Missouri State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.	Implement community-based health promotion efforts. Communicate the value of and collaborate with partners in maternal health initiatives. Raise awareness of the importance of reproductive life planning. Educate women on the importance of immunizations. Promote comprehensive health care for pregnant women and women of childbearing age. Support activities and facilitate partnerships to create environments that support healthy eating and active living. Partner with tobacco control programs and community-based partners to assure delivery of effective tobacco cessation services. Participate in maternal and women's health partnerships by convening public health and advocacy partners for strategic thinking and action, engaging clinicians as partners, and engaging collaboratives to improve maternal health and health care equity. Address underlying social determinants of health. Build program and policy evaluation capacity.	By 2025, DHSS will develop/promote strategies to increase the percent of women who had an annual preventive medical visit from 72.9% (BRFSS 2018) to 73.6%. By 2025, DHSS will promote strategies to reduce the incidence rate of severe maternal morbidity from 74.0 per 10,000 delivery hospitalizations (SMM rate based on without blood transfusion, PAS 2018) to 73.3 per 10,000 delivery hospitalizations.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	ESM 1.1: Percent of women who reported a routine checkup within past 2 years (BRFSS).	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births

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					NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Perinatal/Infant Health					
Promote safe sleep practices among newborns to reduce sleep-related infant deaths.	Distribute information and education about sleep-related infant deaths. Support programs that provide cribs for low-income families. Collaborate with partners to distribute safe sleep resources to low-income families. Assess baseline and post-intervention safe sleep practices among program participants and families. Partner with community service providers and other agencies to conduct trainings on infant safe sleep that target parents, child care providers, grandparents, home health care professionals, staff of obstetric and pediatric clinics, retailers, and faith-based organizations. Facilitate partnerships with other state agencies, hospitals, nonprofits, media, and other stakeholders to develop innovative programs and policies that promote safe infant sleep, reduce infant mortality, encourage smoking cessation, and promote breastfeeding, immunizations, and prenatal care. Build program and policy evaluation capacity.	By 2025, Increase the percent of infants placed to sleep on their backs from 84.0% (2018 PRAMS) to 85.2%. By 2025, Increase the percent of infants placed to sleep on a separate approved sleep surface from 39.9% (2018 PRAMS) to 41.1%. By 2025, Increase the percent of infants placed to sleep without soft objects or loose bedding from 48.7% (2018 PRAMS) to 55.5%.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	ESM 5.1: At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment.	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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Child Health					
Reduce obesity among children and adolescents.	Implement community-based initiatives to promote and support healthy eating and active living. Support activities and facilitate partnerships to create environments that support healthy eating and active living. Encourage local health department staff to participate in school wellness committees at school districts within their jurisdiction. Increase school-community collaborations to promote health. Collaborate with DESE and other stakeholders to support schools to align with the Whole School, While Child, Whole Community model. Support school districts in implementation of comprehensive school physical activity programs. Build program and policy evaluation capacity.	By 2025, Increase the percent of children, ages 6 through 11, who are physically active at least 60 minutes per day in the past week from 37.4% (NSCH 2017-2018) to 37.77%.	NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	ESM 8.1.1: Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.	NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
Enhance access to oral health care services for children.	Establish collaborative relationships between non-oral health professionals and oral health professionals to strengthen the focus on oral health in the medical home and to ensure coordinated care. Develop and distribute oral health educational information and materials geared toward the public and health professionals. Provide oral health education at community-based settings. Promote the delivery of preventive oral health care for children and adolescents by oral health professionals in school-based programs. Build program and policy evaluation capacity.	By 2025, Increase the percent of children, ages 1 through 17, who had a preventive dental visit in the past year from 70.9% (NSCH 2017-2018) to 71.61%.	SPM 1: Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.		
Adolescent Health					
Reduce intentional and	Ensure health care providers have access to tools and best practices regarding injury prevention and are trained to use the tools in an evidence-	By 2025, decrease the rate of hospital admissions for non-fatal	NPM 7.2: Rate of hospitalization for non-fatal	ESM 7.2.1: Percentage of high	NOM 15: Child Mortality rate, ages 1 through 9, per 100,000

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unintentional injuries among children and adolescents.	based manner. Ensure high quality injury prevention counseling is embedded in programs for which Title V has authority. Educate partners regarding evidence-based policy and environmental strategies that prevent or reduce injury rates among children and adolescents, and the relative effectiveness of these policies and strategies. Educate partners regarding existing community resources for referrals or collaboration to support injury reduction and promote injury prevention. Build program and policy evaluation capacity.	injury among adolescents, ages 10 through 19 from 250.2 per 100,000 (PAS 2018) to 247.7 per 100,000.	injury per 100,000 adolescents, ages 10 through 19	school students who reported distracted driving.	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000
Promote Protective Factors for Youth and Families.	Create supportive environments that promote connectedness and healthy and empowered individuals, families, and communities. Foster positive public dialogue, counter shame, prejudice, and silence; and build public support for suicide prevention and mental health promotion. Address the needs of vulnerable groups, tailoring strategies to match the cultural and situational contexts in which they are offered, and seek to eliminate disparities. Coordinate and integrate existing efforts addressing adolescent health and behavioral health to ensure continuity of care. Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems. Collaborate with behavioral health agencies/partners to implement the Strengthening Families Protective Factors Framework. Promote efforts to reduce access to lethal means among individuals with identified suicide risks. Apply the most up-to-date knowledge base for suicide prevention. Implement and spread evidence-based suicide and self-harm prevention	By 2025, reduce the suicide death rate among youth 10-19 years from 7.8% per 100,000 (CY 2019 Vital Statistics) to 7.72 per youth 100,000.	SPM 2: Suicide and self-harm rate among youth ages 10 through 19		

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	strategies and programs. Strengthen collaboration across agencies, develop new tools and capacity, and implement evidence-based change in suicide and self-harm prevention strategies. Implement and spread evidence-based prevention and emergency mental health programs. Build program and policy evaluation capacity.				
Children with Special Health Care Needs					
Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.	Promote evidence-based management of acute, chronic, and/or complex child and adolescent medical conditions. Promote coordinated systems across the child/family care continuum by promoting the medical home approach to care. Partner and collaborate with various stakeholders to integrate the medical home approach across all population health domains. Provide education and outreach on the importance of medical home to DHSS programs, subcontractors, and partners that serve families with children in the household. Build program and policy evaluation capacity.	By 2025, increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home from 50.0% (NSCH 2017-2018) to 51.0%.	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	ESM 11.1: Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
Cross-Cutting/Systems Building					
Address Social Determinants of Health	Ensure culturally and linguistically appropriate resources, education, and care are available for all women of childbearing age, mothers, children, and adolescents, including children and youth with special health care needs, and their families.	Increase the number of DCPH staff and contracted partners working with maternal and child populations who complete core	SPM 3: Number of DCPH staff and contracted partners working with maternal and child		

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Inequities.	Promote breastfeeding in a culturally appropriate manner. Educate DHSS Title V partners on the medical home approach and definition of children and youth with special health care needs. Encourage and employ person-centered approaches to Title V programming. Operationalize core MCH values, establish a standard level of training on the MCH Leadership Competencies, and create a plan to implement training to all Title V funded partners. Build program and policy evaluation capacity.	MCH, Health Equity, and Racial Justice trainings from 0% to 65%.	populations who complete core MCH, Health Equity, and Racial Justice trainings.		