staff in Canton, Mississippi. The main emphasis of the study was to determine whether it was practical and feasible to deliver medications at school without much disruption of the student's activities or interference with the smooth flow of a school day. It is obvious after completing the study that directly observed therapy can be performed with relatively little effort.

The Mississippi Asthma and Allergy Clinic now proposes that this study be performed in a different setting, perhaps looking at one of the schools in the Delta that has reported large numbers of poorly controlled asthma patients. They also would like to propose that the study be performed in a school that does not necessarily have nurse practitioners in attendance so that a qualified lay person could administer the medicines. The investigators would also be interested to see how this project performs in a situation where the children have not received regular asthma care and have more problems than those typically seen with the children in Canton. //2004//

Status:

/2004/ According to data collected by the MSDH's Asthma Surveillance Project within the Jackson Metropolitan Area, children between the ages of 0-4 (< 5) accounted for 3, 131 (19%) of the 16, 520 visits. Of these, 1161 were emergency room visits, 389 were inpatient visits, and 1581 were outpatient visits. African American children under age 5 accounted for 2,652 of the 3,131 number of visits. Also, African American children <5 accounted for 1,037 emergency room Visits, 298 inpatient visits, and 1,317 outpatient visits. In other words, out of the 3131 number of visits, African American children under age 5 accounted for 85% of visits in their age group.

Based on these data, the statewide prevalence rate for children under age 5 is 9,673 per 100,000. //2004//

/2005/ The MSDH has recently completed a four-year (1999-2002) pilot surveillance study of asthma hospital visits in the central tri-county area (Hinds, Rankin, and Madison counties). This area is the state's largest metropolitan center, and is representative of other areas within the state. Data were provided to MSDH by the seven acute care hospitals in the area on all hospital visits, regardless of type. Data elements captured included medical record numbers, all primary 493 ICD-9-CM codes, patient names, social security numbers, age, sex, race, type of admission, and dates of admission and discharge. These data were analyzed for prevalence, age-adjusted, and morbidity rates.

Trends shown during the four-year period are alarming, especially when looking at racial disparities in both the number of hospital visits by African Americans (72% of all visits), and in the number of hospital visits made by African American females (40%). There are also obvious disparities between age groups, with 41% of the total visits being made by those under the age of 15. Of these, 2650 were emergency room visits, 696 were inpatient visits, and 3375 were outpatient visits. White males accounted for 1,421 (10%) visits compared to 5,428 (32%) by African American males. White females accounted for 2,452 (18%) visits compared to 5,983 (40%) by African American females. In variation to the previous study, the percentages show a far greater rate of morbidity and disparity.

Status:

According to data collected by the MSDH's Asthma Surveillance Project within the Jackson Metropolitan Area, children between the ages of 0-4 (< 5) accounted for 3,129 of the 14,629 visits. Of these, 1,160 were Emergency Room visits, 388 were Inpatient visits, and 1581 were

Outpatient visits. //2005//

#02- The percent of Medicaid enrollees whose age is less than one year who receive at least one initial periodic screen.

Status:

/2004/ According to the latest data available (CY 2001) from the Mississippi Division of Medicaid, of the 35,194 Medicaid enrollees whose age is less than one, 76% (26,742) received a screening service. //2004//

/2005/ Calendar Year 2002 data from the Mississippi Division of Medicaid revealed that, of the 35,679 Medicaid enrollees whose age is less than one, 97% (34,623) received a screening service. //2005//

#03- The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

Status:

/2004/ In CY 2001, there were 272 children less than one year of age enrolled in SCHIP. Of this number, 191 (70.2%) had at least one visit to a physician or nurse practitioner while they were under one year of age.

SCHIP is not an expansion of Medicaid so the requirement is not the same for periodic CY 2001 screening. Therefore, these data reflect any visit with a physician and/or nurse practitioner among children less than one year of age. //2004//

/2005/ During CY 2002, there were 743 children enrolled in SCHIP who were less than one year of age at some point during the year, and of these children, 554 (74.6%) had a visit to a health care professional (physician, nurse practitioner, etc.) before one year of age. //2005//

#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.

Status: /2004/ According to the latest data (2001) collected from the Bureau of Health Informatics, 83.3 percent of women (15 through 44) with a live birth during the reporting year had observed to expected prenatal visits greater than or equal to 80 percent of the Kotelchuck Index. //2004//

/2005/ Status: According to 2002 data from the Bureau of Health Informatics, 83.3 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. This represents no change from the percentage reported during CY 2001. //2005//

#05- Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Status:

/2004/ Only 28% of Medicaid women entered prenatal care during the 1st trimester (Form C2). Currently, neither payment source on the birth certificate nor matching birth and Medicaid files are available in Mississippi due to the installation of a new operating system for birth and death registration. After the new system has been installed, Mississippi will move to the new birth certificate which will include payment source at birth. //2004//

/2005/ The birth and death file operating system was just completed. There is no progress toward moving to the new birth certificate. //2005//

#06- The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants

(0 to 1), children, and pregnant women.

Status:

/2005/ The percent of poverty level of infants 0 to 1 for eligibility in Medicaid is 185% for the Medicaid program and 200% for the SCHIP program. For pregnant women it is 185% of the poverty level for Medicaid. For pregnant women under 19, it is 200% of the poverty level for the SCHIP program. //2005//

#07- The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Status:

/2004/ During CY 2001, of the 83,712 EPSDT eligible children (ages 6 through 9), 38% (31,683) received dental services. //2004//

/2005/ During Calendar Year 2002, there were 82,666 EPSDT eligible children ages 6-9. Of these, 39.7% (32,808) received dental services. //2005//

#08- The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

Status:

/2004/ One hundred percent of Mississippi's SSI beneficiaries less than 16 years old received rehabilitative services from the state's CSHCN program, either directly or indirectly. Through a series of meetings with the Division of Disability Determination Services (DDS) representative, it was determined that all SSI beneficiaries less than 16 receive Medicaid. Due to Medicaid regulations, all children on Medicaid are eligible for rehabilitative services. If a child on Medicaid needs a particular service not covered under Medicaid, the CMP will either cover the service if the child is eligible for CMP or assist with the development of a plan of care for the child's physician to submit to Medicaid to achieve coverage. Therefore, all children under the age of 16 who are on SSI are provided rehabilitative services through a collaborative effort of CMP, DDS, and Medicaid. A copy of this agreement is available from the CMP upon request. //2004//

/2005/ In 2002, One hundred percent (100%)of SSI beneficiaries in Mississippi less than 16 years old received rehabilitative services from the state's CSHCN program. When a child on Medicaid needs a particular service not covered under Medicaid, the CMP will either cover the service if the child is eligible for CMP or assist with the development of a plan of care for the child's physician to submit to Medicaid to achieve coverage. Therefore, all children under the age of 16 who are on SSI are provided rehabilitative services through a collaborative effort of CMP, DDS, and Medicaid. //2005//

#09(A)- The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

Status:

/2004/ Scores pertaining to this indicator are on Form 19. The MSDH is continuing to grow in its data capacity. The major change from 2003 is the first year of data collection for PRAMS. Mississippi will be publishing localized results during 2003 and 2004. Another change is that the Mississippi Legislature charged the Mississippi Hospital Association to create a hospital discharge data system. The MSDH will work with them as this system is developed and pursue agreements for data sharing. Lastly, the MSDH is changing the birth and death registration operating system. Once the change has occurred and the new birth certificate is implemented, the state's Title V (MCH) office will work with the MSDH Bureau of Health Informatics to conduct regular data linkages. //2004//

#09(B)- The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

Status: /2004/ According to the latest data (2001) from the Youth Risk Behavior Survey conducted biannually, 29.6 percent of adolescents in grades 9 through 12 reported using tobacco products in the past month. //2004//

/2005/ According to the latest data (2003) from the Youth Risk Behavior Survey conducted biannually, 25 percent of adolescents in grades 9 through 12 reported using tobacco products in the past month. //2005//

#09(C)- The ability of States to determine the percent of children who are obese or overweight.

Status:

/2005/ Efforts are being made to capture these data through a number of initiatives. The Mississippi Council on Obesity Prevention and Management has made a number of recommendations which may impact child health activities. MCH staff are actively involved in ongoing projects and grant initiatives. //2005//

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.

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 the 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.

//2004/ The number of maternity clients seeking prenatal care at county health departments continues to decrease. During FY 1995, the MSDH provided maternity services for 22,579 clients, and during FY 2002 only 11,836 clients received maternity services from county health departments. The decrease in maternity services provided at county health departments is primarily due to the proliferation of rural health clinics and other providers. //2004//

//2005/ Maternity patients seeking prenatal care at county health departments continue to decline. According to fiscal year data, the MSDH provided maternity services for 9,738 maternity patients in FY 2003. //2005//

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.

The Mississippi State Department of Health's (MSDH) Office of Health Services (OHS), through the Bureau of Women's Health and the Bureau 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 are basically preventive in nature and designed for early identification of crippling conditions. Case management services are provided to high risk pregnant and postpartum women and infants by nurses, social workers and nutritionists. Services are provided in clinic and in the clients home.

B. STATE PRIORITIES

Mississippi's health priorities from the 2001 Needs Assessment are enumerated below:

? State Priorities:

1. Reduce repeat teen births.
2. Improve data collection capacity for Title V population.
3. Explore coverage of asthma services for children.
4. Increase EPSDT screening among children on Medicaid.
5. Reduce the state's low birthweight rate and infant mortality rate.
6. Develop a plan to identify, gather data on, and address issues related to maternal deaths.
7. Decrease cigarette smoking among ninth through twelfth graders.
8. Decrease the incidence of teen mortality and unhealthy behaviors.
9. Assure access to pediatric care for all children, including children with special health care needs.
10. Decrease cigarette smoking among pregnant adolescents.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

In FY 2001, approximately 99.4 percent of all newborns in the state received at least one screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies. There was initial follow-up on 100 percent of all positive newborn screens.

b. Current Activities

During CY 2002, approximately 99.7 percent of all newborns in the state received at least one

screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies. In March 2002, newborn screening in Mississippi was expanded to include congenital adrenal hyperplasia (CAH). Three confirmed cases were detected before the end of the year. All cases of PKU, hypothyroidism, galactosemia, sickle cell disease, and CAH received adequate follow-up which included counseling, medical evaluation, diagnostic services, and treatment.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to attain 99.8 percent of all newborns screened and confirmed for genetic disorders. In addition to implementing activities necessary to increase the percent of newborns screened and confirmed, monthly county newborn screening reports will be monitored and evaluated based on the number of positive cases that remain in a system of care for at least 12 months.

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)

a. Last Year's Accomplishments

During 2001, a Parent Advisory Committee was established by the CMP, which meets independently of the CMP Advisory Committee to provide a focus of feedback and advice exclusively from parents of CSHCN. The CMP Advisory Committee includes physicians and other providers.

The Mississippi State Department of Health's Children's Medical Program has a history of families with children with special health care needs providing program and policy input. Program and policy input from CSHCN families has included representation on advisory committees where individuals provide input and/or feedback that is both solicited and unsolicited. Parents of CSHCN are members of the Children's Medical Program Advisory Committee and provide program input along with physicians and other CMP professional and non-professional providers.

b. Current Activities

Program and policy input from CSHCN families has included representation on advisory committees where individuals provide input and/or feedback that is both solicited and unsolicited. Parents of CSHCN are members of the Children's Medical Program Advisory Committee and provide program input along with physicians and other CMP professional and non-professional providers.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to continue to assure family participation in program policy activities in the State's CSHCN Program. The MSDH's Children's Medical Program (CMP) will work to maintain family participation through the program advisory committee, and include patient and family subcommittee's input in the MCH Block Grant Needs Assessment.

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)

a. Last Year's Accomplishments

In 2001, approximately 78 percent of Children With Special Health Care Needs (CSHCN) in the Children's Medical Program in Mississippi had a medical home. However, the Children's Medical Program (CMP) recognizes the importance of every child having an identified, accessible, community medical home. Thus, the CMP staff worked diligently to implement the following process enumerated below:

1. Identify primary care physicians on the CMP application and request that information be provided regarding the child's needs.
2. If the child does not have a primary care physician (PCP), contact the child's family to discuss the need for a PCP and assist with the identification of a local physician and referral sources.
3. Provide copies of all CMP progress notes to the designated PCP.
4. Identify the PCP on the patient record and verify on each clinic visit or encounter.
5. Strongly encourage children who appear to be eligible for Medicaid or other funding sources to apply to establish a payment source for primary and community care.
6. Assist the PCP by providing case management, which includes coordinating clinic appointments, scheduling studies, assisting with referrals for service, recommending technology assistive devices, and technical support to the PCP and staff as requested.
7. Work with the state chapter of the American Academy of Pediatrics (AAP) in promoting national AAP policy on Medical Home Programs for children with special needs.

b. Current Activities

According to data collected by the SLAITS Survey, 44.2 percent of Children With Special Health Care Needs (CSHCN) in the Children's Medical Program in Mississippi had a medical home.

c. Plan for the Coming Year

The MSDH's Children's Medical Program (CMP) will continue to partner with the Coalition of Citizens with Disabilities to implement the Healthy and Ready to Work Grant initiative. The Coalition of Citizens with Disabilities has several activities directly related to Mississippi's Maternal and Child Health (MCH) Children with Special Health Care Needs program efforts, particularly developing access of CSHCN 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)

a. Last Year's Accomplishments

Data for this measure are captured by the SLAITS Survey.

b. Current Activities

Data for this measure are captured by the SLAITS Survey and apply to the CSHCN statewide population. For children served in the Children's Medical Program, the Mississippi CSHCN program, 87% have private or public insurance (see Form 7). The Children's Medical Program makes every effort to help families find insurance coverage.

c. Plan for the Coming Year

Data for this measure are captured by the SLAITS Survey.

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)*

a. Last Year's Accomplishments

Data for this measure are captured by the SLAITS Survey.

b. Current Activities

Data for this measure are captured by the SLAITS Survey.

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.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

Data for this measure are captured by the SLAITS Survey.

b. Current Activities

Data for this measure are captured by the SLAITS Survey.

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 the Mississippi Coalition of Citizens with Disabilities in an effort to help prepare CSHCN for transition into adulthood.

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.*

a. Last Year's Accomplishments

According to the 2002 immunization survey of children at 24 months of age, 87.5 percent have completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B. In 2000 and 2001, the immunization rate for this age group was 85.5 percent.

Mississippi was one of two southern states to earn national recognition for coverage in

childhood basic immunizations. A representative of the Centers for Disease Control and Prevention (CDC) presented the award at its 37th annual National Immunization Conference held in Chicago, Illinois. Mississippi and North Carolina tied for fifth place in the nation in immunization rates.

b. Current Activities

According to the 2003 immunization survey of children at 27 months of age, 86 percent completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B. In 1999, the immunization rate for this age group was 83.9 percent. This survey is conducted annually to obtain statistical estimates of immunization rates of two-year-old children in Mississippi.

c. Plan for the Coming Year

The results of the survey of two-year-old children suggests that the state of Mississippi is moving gradually toward achieving the 90 percent national goal. The MSDH will 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.*

a. Last Year's Accomplishments

The 2001 birth rate (per 1,000) for teenagers age 15 through 17 years was 38.4 per 1,000 live births. Trends in Mississippi are similar to those seen nationally. In Mississippi, 17.8 percent of all babies born during 2001 were born to teenagers, which represented a decrease from 2000 (18.8 percent). 560 girls 15-years-old and younger gave birth in 2001.

Collaboration among public health districts occurred with 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 are being counseled regarding postponing sex.

b. Current Activities

The 2002 birth rate (per 1,000) for teenagers age 15 through 17 years is 37.7 per 1,000 live births, which represents a slight decrease from CY 2001 rate of 38.4 per 1,000 live births. In FY 2002, 73,211 students attended 1,806 presentations about general and reproductive health. All nine public health districts were active in making presentations to schools.

Collaboration among public health districts will continue to take place with 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.

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. Through the EPSDT and Abstinence Programs, counseling will continue to be offered to children and adolescents 9-18 years of age regarding postponing sex.

Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

a. Last Year's Accomplishments

In FY 2001, the Mississippi State Department of Health and the University of Mississippi School of Dentistry began a preventive dental sealant program for second grade children in Public Health District III, which consists of Attala, Boliver, Carroll, Holmes, Humphries, Leflore, Montgomery, Sunflower, and Washington counties. The program was called the Dental Adopt-A-School Program and participating dentists were assigned a local elementary school to "adopt" for sealant placement. Dentists could choose to go on-site and place the dental sealants using portable dental equipment, or have the children bussed to their dental office. During the first year, 594 second-grade children from 10 elementary schools in Leflore and Washington counties were screened for the program. Thirteen private dentists placed a total of 1030 dental sealants in 301 children and received a total reimbursement of \$25,150.00, at \$25.00 per sealant per child. Only sealants placed on the four permanent first molar teeth are eligible for reimbursement. Sixty-three children had no need for sealants, 104 did not show for the procedure, 118 did not have parental permission, and 8 refused treatment. 17 dentists and 29 elementary schools in 3 counties participated in the program.

b. Current Activities

Since the initiation of the school-based dental sealant program, over 3,700 dental sealants were placed between 2001-2003.

c. Plan for the Coming Year

The MSDH's Dental Division will continue working to assure that dental providers in Public Health District III continue to screen new second grade classes for dental sealants at each of the participating elementary schools, and place the sealants when indicated. The Dental Division will also continue to develop strategies to expand the Dental Adopt-A-School Program to other public health districts in Mississippi.

Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

a. Last Year's Accomplishments

In Mississippi in 2001, the death rate of children aged 1-14 by motor vehicle crashes (per 100,000) was 8.5. This rate has decreased considerably since 1930 (13.0) and it is projected to continue to decline.

b. Current Activities

2004/ In Mississippi in 2002, the death rate of children aged 1-14 by motor vehicle crashes (per 100,000) was 8.9. This rate has slightly increased from the 2001 rate of 8.5.

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.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

During CY 2001, data from the Ross Mothers Survey revealed that 50.4 percent of mothers in Mississippi breastfed their infants at hospital discharge, which represented an increase from 2000. Of these mothers, 18.2 percent continued to breastfeed at 6 months, up from 15.4 percent in 2000. Of the WIC population, 41 percent of mothers breastfed their infants at hospital discharge, up from 38.3 percent in 2000; and 12.2 percent continued to breastfeed at 6 months, up from 9.9 percent in 2000.

b. Current Activities

Data from the 2002 Ross Mothers Survey revealed that 52.4 percent of mothers in Mississippi breastfed their infants at hospital discharge, which represented an increase of 2 percent from 2001. Of these mothers, 21.6 percent continued to breastfeed at 6 months, up from 18.2 percent in 2001. Of the WIC population, 56.1 percent of mothers breastfed their infants at hospital discharge, up from 41 percent in 2001, and 16.1 percent continued to breastfeed at 6 months, up from 12.2 percent in 2001.

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.*

a. Last Year's Accomplishments

During CY 2001, 96 percent of all babies born in Mississippi hospitals were screened for hearing impairments prior to discharge from the facility. All hospitals who delivered 100 or more babies per year provided universal screening on site. Approximately 200 babies were born either in hospitals that did not provide screening or in a non-hospital setting. Infants born in a non-screening hospital were generally transferred to a screening hospital, and the results were included in the screening hospital's monthly reports. Phone calls and/or certified letters were sent to families of infants born in non-hospital settings to arrange for screening. The Mississippi State Legislature has mandated universal hearing screening for all newborns.

b. Current Activities

Calendar Year (CY) records for 2002 reveal that 39,899 (96.1%) infants have been screened prior to hospital discharge. Extensive training is being 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 upgrading of screening equipment that will improve the accuracy and completeness in the reporting of screening results. Also, the MSDH plans to continue efforts to assure the implementation of universal screening at all hospitals for early detection of hearing impairments in newborns.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

During 2001, the Division of Medicaid contracted with the Institutions of Higher Learning to provide a study of the number of uninsured in the state. These data should be available during the fall and will provide more state specific data on the number of uninsured.

b. Current Activities

The Division of Medicaid has contracted with the Institutions of Higher Learning to provide a study of the number of uninsured in the state. These data are not currently available but will provide more state specific data on the number of uninsured.

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: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

According to data provided by representatives of the Division of Medicaid, 361,461 children were potentially eligible to receive Medicaid services in 2001. However, of that number, 312,836 (87%) received a service paid by the Medicaid program.

b. Current Activities

According to data provided by representatives of the Division of Medicaid, during FY 2002, of the 406,847 potentially Medicaid eligible children age children 1-20, (61%) 246,960, received a service paid by the Medicaid program.

c. Plan for the Coming Year

During the coming year, the MSDH plans to continue collaborating with Medicaid to develop a system for data sharing to determine the number of potentially Medicaid eligible children, and to track the number of eligible children receiving a service through the Medicaid program.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

During 2001, 2.1 percent of all the births in Mississippi were very low birthweight births. This rate represented a slight decrease from 2.2 in 2000. The Perinatal High Risk Management/Infant Services System (PHRM/ISS), Pregnancy Risk Assessment Monitoring System (PRAMS) and WIC participation continued to be priorities for Mississippi.

b. Current Activities

During 2002, 2.2 percent of all the births in Mississippi were very low birthweight births. This rate represents a slight increase from 2.1 in 2001. Projections indicate that this percent is likely to continue to increase. Implementing the Perinatal High Risk Management/Infant Services System (PHRM/ISS), Pregnancy Risk Assessment Monitoring System (PRAMS) and WIC participation will continue to be priorities for Mississippi.

c. Plan for the Coming Year

Mississippi's plan for the coming year relative to this measure is to continue implementing activities targeted at reducing the percent of very low birthweight births. Activities such as working closely with WIC to provide new and continued outreach efforts to potentially eligible populations and assessing pregnant women for smoking and offering smoking cessation classes, materials, and counseling will be implemented.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

In 2001, the suicide death rate in Mississippi (per 100,000) among youths 15-19 was 7.7, which represented a decrease from the 2000 rate of 10.7. 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 and bridging the communication gaps between adolescents and their families.

b. Current Activities

During 2002, the suicide death rate in Mississippi (per 100,000) among youths 15-19 was 10.9, which represents an increase from the CY 2001 rate of 7.7. 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 and bridging the communication gaps between adolescents and their families.

c. Plan for the Coming Year

Mississippi plans to reduce the rate of suicide deaths among youths 15-19 in the coming year by developing strategies for utilization of school health nurses as a school and community resource for health education.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

During 2001, 33.7 percent of very low birthweight infants were delivered at tertiary centers. The MSDH continued working to develop plans to address perinatal regionalization issues in Mississippi.

b. Current Activities

During 2002, 33.2 percent of very low birthweight infants were delivered at tertiary centers. The MSDH will continue working to develop plans to address perinatal regionalization issues in Mississippi.

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.*

a. Last Year's Accomplishments

During CY 2001, 82.2 percent of infants born were to women who had received prenatal care beginning in the first trimester. This represented an increase of 8.2 percent from 1990 (74.0). projections indicated that by 2010, 90% of infants may be born to women who begin prenatal care in the first trimester.

b. Current Activities

During CY 2002, 83.1 percent of infants born were to women who had received prenatal care beginning in the first trimester. This represents a slight increase from 82.2 percent reported for CY 2001.

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.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Continue to provide screening of all births occurring in the state and follow-up on all inconclusive, abnormal, and presumptive positive results.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Identify family counseling and arrange for repeat screens for all babies with inconclusive and abnormal results, and arrange for diagnostic evaluations for all babies with presumptive positive results.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Identify all confirmed cases of genetic disorders detected through the screening process.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assure that infants diagnosed with a genetic disorder have a local medical home and are under the care of a physician.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continue to assist in coordinating the case management of effected children with local health department and physicians.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				
1. Maintain family participation through the program advisory committee	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Maintain CMP Parent Advisory Council	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Include patient and family subcommittee input in the MCH Block Grant Needs Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Initiate a contractual program with the Mississippi Cerebral Palsy Foundation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

5. /2005/ Utilize a Family Satisfaction Survey tool to obtain information from families regarding the services they receive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. Include medical home information on CMP applications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Screen medical home status at all clinic encounters and make referrals as needed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Collaborate with primary care physician groups to increase the availability of medical homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to coordinate with the University Medical Center to provide care coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop CMP case management positions (as funds allow) to provide care coordination services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Utilize district CMP/Genetics Coordinators to assist in care coordination at the community level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Collaborate with Coalition of Citizens With Disabilities on Healthy and Ready to Work grant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue to provide continuing education opportunities for primary care providers on topics related to CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) 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)				
1. Include insurance information on CMP applications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Verify insurance status at all patient encounters and make referrals to other sources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Maintain CMP data system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to work with Medicaid insurers and advocacy groups to promote adequate health coverage for CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. Provide and coordinate 19 community-based CSHCN subspecialty medical clinics throughout the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Implement a medical home initiative for CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Maintain a collaborative relationship with community health centers to provide other needed services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Facilitate communication between specialty and primary care providers through care coordination initiatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Continue to implement the Health and Ready to Work initiative	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Develop a life-skills clinic for the transition of CSHCN to adulthood	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Develop a system at Blake Clinic to ensure that transition services are discussed with patients at every opportunity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) 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.				
1. Continue to conduct annual immunization surveys to obtain statistical estimates of immunization rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to emphasize, through the Statewide Immunization Coalition, immunizations' significance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to work with the Mississippi Chapter of the American Academy of Pediatrics (AAP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Support MSDH Statewide Abstinence Education Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Meet with ministers and church organizations to solicit help in addressing teen pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Increase collaboration between adolescent pregnancy prevention programs that focus on minorities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborate with community health centers in all medically underserved counties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. During postpartum home visits, counsel teens regarding availability of family planning services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Work with school nurses on counseling teens regarding risky behaviors and goal setting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Counsel children ages 9-18 regarding postponing sex, reproductive health, and contraception.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. /2004/ Develop partnerships between the State OB/GYN medical consultants and other providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Encourage increased utilization of dental services provided by Medicaid.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. /2005/ Continue to work with the University Schools of Nursing and				

Dentistry to facilitate access to protective sealant services in the Public Health District III area and plan to expand services as resources allow	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Collaborate with the Safe Kids of Mississippi Coalition to initiate the passage of legislation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Partner with local health departments to provide child safety seats to residents of the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop and implement an initiative to educate and provide information to parents on the proper use of child safety seats	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Utilize educational videos and informational TIPP sheets developed by the Ford Motor Company	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Maintain MSDH participation with the Mississippi Association of Highway Safety Coalition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Work with school nurses and other school personnel to promote safety education related to motor vehicle crashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Certify and promote MSDH clinics as breastfeeding-friendly facilities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue the nationally recognized peer counselor breastfeeding program through the MSDH	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue the implementation of USDA National Breastfeeding Promotion Campaign	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Distribute a promotional video to assist WIC clients, physician clinics and hospitals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide technical training opportunities for health care providers on breastfeeding promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Conduct outreach activities with worksites employing large numbers of women in the childbearing age range	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Increase collaboration among MSDH agency programs and private providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue to partner with the March of Dimes to encourage providers to apply for funding to provide patient education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Purchase and distribute 60 percent of supplies necessary to carry out universal screening	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. /2004/ Provide technical support to hospitals with regard to the screening process and upgrading equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Receive and review written, electronic and faxed reports from birthing hospitals and/or facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Review screening reports for risk factors	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Monitor referral of infants to diagnostic centers for confirmation of hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Meet with DFA and Medicaid to discuss alternatives for determining the percent of children without health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assist DFA and Medicaid in marketing the availability of CHIP to eligible families and/or clients	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assess health coverage status at every opportunity and provide assistance to families in the completion of applications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Develop a Memorandum of Understanding with Medicaid regarding the exchange of data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Encourage use of out-stationed eligibility workers to assist Medicaid eligible clients	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assign local health department staff to assist potentially eligible clients to apply	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. /2004/ Assess capacity in local health department clinics to increase EPSDT screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. /2004/ Identify local resources to improve access and utilization of services for Medicaid and CHIP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Coordinate WIC promotion activities with LBW prevention strategies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Work closely with WIC to provide new and continued outreach efforts to potentially eligible women	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue to work with MSDH districts to explore the possibility of off-site (out of clinic) WIC certification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assess pregnant women for smoking and offer smoking cessation classes and materials	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Increase participation in PHRM/ISS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Track changes in the prevalence of maternal behaviors, attitudes, and experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Develop strategies for utilization of school health nurses as a school and community resource for health education and to assist in bridging the	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

communication gaps between adolescents and their families.				
2. Collaborate with the Department of Mental Health to explore initiatives for preventing suicide deaths among youths, such as suicide risk assessments and prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Review records to screen for high risk youth	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. /2005/ Through networks of the Suicide Prevention Coalition, provide information on available resources throughout the state.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Continue to work with the Mississippi Perinatal Association, the Infant Mortality Task Force, and the March of Dimes to evaluate the regionalization system in the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Evaluate the current system and develop a plan of improvement if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to conduct annual hospital surveys to obtain status of available manpower for multiple medical services, including maternity and newborn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assess facility availability across the state for perinatal practices and statistics for use in state planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaborate with Miss. Food Network to distribute information about prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with the March of Dimes to develop media materials related				

to early prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborate with the Healthy Baby Campaign, a multi-state campaign, to provide coupons for pregnant women who initiate and continue prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaborate with March of Dimes to implement Stork Nests for clients receiving continuous prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of children on Medicaid who receive EPSDT screening*

a. Last Year's Accomplishments

During FY 2001, of the 236,562 Medicaid eligibles, 32,223 (14%) received screening services. In efforts to improve EPSDT screening, the MSDH staff encouraged parents who received services through programs such as the Immunization program and/or postpartum home visits to take advantage of EPSDT screening.

b. Current Activities

In CY 2002, of the 269,555 Medicaid eligible children (6-20 years old), 32,191(12%) received screening services. The MSDH staff encouraged parents who received services through programs such as the Immunization program and/or postpartum home visits to take advantage of EPSDT screening.

The MSDH has been working 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 area of the state as well.

State Performance Measure 2: *Current percent of cigarette smoking among ninth through twelfth graders.*

a. Last Year's Accomplishments

According to the 2001 Youth Risk Behavior Survey (YRBS), 23.6 percent of Mississippi's adolescents in grades 9 through 12 used tobacco products. Twenty two percent were current

smokers. With the availability of funds from tobacco companies, the Attorney General at that time (Mike Moore) met with various medical associations, education groups, youth and and others organizations to develop strategies to address tobacco use among children in Mississippi. As a result, the Partnership for a Healthy Mississippi (the Partnership) was formed with the mission of creating a youth-centered, statewide collaboration dedicated to creating a healthier Mississippi and eliminating tobacco use among Mississippi's youth.

b. Current Activities

According to data from the 2003 YRBS Survey, 25 percent of Mississippi's public high school students age 9 through 12 are current smokers. This represents a slight increase from 23.6 in CY 2002. Through EPSDT, family planning, and other adolescent visits, the MSDH staff will continue to directly counsel youths concerning the hazards of tobacco use.

c. Plan for the Coming Year

Mississippi's plan for the coming year regarding this measure is to reduce cigarette smoking among 9 through 12 graders. This will be achieved through education and counseling in programs such as EPSDT, Family Planning, maintaining community-based tobacco prevention programs, and collaborating with school health nurses.

State Performance Measure 3: *Percent of smoking among pregnant adolescents.*

a. Last Year's Accomplishments

During 2001, 12.3 percent of all pregnant adolescents in Mississippi smoked cigarettes. This represented no change from the 12.3 percent reported in both 1999 and 2000. In an effort to reduce smoking among pregnant adolescents, the MSDH staff continued to work with school nurses and health educators to increase school-based health education classes related to smoking cessation. Pregnant adolescents were also informed and/or provided educational materials as they utilized other MSDH services.

b. Current Activities

During CY 2002, 12.5 percent of all pregnant adolescents smoked cigarettes. This represents a slight increase from 12.3 in CY 2001.

c. Plan for the Coming Year

Mississippi's plan for the coming year is to continue its efforts to decrease cigarette smoking among pregnant adolescents by collaborating with school nurses and health educators to increase school-based health education programs related to smoking cessation. The MSDH will also continue to educate adolescent pregnant women receiving health department services.

State Performance Measure 4: *Percent of children with genetic disorders who receive case management services*

a. Last Year's Accomplishments

During FY 2001, 94.8 percent of children with genetic disorders received case management services. The number of genetic clinics increased to seven statewide. These clinics provide clients the opportunity for local health care and case management.

b. Current Activities

In CY 2002, approximately 93.7 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: Infants screened and referred for hearing impairment =35 dB nHL will receive appropriate follow-up and intervention upon h

a. Last Year's Accomplishments

In CY 2001, 400 infants were referred from hospital hearing screening processes; 257 (64%) completed a diagnostic evaluation. There were 80 confirmed hearing losses. One hundred

percent of these infants were referred for early intervention.

b. Current Activities

During 2002, 386 infants were referred from the hospital hearing screening processes, and 295 (76%) have completed the diagnostic process. Fifty two (52) of these infants were diagnosed with a confirmed hearing loss. Activities have been implemented to provide aggressive follow-up for those infants being referred from hospital hearing screening processes.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to improve efforts to identify infants who are born with permanent congenital hearing loss by receiving reports on all infants referred on hospital hearing screening, monitoring, and assisting with referred children receiving diagnostic evaluations for confirmation of hearing loss, and training hospital staff and audiologists on proper referral procedures.

State Performance Measure 6: *Prevalence of infants born with neural tube defects.*

a. Last Year's Accomplishments

In Calendar Year 2001, of the 42,277 live births in Mississippi, the prevalence of neural tube defects was 4.7 per 10,000 live births. The Mississippi Folic Acid Council was organized April 23, 2002, and meets quarterly for educational programs and to discuss ways to increase public awareness of folic acid within Mississippi.

b. Current Activities

In Calendar Year 2002, of the 41,511 live births in Mississippi, the prevalence of neural tube defects was 3.1 per 10,000 live births. The Mississippi Folic Acid Council continues to meet quarterly for educational programs and discuss ways to increase public awareness of folic acid within Mississippi. The August and September Morbidity report focused on Mississippi family planning clients' knowledge and behaviors related to folic acid and included recommendations for health care providers.

c. Plan for the Coming Year

Mississippi's plan for this measure is to continue to implement initiatives to ensure that women in the reproductive age range consume the appropriate amount of folic acid for improved pregnancy outcome. This will be achieved by continuing to conduct initiatives such as counseling women in family planning clinics regarding the need for the daily consumption of folic acid or a multi-vitamin containing 0.4 mg of folic acid for all women capable of becoming pregnant, partnering with the March of Dimes to provide education to clinicians statewide, and making folic acid available to the MSDH Family Planning population that are at high risk of having an infant with a NTD.

State Performance Measure 7: *The rate of repeat births (per 1,000) for adolescents less than 18 years old.*

a. Last Year's Accomplishments

The rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years old decreased from 15.1 in 2000, to 14.1 percent during CY 2001. Projections indicate this rate will continue to decrease. The MSDH continues to sponsor, through MSDH's Family Planning Program, collaborative training such as conferences and male involvement workshops, and supports 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.

b. Current Activities

During CY 2002, the rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years was 14.1 percent. Although there was no change in the percent of repeat births for this group from 2001, projections still indicate that this rate will continue to decrease. The MSDH continues to sponsor, through MSDH's Family Planning Program, collaborative training such as conferences and male involvement workshops, and supports 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 MSDH's Family Planning Program, collaborative training such as conferences and male involvement workshops, work with local health department staff to make prevention of repeat adolescent pregnancy a priority in care plans for teen clients, and 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 8: *The degree to which the MCH program is developing data infrastructure.*

a. Last Year's Accomplishments

Data capacity remained essentially the same even though a permanent Operations Management Analyst Principal (OMAP) was hired in August 2003. Her major responsibilities relate to overseeing the State Systems Development Initiative (SSDI) grant. MCH Data Unit strategic planning and training was conducted in October 2003 and annual project assignments were made. Also, an ORISE/CDC Fellow joined MSDH in September 2003. Her initial responsibility was to conduct analyses specific to Mississippi on the SLAITS CSHCN dataset.

b. Current Activities

Data capacity is beginning to grow. The MCH Data Unit remains fully staffed, PRAMS now has a data manager/analyst, and some MCH Data Unit staff were trained related to data analysis programs and using census data. Assignments, plans, and deadlines for the statewide MCH needs assessment have been initiated.

c. Plan for the Coming Year

Enumerated below are the MCH Data Unit's plan and/or strategies to improve data capacity and infrastructure during the upcoming year:

1. The new OMAP and PRAMS data manager/analyst will complete in the MCH Epidemiology certificate graduate program at Emory University;
2. Area is being designed to house MCH Data Unit staff together;
3. Additional staff from epidemiology and health promotion will be added to the MCH Data Unit;
4. A Health Program Specialist Senior, funded by SSDI, will be hired to work with genetics to assess the surveillance systems, work with hospitals to improve reporting, and develop appropriate reports;
5. The data skills of each member will be assessed and an annual plan will be designed for each member to increase data skills;
6. Additional training will be available about statistical analysis programs;
7. Two conferences related to the needs assessment (kick-off and report of findings) will be implemented;
8. A report of PRAMS findings will be developed.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of children on Medicaid who receive EPSDT screening				
1. Encourage parents during postpartum home visits to take advantage of EPSDT screenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide information about EPSDT in WIC Packets	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Remind parents at immunization visits about the importance of EPSDT and to seek health care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Check whether EPSDT screenings are due on children being seen for WIC services and screen if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop a plan to provide and ensure EPSDT services to all eligible children in the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Conduct mass EPSDT screening in select areas	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Support funding sources to school nurses to perform EPSDT screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Current percent of cigarette smoking among ninth through twelfth graders.				

1. Through EPSDT, Family Planning and other adolescent visits, counsel youths about tobacco use	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Maintain community-based tobacco prevention programs in collaboration with the Partnership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Maintain use of tobacco prevention curricula in school through the School Health Nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Conduct site visits to at least 15 schools to assess tobacco prevention activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Train staff on smoking cessation specifically targeted to adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Make literature available to communities and schools on smoking cessation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Percent of smoking among pregnant adolescents.				
1. Work with school nurses and health educators to increase school-based health education	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue to educate adolescent pregnant women receiving services on the dangers of prenatal smoking	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide training about smoking cessation and pregnancy to nurses, nutritionists and social workers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Refer to PHRM/ISS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Refer to Tobacco Quitline Mississippi for information on smoking cessation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of children with genetic disorders who receive case management services				
1. Report all inconclusive, abnormal, and presumptive positive test results to genetics field staff for counseling, clinic appointments, and follow-up.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Contact families of babies with inconclusive, abnormal, or presumptive positive test results by phone or home visit, and arrange for counseling or case management.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Repeat newborn screens or collect diagnostic specimens as needed, and arrange for medical evaluation and treatment if indicated.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Assure that children diagnosed with genetic disorders have a local medical home and are under the care of a physician.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Infants screened and referred for hearing impairment =35 dB nHL will receive appropriate follow-up and intervention upon h				
1. Receive reports on all Mississippi infants who are referred on hospital hearing screening	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Monitor and/or assist with referred children receiving diagnostic evaluations for confirmation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Train hospital staff and audiologists on proper referral procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop protocol for follow-up in collaboration with PHRM/ISS, Early Intervention and child health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Prevalence of infants born with neural tube defects.				
1. Counsel women in family planning clinics regarding the need for the daily consumption of folic acid	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Partner with the March of Dimes to provide education to clinicians statewide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Make folic acid available to the MSDH Family Planning population	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Pilot a project in one public health district to provide folic acid education to all women	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Maintain collaboration with the MSDH OB/GYN Medical Consultant and March of Dimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. /2004/ Publish a Mississippi Morbidity Report about Miss. women's folic acid knowledge and behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. /2005/ Assess folic acid knowledge and behavior among Mississippi women using PRAMS data. //2005//	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
7) The rate of repeat births (per 1,000) for adolescents less than 18 years old.					
1. Continue to sponsor, through MSDHs Family Planning Program, collaborative training		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to support the training of MCH/Family Planning (MCH/FP) Coordinators		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to work with staff to make prevention of repeat adolescent pregnancies a priority		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Encourage health departments to provide enhanced family planning services to adolescents		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Partner with March of Dimes to implement more Project Alpha Projects		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue to collaborate with Delta Health Partners (Healthy Start Initiative)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
8) The degree to which the MCH program is developing data infrastructure.					
1. Continue to create permanent infrastructure and functions of MCH Data Unit		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Create MCH district performance indicators and develop mechanism for semi-annual reporting		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Create permanent positions to support data functions such as surveillance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Select and initiate special MCH projects		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to request graduate interns and Fellows to assist with special projects		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

E. OTHER PROGRAM ACTIVITIES

/2004/ In Mississippi, there is increasing concern within the medical community regarding the lack of affordable medical liability Insurance. Currently, the Medical Assurance Company of Mississippi is the only remaining insurance company in Mississippi. It remains primarily because it was established by a group of physicians to assist in providing additional coverage for medical professionals in the state. However, because the Medical Assurance Company of Mississippi has become the sole source of medical liability insurance, it is impossible for this company to provide coverage for all of the medical professionals in the state. As a result of this, insurance premiums are at a 60% rate increase and expected to rise another 40%. Some medical professionals are considering or have already moved their practices to other states that have affordable insurance premiums.

Until December 31, 2002, Mississippi residents were allowed to sue for any amount of money they deemed commensurate with their loss. There were a number of lawsuits being filed daily and insurance companies had no way of determining the costs they would incur as a result of high claim lawsuits. Insurance companies, fearing that the number of large claims could force them out of business, decided they could no longer afford to provide medical liability coverage in Mississippi.

In the fall of 2002, the Mississippi State Legislature passed a tort claims bill that basically put a cap or limit on the amount of money a person could obtain from a medical lawsuit. The bill became effective January 1, 2003. A cap of \$500,000 was signed into law as the maximum amount of money a person could receive. As a result of this bill, thousands of lawsuits were filed December 31, 2002 to avoid the new law. For instance, more than 100 lawsuits were filed in Pike County alone, representing only one of 82 counties. Insurance companies, realizing that it will be years before this legal nightmare is resolved, have not returned to the state.

/2005/ The malpractice climate in this state has changed very little, and it is too soon to determine if recent laws can help resolve this issue. Obstetricians are currently paying premiums on the average of \$100,000. //2005//

CAMP NOAH REPORT

/2005/ Disaster

On April 6, 2004 severe weather including floods and tornadoes affected 1,401 homes, 150 mobile homes, 72 apartment complexes, 155 businesses, and 42 agricultural areas in 15 Mississippi counties. The storms caused injuries to nine individuals and contributed to the death of one individual. Flash floods did extensive damage in Canton, MS. In February 2004 Canton community and church leaders, school officials and parents reported that children affected by the tornado were still exhibiting many symptoms associated with disaster, including headaches, stomach aches and vomiting, inability to separate from parents, distractibility, aggressiveness or withdrawal, and excessive fears of stormy weather.

Camp Activities

This camp was designed by Lutheran Social Services of Minnesota and has been adopted by Lutheran Disaster Response as a national strategy for children affected by natural disaster. Camp Noah is a free day camp with the goal of decreasing trauma-reactive behaviors and symptoms among elementary school age children affected by natural disaster. Intervention components include (1) helping children to process the disaster experience within a faith-based context, (2) providing a fun environment in the midst of a stressful time, and (3) promoting community and ecumenical collaboration. This camp employed a low ratio of staff to children (1 counselor and at least one assistant per 7 children) and had one mental health therapist available interacting with the children at all times.

The camp used a structured curriculum that follows the disaster cycle of recovery and applies the story of Noah. Bible story discussions, music, art projects, and storytelling, as well as time with a mental health therapist, were approaches used to help the children process their experiences.

Thirty-nine (39) children in kindergarten through sixth grade attended Camp Noah at St. Paul's

AME Baptist Church in Canton from March 15-19, 2004. Crafts included making preparedness boxes (a strategy recommended by the American Red Cross), sock puppets for storytelling, masks with animal faces on the outside and feelings written on the inside, and clay bridges that showed progress in moving from the life before the tornado to the new life afterwards. Contributions for the preparedness boxes included materials to support good dental health and discourage use of alcohol and illegal drugs. Besides lessons and crafts, the camp consisted of music and games such as parachutes. New evaluation approaches were used, but data are not yet available.

Other Special Activities of the Camp

A local meteorologist, talked about warnings and weather safety activities. The Canton Fire Department also gave a presentation about fire safety. A session on good nutrition which involved didactic teaching plus the game "Food Bingo" was conducted by the Madison County Extension Service.

The MSDH is also conducting a program evaluation on the nationwide Camp Noah program. This evaluation focuses on symptoms and outcomes among children, critical program elements, and implementation procedures. //2005//

STATEWIDE EARLY CHILDHOOD COMPREHENSIVE SYSTEMS (SECCS)

//2005/ The Mississippi State Department of Health, the state's Title V agency, was awarded a two-year planning grant by the Health Resources and Services Administration (HRSA 03-054) to coordinate the development of a Statewide Early Childhood Comprehensive System (SECCS) for children in Mississippi ages 0-5, and their families. The initial planning grant was awarded July 1, 2003, with the implementation phase to begin in 2005. The purpose of the SECCS grant is to plan and implement a comprehensive early childhood interagency system that bridges gaps among federal, state, and community program in five areas: Access to Medical Homes, Mental Health and Social-Emotional Development, Early Care and Education Services, Parent Education, and Family Support Services. //2005//

F. TECHNICAL ASSISTANCE

F. Technical Assistance Needs.

//2005/ The MSDH is not requesting any technical assistance during this particular grant period. //2005//

V. BUDGET NARRATIVE

A. 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 2003: \$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 2003: \$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 2003: \$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 \$0.375 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

The budget for Mississippi's MCH Block Grant application was developed by the Office of Health Services in cooperation with the Office of Administrative and Technical Support, Bureau of Finance and Accounts. The total program for FY 2005 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 2005 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 are 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.