Missouri State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.	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.	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 drivers of health. Build program and policy evaluation capacity.	ESM WWV.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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					NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
	By September 30, 2025, Missouri will increase the percent of women who attended a postpartum checkup within 12 weeks after giving birth from 89.3% to 90.3% (Pregnancy Risk Assessment Monitoring System (PRAMS) 2022). By September 30, 2025, Missouri will increase the percent of women who attended a postpartum checkup and received recommended care components from 79.7% to 80.7% (Pregnancy Risk Assessment Monitoring System (PRAMS) 2022).	Implement community-based health promotion efforts. Expand the use of quality improvement efforts to eliminate preventable postpartum morbidity and mortality and assure equitable outcomes. Advance policies that support postpartum care as an ongoing process, rather than an isolated visit, and operationalize whole-person postpartum care. Support activities and facilitate partnerships to create environments that support optimal postpartum health. Participate in perinatal/postpartum health partnerships by convening public health and advocacy partners for strategic thinking and action, engaging clinicians as partners, and engaging collaboratives to address postpartum health disparities and improve maternal health during the postpartum period. Address underlying social drivers of health that are barriers to optimal postpartum care.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Promote safe sleep practices among newborns to reduce sleep-related infant deaths.	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%.	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.	ESM SS.1 - At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment.	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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		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.		during sleep (Safe Sleep) - SS	
Child Health					
Reduce obesity among children and adolescents.	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%.	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.	ESM PA-Child.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.	NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Enhance access to oral health care services for children.	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%.	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.		SPM 1: Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.	

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		Build program and policy evaluation capacity.			
Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.	By September 30, 2025, Missouri will increase the percent of children without special health care needs, ages 0 through 17, who have a medical home from 49.2% to 50.2% (NSCH 2022).	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 diverse stakeholders to integrate the medical home approach and promote care coordination and community referrals to facilitate the linkage of children and their families with appropriate services and resources. Provide education and outreach on the importance of medical home to DHSS programs, subcontractors, and partners that serve families with children in the household. Promote effective partnerships between families and integrated clinical-community health care teams to enhance equitable access to a medical home for vulnerable populations.	ESM MH.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Reduce intentional and unintentional injuries among children and adolescents.	By 2025, decrease the rate of hospital admissions for non-fatal injury among adolescents, ages 10 through 19 from 250.2 per 100,000 (PAS 2018) to 247.7 per 100,000.	Ensure health care providers have access to tools and best practices regarding injury prevention and are trained to use the tools in an evidence-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.	ESM IH-Adolescent.1 - Percentage of high school students who reported distracted driving.	NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - Adolescent, Formerly NPM 7.2) - IH-Adolescent	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19,

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		Educate partners regarding existing community resources for referrals or collaboration to support injury reduction and promote injury prevention. Build program and policy evaluation capacity.			per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Promote Protective Factors for Youth and Families.	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.	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 strategies and programs. Strengthen collaboration across agencies, develop new tools and capacity, and implement evidence-based change in suicide and self-harm prevention strategies.		SPM 2: Suicide and self-harm rate among youth ages 10 through 19	

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		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.	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%.	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. Promote effective partnerships between families and integrated clinical-community health care teams to enhance equitable access to a medical home for vulnerable populations.	ESM MH.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Cross-Cutting/Systems Building					
Address Social Determinants of Health Inequities.	Increase the number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial	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.		SPM 3: Number of DCPH staff and contracted partners working with maternal and child populations who complete	

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	Justice trainings from 0% to 65%.	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.		core MCH, Health Equity, and Racial Justice trainings.	