Mississippi State Action Plan Table 2026 Application/2024 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 Maternal Health Outcomes	Objective: By September 30, 2030, 80% of postpartum mothers participating in a case management / home visiting program received a postpartum visit with a healthcare provider within 84 days of delivery.	Strategy: Home visiting/case management programs will develop and improve relationships with internal and external partners to increase referral and enrollments to the program.	ESM PPV.1 - Percent of mothers enrolled in home visiting programs who received a postpartum visit with a healthcare providers within 84 days of delivery.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Improve Maternal Health Outcomes	Objective: By September 30, 2030, increase the number of pregnant and postpartum women receiving education about importance of oral health care during pregnancy and postpartum period by 2% annually (baseline 3686).	Strategy: Provide oral health education and distribute dental toolkits to women within WIC programs and community events.	ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education through the collaborative with WIC	NPM - Preventive Dental Visit - Pregnancy	**Linked NOMs:** Women's Health Status Children's Health Status
Improve Maternal Health Outcomes	By September 30, 2030, increase the number of female family planning users, ages 13 to 44, within MSDH clinics by 5% (from 13,457 to 14,129). By September 30, 2030, increase the number of female Family Planning Waiver beneficiaries receiving family planning services within MSDH clinics by 5% (from 3,475 to 3,648).	Strategy: Increase access to subsidized or low-cost contraception methods to ensure greater utilization and uptake during the preconception and interconception periods.	ESM CU.1 - Percent of females seen in the MSDH county health departments for family planning services who are screened for and accept the Family Planning Waiver.	NPM - Postpartum Contraception Use	**Linked NOMs:** Severe Maternal Morbidity Maternal Mortality Low Birth Weight Preterm Birth Infant Mortality Neonatal Abstinence Syndrome
Improve Maternal	By September 30, 2030, 80% of pregnant and postpartum women	Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward	ESM MHS.1 - Percent of pregnant	NPM - Postpartum Mental Health Screening	**Linked NOMs:** Maternal Mortality

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Health Outcomes	participating in case management / home visiting programs are referred for services following a positive screening for depression. By September 30, 2030, 80% of pregnant and postpartum women participating in case management / home visiting programs are referred for services following a positive screening for substance use disorder.	improving maternal mortality based on MMRC recommendations.	and postpartum women screened positive for depression and are referred for appropriate follow-up care and support. ESM MHS.2 - Percent of pregnant and postpartum women screened for substance use disorder who receive appropriate follow-up care and support.		Infant Mortality SUID Mortality Neonatal Abstinence Syndrome Child Injury Hospitalization Women's Health Status Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Reduce Infant Mortality	By September 30, 2030, implement three or more recommendations that are provided from the Child Death Review and FIMRs across the state directed towards reducing infant deaths.	Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward improving infant mortality based on FIMR and Child Death Review recommendations. (Risk-Appropriate Perinatal Care)	ESM RAC.1 - Number of Child Death Review and Fetal Infant Mortality Review recommendations implemented annually (Risk Appropriate Perinatal Care)	NPM - Risk-Appropriate Perinatal Care	**Linked NOMs:** Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality
Reduce Infant Mortality	By September 30, 2030, implement three or more recommendations that are provided from the Child Death Review and FIMRs across the state directed towards reducing infant deaths.	Strategy: Work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward improving infant mortality based on FIMR and Child Death Review recommendations.(Breastfeeding)	***Inactive -*** *ESM BF.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals* ESM BF.2 - Number of Child Death Review and Fetal Infant Mortality Review recommendations	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality

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			implemented annually (Breastfeeding)		
Reduce Infant Mortality	By September 30, 2030, distribute 500 cribs to infants in need through MSDH and Title V MCH-serving programs.	Strategy: Provide safe sleep education and distribute cribs to individuals in need through MCH-serving programs and community events.	***Inactive -*** *ESM SS.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals* ESM SS.2 - Number of cribs distributed to participants of MCH-serving programs	NPM - Safe Sleep	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality
Child Health					
Increase access to timely, health, developmental, behavioral health screenings	By September 30, 2030, increase the number of EPSDT screenings performed among children 0-36 months old in CHDs annually by 5%. (Baseline: 353)	Strategy: Promote education and awareness timely health, developmental, and behavioral screenings, and EPSDT visits for children ages 0 to 17.	***Inactive -*** *ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care* ESM MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and insurance access. ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			old in county health department clinics annually.		
Increase access to timely, health, developmental, behavioral health screenings	Increase the referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses by 2% annually. (baseline to target)	Strategy: Provide professional development opportunities for healthcare professionals and providers to educate on best practices regarding developmental screenings.	***Inactive -*** *ESM PDV-Child.1 - Number of children 0-3 years who had a preventive dental visit with referred dentist* ***Inactive -*** *ESM PDV-Child.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurse* ***Inactive -*** *ESM PDV-Child.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting* ESM PDV-Child.4 - Number of referrals for dental care among children 0-6 years of age who received an EPSDT screening involving Oral Health by MSDH nurses.	NPM - Preventive Dental Visit - Child	**Linked NOMs:** Tooth decay or cavities Children's Health Status CSHCN Systems of Care
Increase access to timely, health, developmental, behavioral health screenings	By September 30, 2023, increase the number of newborns receiving timely screening and timely referrals by 3%.	Strategy: Strengthen collaborative efforts for timely newborn screenings and referrals with internal and external partners through strategic planning and implementation.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 11: Percent of Mississippi newborns screened (Newborn Screening program)	
Increase	By September 30, 2030, to	Strategy: Maintain and enhance coordinated infrastructure and	No ESMs were	SPM 6: Percentage of	

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access to timely, health, developmental, behavioral health screenings	increase referrals of individuals with sickle cell trait and/ or disease from the Genetic Newborn Screening program to the Lead Poisoning Prevention Program by 2% (from BASELINE TBD to TARGET TBD).	partnerships between Lead Poisoning Prevention and Healthy Homes and Genetic Newborn Screening programs for referrals.	created by the State. ESMs are optional for this measure.	individuals who have been identified as having sickle cell trait and/ or disease by the Genetic program who were referred to the Lead poisoning prevention program	
Increase access to timely, health, developmental, behavioral health screenings	By September 30, 2030, the percent of First Steps Early Intervention Program (FSIEP) referrals who get an Individualized Family Service Plan (IFSP) will increase by 5%	Strategy: Maintain and enhance infrastructure to increase referrals where an Individualized Family Service Plan is obtained.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 7: Percentage of First Step Early Intervention Program referrals who get an Individualized Family Service Plan	
Increase access to timely, health, developmental, behavioral health screenings	By September 30, 2030, EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% (from BASELINE TBD to TARGET TBD) (for screened (passed and not passed) before 6 months of age.)	Strategy: Maintain and enhance coordinated infrastructure and partnerships with health care providers to conduct follow-up with families for referral, training, and information sharing to meet 1-3-6 recommendations and reduce LTF/D.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 8: Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for screened (passed and not passed) before 6 months of age.	
Increase access to timely, health, developmental, behavioral health screenings	By September 30, 2030, EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% (from BASELINE TBD to TARGET TBD) (for diagnosis with permanent hearing loss: before 3 months of age.)	Strategy: Maintain and enhance coordinated infrastructure and partnerships with health care providers to conduct follow-up with families for referral, training, and information sharing to meet 1-3-6 recommendations and reduce LTF/D.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 9: Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for diagnosis with permanent hearing loss: before 3 months of age.	
Increase access to timely, health, developmental, behavioral health screenings	By September 30, 2030, EHDI-MS will increase the percent of babies who meet the 1-3-6 recommendations by 1% (from BASELINE TBD to TARGET TBD) (for babies referred to Part C EI: before 6 months of age.)	Strategy: Maintain and enhance coordinated infrastructure and partnerships with health care providers to conduct follow-up with families for referral, training, and information sharing to meet 1-3-6 recommendations and reduce LTF/D.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 10: Percentage of babies in the EHDI program who meet the 1-3-6 recommendations for babies referred to Part C EI: before 6 months of age	
Increase	By September 30, 2023, increase	Strengthen collaborative efforts for timely newborn screenings and	No ESMs were	SPM 12: Percent of	

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access to timely, health, developmental, behavioral health screenings	the number of newborns receiving timely screening and timely referrals by 3%	referrals with internal and external partners through strategic planning and implementation.	created by the State. ESMs are optional for this measure.	Mississippi newborns who received a newborn screening during 24-48 hours after birth. (Newborn Screening Program)	
Increase access to timely, health, developmental, behavioral health screenings	By September 30, 2023, increase the number of newborns receiving timely screening and timely referrals by 3%.	Strengthen collaborative efforts for timely newborn screenings and referrals with internal and external partners through strategic planning and implementation.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 13: Percent of Mississippi newborns who received a newborn screening during 24-48 hours after birth with an abnormal result. (Newborn Screening)	
Adolescent Health					
Improve Adolescent Health	By September 30, 2030, increase access to timely, health, developmental, and behavioral health screenings performed among 13–20-year-olds in CHDs annually by 5%. (Baseline: 102)	Strategy: Provide training and professional development to adolescents, school staff, partners, and providers to educate on adolescent health factors.	***Inactive -*** *ESM AWV.1 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling to adolescents, ages 12-17 years* ESM AWV.2 - Percentage of adolescents ages 13-17 who received all recommended doses of the human papillomavirus (HPV) vaccine ESM AWV.3 - Percent of adolescents, ages	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			12-17, with an EPSDT medical visit and screening in the MSDH county Health Departments		
Improve Adolescent Health	By September 30, 2030, reduce youth suicide attempts by 5% (baseline to target) By September 30, 2030, increase youth access to mental health resources by 5% (from BASELINE TBD to TARGET TBD).	Strategy: Launch a Youth Mental Health Awareness campaign focused on mental health care.	ESM MHT.1 - Number of presentations surrounding suicide awareness for youths ESM MHT.2 - Percent of community partners in a collaboration addressing youth mental health care and suicide prevention awareness.	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
Ensure a medial homes for CYSHCN	By September 30, 2030, the percentage of CYSHCN who receive care coordination services will increase by 5%	Strategy: Implement standardized population-based strategies to improve care coordination services for children with special health care needs.	***Inactive -*** *ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care* ESM MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding how to navigate a comprehensive system of care for medical and	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			insurance access. ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months old in county health department clinics annually. ESM MH_CC.1 - Percent of CYSHCN referrals who accept enrollment into CYSHCN care coordination program		
Ensure a medial homes for CYSHCN	By September 30, 2030, the percentage of participating CYSHCN partnering healthcare systems with policies regarding transitioning youth with special health care needs to an adult provider will increase by 10%	Strategy: Implement standardized population-based strategies to improve care coordination services for youth transitioning towards adult medical services	ESM TAHC.1 - Percent of MSDH and external health care professionals/ providers who attend educational opportunities regarding health care transition for CYSHCN.	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care
Ensure a medial homes for CYSHCN	By September 30, 2030, the percentage of Parent Consultants and care coordinators, of a child with special health care needs who can help parents and caregivers navigate a comprehensive system of care (for medical and insurance access), hired by systems participating in the CYSHCN partnership will increase by 10%.	Strategy: Increase the number of Parent Consultants and Care Coordinators involved in programs addressing the needs of children and Youth with special health care needs.	***Inactive -*** *ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered care* ESM MH.2 - Percent of CYSHCN Parent Consultants and Care Coordinators who attend an educational opportunity regarding	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			how to navigate a comprehensive system of care for medical and insurance access. ESM MH.3 - Percent of EPSDT screenings performed among children 0-36 months old in county health department clinics annually. ESM MH_CC.1 - Percent of CYSHCN referrals who accept enrollment into CYSHCN care coordination program		
Cross-Cutting/Systems Building					
Increase access to timely, health, developmental, behavioral health screenings	By September 30, 2030, increase the number of referrals for social conditions affecting maternal, infants, children, adolescents and CYSHCN by 5%. (from BASELINE TBD to TARGET TBD).	Strategy: Build a responsive infrastructure and workforce to address a range of health-related and social conditions affecting the needs of women, infants, children, adolescents, and CYSHCN identified through developmental and other screening.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 4: The total number of referrals for social conditions affecting the health of patients being served by the MSDH county health department clinics	
Maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment	By September 30, 2030, completed the published reports 100% per their assigned periodicity.	Strategy: Title V will maintain and expand state MCH data capacity to include increasing data collaborations, ongoing needs assessment activities, and program evaluations.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 5: Percentage of MSDH MCH-Serving programs that have administered a patient satisfaction survey in the past year to engage the community in program improvement	

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activities, and program evaluations					
Improve Access to and Utilization of MCH-serving programs and activities available through MSDH	By September 30, 2030, increase the percent of referrals MCH-serving programs receive using the on-line Universal Referral form by 20% (from BASELINE TBD to TARGET TBD). (4% annually)	Strategy: Title V will strengthen the relationships with internal and external partners and the community to increase referral to MCH-serving program.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: Number of social media messages focused on MCH-serving programs per year	
Improve Access to and Utilization of MCH-serving programs and activities available through MSDH	By September 30, 2030, increase the percent of referrals MCH-serving programs receive using the on-line Universal Referral form by 20% (from BASELINE TBD to TARGET TBD). (4% annually)	Strategy: Title V will strengthen the relationships with internal and external partners and the community to increase referral to MCH-serving program.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Number of community-based activities attended where MSDH staff focused on educating external partners and community members about the MSDH MCH program electronic Universal Referral Form	
Improve Access to and Utilization of MCH-serving programs and activities available through MSDH	By September 30, 2030, increase the percent of referrals MCH-serving programs receive using the on-line Universal Referral form by 20% (from BASELINE TBD to TARGET TBD). (4% annually)	Strategy: Title V will strengthen the relationships with internal and external partners and the community to increase referral to MCH-serving program.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Percentage of referrals received by MSDH MCH-serving programs that are on the on-line Universal Referral Form.	