Mississippi 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 Access to Care	By September 30, 2025, increase the number of family planning users within MSDH clinics by 5% (from 20,839 to 21,880). By September 30, 2025, increase the number of Family Planning Waiver beneficiaries receiving family planning services within MSDH clinics by 5% (from 4,254 to 4,467). By September 30, 2025, increase the number of women enrolled in the MS Breast and Cervical Cancer Program by 10% (from 3,548 to 3,903). By September 30, 2025, 90% of enrolled women, actively participating in a home visiting/case management program will be screened for pregnancy intention and provided interconception care education and support to access services as needed By September 30, 2025, increase the number of pregnant/postpartum women participating in a case	MCH-serving/supported programs will collaborate with internal and external partners to develop promotional strategies to increase family planning users MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving women's/maternal health Home visiting/case management programs will develop and improve relationships with internal and external partners to increase referrals to the program MCH programs will collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of women's/maternal health issues MCH-serving/supported programs will work with internal and external partners to provide information and linkages to services to promote tobacco cessation among pregnant parents	***Inactive -*** *ESM WWV.1 - Number of community group and activities program attends and partners with* ***Inactive -*** *ESM WWV.2 - Number of engaged users viewing social media messages delivered by MSDH social sites promoting women's preventive health services* ***Inactive -*** *ESM WWV.3 - Number of social media message months promoting women's preventive health services* ***Inactive -*** *ESM WWV.4 - Number of strategies or measures for racial equity related policy, practices and systems changes implemented*	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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	management/home visiting program by 30% (from 923 to 1,200). By September 30, 2025, increase the number of outside MSDH referrals for the case management/home visiting program by 20% (from 1,867 to 2,240). By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to women's health via media, social media, and other public-facing platforms.		*at the program, division and department level.* ESM WWV.5 - Promote the use of the Mississippi Quitline and Baby and Me Tobacco Free to assist women in quitting smoking during pregnancy		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
Reduce Maternal Morbidity and Mortality	By September 30, 2025, produce the annual Maternal Mortality Report inclusive of 2017-2021 maternal deaths to include recommendations for preventing maternal deaths By September 30, 2025, increase the number of birthing hospitals and other health systems implementing one or more AIMS Safety Bundles by 10% (from 41 to 46). By September 30, 2025, 10 pregnant women will have been referred to a home visiting/case management program to support syphilis treatment before delivery By September 30, 2025, participate in at least 18 community outreach events to address maternal mortality disparities and promote Maternal Mortality Review Committee recommendations	Provide administrative support and coordination with other MSDH Offices, health facilities, state agencies, et al. for the maternal mortality review case abstraction, exploration, and determination process for all maternal deaths through the Maternal Mortality Review Committee Provide and/or partner with other stakeholders to offer educational opportunities and evidence-based trainings to birthing hospitals and other systems on strategies to reduce severe maternal mortality and morbidity MCH-serving/supported programs will work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward reducing maternal mortality based on MMRC recommendations Lead the promotion of health observances, and other outreach/engagement strategies to increase public awareness of maternal health issues		SPM 16: Nulliparous, term singleton, vertex (NTSV) cesarean rate	
Reduce Maternal Morbidity and Mortality	By September 30, 2025, participate in at least 18 community outreach events to address maternal mortality disparities and promote Maternal Mortality Review Committee recommendations.	MCH-serving/supported programs will work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward reducing maternal mortality based on MMRC recommendations Lead the promotion of health observances, and other outreach/engagement strategies to increase public awareness of maternal health issues		SPM 10: Percent of severe maternal morbidity events related to hypertension	
Reduce Maternal Morbidity and Mortality	By September 30, 2025, increase the number of postpartum women participating in a case management/home visiting	MCH-serving/supported programs will work with internal and external partners (including consumers) to identify opportunities for collaboration in providing services geared toward reducing maternal mortality based on MMRC recommendations	No ESMs were created by the State. ESMs were optional for this measure in the	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026

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	program who attend a postpartum checkup within 12 weeks and receive recommended care components by 5%.		2025 application/2023 annual report.	(Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	application/2024 annual report.
Improve Oral Health	By September 30, 2025, increase the percentage of women who have a preventive dental visit in pregnancy by 10%	Provide education to women on the safety and importance of proper oral health during pregnancy and postpartum	ESM PDV-Pregnancy.1 - Number of pregnant and postpartum women who received oral health education ***Inactive -*** *ESM PDV-Pregnancy.2 - Number of WIC sites where oral health education is given to program participants by ROHCs* ***Inactive -*** *ESM PDV-Pregnancy.3 - Number of pregnant women who saw the dentist post referral*	NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC 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 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Perinatal/Infant Health					
Improve Access to Family-Centered Care	By September 30, 2025, increase the number of infants participating in a case management/home visiting program by 30% (from 533 to 693) By September 30, 2025, increase the number of outside MSDH referrals for the case	MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving perinatal/infant health. Home visiting/case management programs will develop and improve relationships with internal and external partners to increase referrals to the program MCH programs will collaborate on health promotion activities, health		SPM 17: Percent of women, ages 18 through 44, on Medicaid with a preventive medical visit in the past year	

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	management/home visiting program by 20% (from 1,867 to 2,240) By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to perinatal/infant health via media, social media, and other public-facing platforms.	observances, and other outreach/engagement strategies to increase awareness of perinatal/infant health issues			
Reduce Infant Mortality	By September 30, 2025, produce the annual Child Death Review Report to include recommendations for preventing infant deaths By September 30, 2025, participate in at least 18 community outreach events to address infant mortality disparities and promote Child Death Review and FIMR Committee recommendations By September 30, 2025, expand the FIMR program to all 9 public health districts of Mississippi By September 30, 2024, add informant interviewing of family members/next-of-kin to the Child Death Review and FIMR case exploration processes	Provide the administrative support for the death case abstraction, exploration, and determination process to fidelity for all maternal deaths through the Child Death Review Panel and FIMR MCH-serving/supported programs will work with internal and external partners to identify opportunities for collaboration in providing services geared toward improving infant mortality based on CDR and FIMR recommendations	ESM SS.1 - Number of safe sleep educational books and resources distributed to families in all birthing hospitals	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 during sleep (Safe Sleep) - SS	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
Increase Breastfeeding, Healthy Nutrition and Healthy Weight	By September 30, 2025, increase enrollment and participation in the WIC Program by 5% via partnerships and evidence-based initiatives	Partner with other MCH-serving program on community innovation project activities		SPM 12: Percent of women who are enrolled in WIC and initiate breastfeeding	

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Increase Breastfeeding, Healthy Nutrition and Healthy Weight	By September 30, 2025, increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support	Increase breastfeeding initiation and duration rates through prenatal breastfeeding education, during delivery admission, and post discharge support Assist in the creation and maintenance of Mississippi MILC Leagues across the state of Mississippi	ESM BF.1 - Number of hospitals certified as Baby Friendly to increase the percent of births occurring in Baby Friendly hospitals	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	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
Child Health					
Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings	By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually Objective: By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation Objective: By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results By September 30, 2025, increase	Develop a comprehensive, coordinated and integrated system of services for children Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues	***Inactive -*** *ESM DS.1 - The number of participants who received training about Bright Futures Guidelines for Infants, Children, and Adolescents.* ESM DS.2 - Number of health professionals and parents / families who receive training on developmental screening and/or monitoring	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	screening rates in low-resource areas of the state By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings	Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings			
Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings	By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results	Develop a comprehensive, coordinated and integrated system of services for children Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners Collaborate on health promotion activities, health observances, and other		SPM 14: Number of children ages 9-35 months of age who receive developmental screening using a parent completed tool during an EPSDT visit	

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	By September 30, 2025, increase screening rates in low-resource areas of the state By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings.	outreach/engagement strategies to increase awareness of child health issues Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings			
Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings	By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation By September 30, 2025, increase the knowledge of health	Develop a comprehensive, coordinated and integrated system of services for children Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners		SPM 13: Percent of infants with a hearing loss who received confirmation of hearing status by 3 months of age	

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	professionals on collecting and submitting screening results By September 30, 2025, increase screening rates in low-resource areas of the state By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings	Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings			
Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings	By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss By September 30, 2025, increase the number of children with timely screening and diagnosis/confirmation	Develop a comprehensive, coordinated and integrated system of services for children Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening Analyze screening data to identify low-resource areas with gaps to be		SPM 15: Percent of newborns and infants diagnosed with a genetic or metabolic condition who were screened and referred for diagnosis timely	

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	By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results By September 30, 2025, increase screening rates in low-resource areas of the state By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings	addressed through program improvement or development and to support quality improvement efforts with internal and external partners Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings			
Increase Access to Timely, Appropriate, and Consistent Health and Developmental Screenings	By September 30, 2025, increase the number of children receiving developmental screenings by 1% annually By September 30, 2025, extend the early childhood hearing screening program for children between 6 and 36 months of age to increase identification of children with late onset hearing loss By September 30, 2025, increase the number of children with timely screening and	Develop a comprehensive, coordinated and integrated system of services for children Coordinate and collaborate with birthing hospitals, healthcare providers, interventionist, and specialists to conduct screening and ongoing monitoring to improve timely identification Develop and implement plans to increase coordination and integration with traditional and non-traditional early childhood partners to improve timely identification Provide professional development opportunities for healthcare professionals to learn about best practices and state requirements for screening, including bloodspot, CCHD, hearing, lead, and developmental screening		SPM 3: Percent of children on Medicaid who receive a blood lead screening test at age 12 and 24 months of age	

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	diagnosis/confirmation By September 30, 2025, increase the knowledge of health professionals on collecting and submitting screening results By September 30, 2025, increase screening rates in low-resource areas of the state By September 30, 2025, reduce the loss to follow-up and loss to documentation in screening programs By September 30, 2025, promote 15 or more health observances, activities, or educational campaigns related to child health via media, social media, and other public-facing platforms to promote timely, appropriate, and consistent health and developmental screenings	Analyze screening data to identify low-resource areas with gaps to be addressed through program improvement or development and to support quality improvement efforts with internal and external partners Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of child health issues Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners on timely, appropriate, and consistent health and developmental screenings			
Improve Access to Family-Centered Care	By September 30, 2025, increase the percentage of children enrolled into family-centered services in a medical home By September 30, 2025, increase the percentage of the children who demonstrate improvements in their growth, health, and development through participation in MCH child health programs providing early intervening services (i.e., service/care coordination and/or	Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners of MCH child health programs to improve timely referrals for early intervening services Implement interventions with families to promote the adoption of home- and community-based strategies to promote the health and development of their children (e.g., safe sleep, healthy homes, nutrition, and physical activity) Implement evidence-based approaches using family-centered practices to improve health and developmental outcomes for young children, including school readiness	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	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

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	home visiting programs) by 5% By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5% By September 30, 2025, increase the number of families of children who have access to peer-to-peer support and role models by 5%	Provide professional development opportunities for healthcare professionals to learn about family-centered care practices and medical homes Coordinate and collaborate with birthing hospitals, healthcare providers, interventionists, and specialists to implement family-centered care practices Increase knowledge and awareness among families on family-centered care practices			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
Improve Access to Family-Centered Care	By September 30, 2025, increase the percentage of children enrolled into family-centered services in a medical home By September 30, 2025, increase the percentage of the children who demonstrate improvements in their growth, health, and development through participation in MCH child health programs providing early intervening services (i.e., service/care coordination and/or home visiting programs) by 5% By September 30, 2025, increase the percentage of families who report child health programs help them help their children by 5% By September 30, 2025, increase the number of families of children who have access to peer-to-peer support and role models by 5%	Increase knowledge and awareness among the public, public health professionals, healthcare providers, and other child health partners of MCH child health programs to improve timely referrals for early intervening services Implement interventions with families to promote the adoption of home- and community-based strategies to promote the health and development of their children (e.g., safe sleep, healthy homes, nutrition, and physical activity) Implement evidence-based approaches using family-centered practices to improve health and developmental outcomes for young children, including school readiness Provide professional development opportunities for healthcare professionals to learn about family-centered care practices and medical homes Coordinate and collaborate with birthing hospitals, healthcare providers, interventionists, and specialists to implement family-centered care practices Increase knowledge and awareness among families on family-centered care practices		SPM 21: Percent of children with and without special healthcare needs who have a medical home	
Improve Oral Health	By September 30, 2025, increase the percent of children with a preventive dental visit by 1%	Promote the delivery of preventive oral health care for children and adolescents enrolled in Medicaid by oral health professionals and nondental providers	ESM PDV-Child.1 - Number of children 0-3 years who had a	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth

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	annually.	Support trainings of medical providers, including doctors, nurse practitioners, and physician assistants, on oral health assessments and use of fluoride varnish in the primary care setting Work with internal and external partners to identify barriers and solutions to access and utilization of preventive dental services	preventive dental visit with referred dentist ESM PDV-Child.2 - Number of referrals of children 0-3 years for a preventive dental visit by MSDH nurses ESM PDV-Child.3 - Number of trainings completed by medical providers on use of fluoride varnish in the primary care setting	in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	decay or cavities, Formerly NOM 14) - TDC 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 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Increase Breastfeeding, Healthy Nutrition and Healthy Weight	By September 30, 2025, decrease the percentage of children, ages 2-5 years, who receive WIC services and have a BMI at or above the 85th percentile	Increase breastfeeding initiation and duration rates through prenatal breastfeeding education and post discharge support to reduce childhood obesity Implement evidence-based practices to decrease obesity in early childhood		SPM 11: Percent of children, ages 2-5 years, who have a BMI at or above the 85th percentile	
Adolescent Health					
Improve Access to Care	By September 30, 2025, increase percentage of youth who complete an annual EPSDT visit By September 30, 2025, increase HPV vaccination rate among youth 9-13 years and 14-17 years	Provide professional development opportunities for healthcare professionals to learn about best practices in teen-friendly care Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase awareness of adolescent health issues and preventative care and the importance of medical homes Educate transitioning youths and their families about accessing adult care, healthcare coverage options, health literacy, and self-advocacy	***Inactive -*** *ESM AWV.1 - Number of clinic sites engaged in youth-centered care quality improvement cycles.* ESM AWV.2 - Number of MSDH county health departments who provide integrated health services, including family planning, HIV/STI services, cancer	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	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, 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

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			screening, and sexual health counseling to adolescents, ages 12-17 years		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 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Increase Breastfeeding, Healthy Nutrition and Healthy Weight	By September 30, 2025, increase the percent of adolescents, ages 12-17 years who are physically active at least 60 minutes per day	Develop partnerships and work with internal and external partners and schools to complete the School Health Index (SHI) Self-Assessment and Planning Guide Collaborate on health promotion activities, health observances, and other outreach/engagement strategies to increase daily physical activity among adolescents ages 12-17 Provide professional development opportunities for healthcare and education professionals to learn about best practices to promote daily physical activity among adolescents ages 12-17	ESM PA-Adolescent.1 - Percent of junior high schools and high schools that complete the School Health Index (SHI) Self-Assessment and Planning Guide	NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent	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
Children with Special Health Care Needs					
Assure Medical Homes for Children and Youth With/Without Special Health	By September 30, 2025, increase the percentage of CYSHCN who receive care coordination services by 10%	Ensure the delivery of high-quality care coordination services across the state through alignment of practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) in internal and partnering MCH programs, including in FQHCs and specialty clinics Provide education to CYSHCN and families on the importance of medical	ESM MH.1 - Number of providers receiving education or technical assistance about the need and importance of a medical home and/or family-centered	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

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Care Needs		homes, family-centered care, healthcare coverage options, and health literacy Work with internal and external partners to increase referrals to home visiting/care coordination programs	care		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
Assure Medical Homes for Children and Youth With/Without Special Health Care Needs	By September 30, 2025, increase the percentage of CYSHCN participating in home visiting/care coordination programs who have plans for transitioning to adult care in place by age 16 years	Ensure the delivery of high-quality care coordination services across the state through alignment of practices with the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) in internal and partnering MCH programs, including in FQHCs and specialty clinics Educate transitioning youths with special health care needs and their families on accessing adult care, healthcare coverage options, health literacy, and self-advocacy		SPM 18: Percent of children with and without special health care needs who received services necessary to make transitions to adult health care	
Cross-Cutting/Systems Building					
Improve Access to Mental Health Services Across MCH Populations	By September 30, 2025, reduce the percentage of suicide attempts among high school student by 1% By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities on mental health for MCH workforce, partners, and providers serving MCH populations	Promote, provide, sponsor, or facilitate education, training, and reflective supervision on mental health for MCH workforce, partners, and providers serving MCH populations Engage with Regional Department of Mental Health MAP Teams to coordinate home/community-based services for children and youth with mental health or behavioral disorders at risk of institutional placement Promote mental health awareness in children, youth, young adults, and families and linkages to resources to support positive mental/behavioral		SPM 19: Adolescent suicide rate	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		health			
Ensure Health Equity by Addressing Implicit Bias, Discrimination, and Racism	By September 30, 2025, establish partnerships or collaborations with at least 10 new MSDH program areas, providers, or external organizations and businesses to improve equitable access to services and care By September 30, 2025, communicate with health care professionals, service providers, and families to address diversity and inclusion across MCH programs By September 30, 2025, promote, provide, sponsor, or facilitate 3 or more education activities to support providers in delivering culturally and linguistically appropriate healthcare setting.	Ensure language access through interpretation for public meetings and service delivery and translation of program materials Partner and collaborate with internal and external partners, providers, organizations, and businesses across the state to improve equitable access to services and care Use language, images, graphics, and messaging that is both responsive to diversity and health literacy Conduct PDSA cycles to improve systems, programs, and outcomes to decrease health inequities Educate MCH workforce, partners, and providers on implicit bias, discrimination, racism, and implementing culturally and linguistically appropriate practices in healthcare settings.		SPM 20: Number of MCH programs that have developed a written plan to address health equity	