Maternal and Child Health Services
Title V Block Grant

State Narrative for MISSISSIPPI

Application for 2007
Annual Report for 2005

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The MDH has a copy of the Assurances and Certifications on file. If you wish to review this file, please contact Ulysses Conley by email (uconley@msdh.state.ms.us) or phone at (601) 576-7688.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

The Mississippi Department of Health (MDH) solicits public input by conducting public hearings strategically across the state to allow residents an opportunity to make comments or discuss concerns. Also, copies of the Block Grant Application are made available at each of the nine (9) public health district offices in the state to allow local citizens an opportunity to visit and view this document at their convenience. A copy of the 2007 Block Grant will also be placed on the agency's website (www.msdh.state.ms.us) to be viewed by citizens who have access to computers.

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

When the MDH conducts its five-year needs assessment, public input is also solicited in the form of consumer surveys, focus groups, and needs assessment conferences. Input is provided by professionals and consumers alike.

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

Mississippi is a predominately rural state with approximately three-quarters of the 2.8 million state residents living in non-metropolitan areas. On the south, it borders Louisiana and the Gulf of Mexico; its western border is the Mississippi River; to the north is Tennessee; and to the east is Alabama. Mississippi's 82 counties occupy 47,715 square miles. Although services are offered in high risk areas in Mississippi, the Mississippi Delta area is at greatest risk for disparities in services to occur. However, all of Mississippi's 82 counties are Designated Medically Underserved Areas.

The racial composition of Mississippi residents is mixed, with three fifths of the residents white and about two fifths black. Mississippi has the largest proportion (nearly 40 percent) of black residents among all the states. The Hispanic and non-citizen immigrant populations are small but growing, as Cubans and Central Americans have been brought in to work for the poultry, forestry, and construction industries in the state. According to 2000 U.S. Census data, Hispanics comprise 1.4% of the state's population. A substantial share of employment in Mississippi is agricultural work. Because national economic statistics do not adjust for the local cost of living, these statistics probably overstate the relative level of poverty in the state. According to the Kaiser Family Foundation's 2003-2004 State Health Facts, 32% of Mississippi's children aged 18 and under live at or below the federal poverty rate. Because of the high level of poverty, Mississippi faces challenges more severe than those of other states when it tries to craft policies to help low-income families. The state relies on a regressive tax system to generate revenues, with a high sales tax and a low income tax relative to national averages. It also relies heavily on federal funding sources to augment its budget.

Political power in Mississippi is distributed among a number of independent bodies. There is a sense of equitable, if not necessarily shared, influence over state functions between the Governor and the legislature. Much of this shared influence stems from the organization of state agencies, some of which fall under the Governor's purview and some of which are independent agencies. For example, the Mississippi Development Authority (MDA), the Division of Medicaid, and the Department of Human Services (DHS) are executive branch agencies, while the Mississippi Department of Health (MDH) is independent. Independent agencies are governed by boards whose members are appointed by the Governor. The Governor maintains indirect influence through these appointments, but independent agencies must deal more directly with the legislature in negotiating budgets and significant policy changes. With the mix of executive and independent agencies, state agency heads do not function together as a cabinet, a situation that results in a number of horizontal power bases within the state government structure. Thus, economic factors continue to influence the Title V delivery system.

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

The State Legislature created a Child Health Insurance Task Force in 1998 to develop a State Plan for the implementation of a State Child Health Insurance Program (SCHIP), which began providing coverage in late 1998 to children aged 15 through 18 years of age whose family income was between 33 percent and 100 percent of the federal poverty level (Phase I). A state plan to extend coverage to all children between 100 percent and 200 percent of the federal poverty level was approved by the Centers for Medicare and Medicaid Services (CMMS) in February 1999. The implementation of Phase II began in January, 2000. This new coverage for children continues the evolution of child health services. SCHIP outreach has resulted in an increase in the number of children enrolled in Medicaid, as well as a cumulative rise in SCHIP enrollment.

Over 50,000 children are now enrolled in SCHIP.

The 2005 immunization rate for two-year old children is one of the highest among the states at 87.6 percent, and is continually improving because of the development of a statewide immunization registry and outreach campaign. Other measures of child health and well-being are less encouraging. Compared with the nation as a whole, a greater percentage of children in Mississippi are born out of wedlock and live in one-parent families. According to the 2005 Kids Count data, Mississippi ranks 49th of the 50 states in births to females ages 15-17. However, Mississippi improved in 4 out of 10 measures that reflect child well-being between 2001 and 2006. Improvements were seen in child well-being in the following areas: infant mortality rate; teen birth by age group; percent of children living in families where no parent has full-time, year-round employment and; percent of children in poverty. According to this same source, Mississippi had the highest percentages of low birth-weight babies in 2003, the highest infant mortality and child death rates, and ranks number 46 in teen deaths by accidents, homicide, and suicide. Mississippi, overall, was ranked last among the states in a composite rating of 10 selected measures of child well-being. Thus, while the economic outlook for Mississippi has become more positive in recent years, the state still remains one of the poorest in the nation.

After Hurricane Katrina devastated the Mississippi Coast on August 29th, employment output and income in the state dropped sharply in September. Normal activity ground to a halt, as search and rescue, relief and clean-up operations dominated. The three coastal counties, which account for 14% of total state employment, were hit hardest by the storm, but property damage was severe as far north as Jackson and Meridian, and most of the state was without electricity in the aftermath of the storm.

With regards to public health in Mississippi, and according to information from the Medical Support/Demobilization/Transition Plan for the State of Mississippi, the intensity of Hurricane Katrina resulted in significant damage to the Mississippi Department of Health (MDH) infrastructure along the Mississippi Gulf Coast. The MDH Environmental Health Department at Biloxi was destroyed. The Hancock County Health Department, Jones County Health Department, and the Jackson County Health Department buildings suffered major damage. Tents and mobile clinics were used in these locations to provide storm related immunizations and represented the extent of public health clinical services. Many of the MDH staff in the lower six counties, along with Jones County, were personally affected by the storm and were on administrative leave until September 30, 2005. MDH staff from other areas of Mississippi were tasked to provide storm related immunizations and other functions in the many affected areas of Mississippi. The MDH, though Emergency Mutual Aid Compact (EMAC) requests, also rotated numerous teams into Mississippi to provide much needed relief due to the pace and scope of this event.

Evacuees from the affected area were placed in shelters, including a shelter cruise ship in Pascagoula, Mississippi (approximately 1,145 displaced persons and 56 FEMA staff were sheltered) and throughout Mississippi and surrounding States. Although 49 counties in Mississippi were affected, the most affected counties included George, Hancock, Harrison, Jackson, Jones, Pearl River, and Stone.

Unlike most disasters of this nature, Hurricane Katrina had a sustained response phase, which has significantly extended the short and long-term recovery phases. Utilities were disrupted, damaged, or destroyed within the affected areas. Electricity was restored to the majority of the affected areas but power generation within heavily damaged areas was minimal, with most of the power being purchased from a variety of external utilities companies. Large portions of Hancock County were without power.

The disruption and destruction of the water utilities generated widespread shortages and contamination. Most, if not all, of the water systems in the area have currently been cleared. Similar disruptions and destruction was also true of the sewage system which contributed to the

contamination of the water supply and a significant decline in sanitation.

An initial assessment completed by Information and Quality Healthcare (IQH) reported that the vast majority of physicians are reopening practices and planning to remain in the area. IQH, Mississippi Hospital Association, American Medical Response, and Gulfport Memorial Hospital worked to maintain a current list of area physician status, hospital status, pharmacy status, long term care facility status, and dentists' status. Many of these health care providers suffered significant personal loss and did not have adequate housing for themselves or their families. Thus, many providers and workers found themselves recruited by out-of-area hospitals and clinics, which contributed to a "talent drain" on the Mississippi Coast. Federal medical assets that were deployed in support of the response phase included the following:

1. Nevada State Health Division -- 100 bed facility providing special medical needs and primary care. (Federalized by DHHS)

   Organic medical assets to the Navy Seabee Base and Keesler Air Force Base.

   Two mobile dental facilities in Waveland, Ms and Gulfport, MS (Federalized by DHHS)

2. Mobil Medical Clinic serving the Hancock County Health Department (Federalized by DHHS)

3. DMORT (Disaster Mortuary Team) personnel with equipment providing training and technical assistance to local mortuary teams in support of assisting Mississippi with storm deaths

4. DHHS medical staffing to support ESF-6 Shelter ship in Mobile, AL. This shelter ship housed Mississippi evacuees and was docked at Pascagoula, Mississippi.

5. DHHS augmentation of staff for numerous shelters and clinics in affected area.

6. Nine Disaster Medical Assistance Teams (DMATs), seven DMAT Strike Teams; two Veterinarian Assistance Medical Teams (VAMTs); and one VAMT Strike Team.

Hurricane Katrina damage resulted in the destruction of 4 of the 5 bridges providing cross-county access to the area. In addition, Highway 90, an east to west coastal highway, was virtually destroyed and will take months to rebuild. The damage and destruction of highway infrastructure resulted in increased ambulance response times and the need for additional ground and air ambulance assets. Normal referral patterns for care and access to care issues were complicated by the lack of infrastructure.

The public health department's budget and capabilities were severely impacted due to its response to the devastation brought on by Hurricane Katrina. Many of its budgeted programs were significantly impacted due to financial constraints resulting from the hurricane response mission. Also, normal methods of communicating public health service messages were severely impacted. Most Mississippians in the affected area were unable to receive mass media messages. In response, the Mississippi Department of Health resorted to pamphlets and hand-mail distribution to support its health education mission. Some newspapers were not publishing and some television broadcast studios and transmission facilities were severely damaged. Many

television and radio stations have since restored their broadcasts.

Due to the widespread post-storm destruction and unemployment, many previously employed and health insured citizens were rendered indigent and had to seek public assistance such as Medicaid to obtain necessary medications and health services. Over 100,000 coastal residents applied for unemployment assistance. Over 20% of the customers of Mississippi Power in the three coastal counties were unable to accept power after electricity had been restored, and it is likely that a similar percentage of housing in that area was destroyed. Businesses were hit hard as well. Most casinos were destroyed, as were most small businesses hit by the storm surge, which was over 30 feet high in some areas. Many large businesses suffered staggering losses. In the agricultural sector, poultry and timber were two of several industries that were hard hit.

According to the "Mississippi Economic Review and Outlook" December 2005 report, employment figures show a 4.9% drop in payroll employment in Mississippi between August and September. Employment figures for the Coast, of course, are more dismal. Employment in the Gulfport-Biloxi Metropolitan Statistical Area (MSA) dived 26.5% in September, and in the Pascagoula MSA dived 16%. The two MSAs lost 39,400 jobs, representing 70% of the 56,000 jobs lost statewide. Overall, over 20% of jobs lost, both statewide and on the Coast, were in manufacturing jobs, although only 16% of employment is in manufacturing. Before the devastation brought on by Hurricane Katrina, Mississippi's economy was enjoying an upswing. Employment through August was up 1.2% compared to the first eight months of the previous year, and retail sales were running 4.8% ahead of figures for the previous year. State general fund collections for FY 2005, which ended June, were up 7.3% over FY 2004. The number of building permits issued was higher than in 2004, despite rising interest rates. Personal income in the second quarter had risen at an annualized rate of 6.8%, the 13th highest rate in the nation. However, less understood are the economic consequences of the damage brought on by Katrina, and in particular, its effect on the state budget.

Estimates of the total property damage in Mississippi are between $20 and $50 billion. Apart from the initial damage, some establishments located in the coastal counties are trying to operate, but employees are unable to get to work. Many have no place to live and have not returned to the area. These businesses are operating at less than full capacity. Other businesses have been forced to close their doors. The negative effects to the state, while difficult to quantify, are not difficult to see. There are, however, positive effects. Mississippi has seen an inflow of evacuees, emergency personnel and construction workers, all of whom are generating economic activity. Some Louisiana businesses have relocated all or part of their operations to Mississippi. Rebuilding efforts are already underway and this also generates economic activity. As the rebuilding efforts expand, the influx of reinvestment dollars will be tremendous. The historical pattern for an area recovering from a natural disaster is to experience an initial downturn in economic activity followed by an economic boom as the rebuilding phase gets underway.

With regard to the state's budget, there are two sides to be considered: revenues and expenditures. At this stage, very little is known about the expenditure side, but the revenue picture is a bit more foreseeable. Tax revenues generally follow the level of economic activity. This is particularly true for states such as Mississippi that are highly dependent upon sales and income taxes. In Mississippi, these two revenue sources account for 72% of the General fund.

B. Agency Capacity

The MDH is the state agency responsible for administering the Maternal and Child Health (MCH) Block Grant. MCH Block Grant funds are allocated in the central office to the Offices of Women's Health and Child and Adolescent Health. The Children's Medical Program (CMP), the program of services for Children With Special Health Care Needs (CSHCN), is located organizationally in the Office of Child and Adolescent Health. All are located organizationally within Health Services

(HS). (see organization chart at www.msdh.state.ms.us). These two HS Offices (Women's Health and Child and Adolescent Health) provide services for the three major populations targeted by the MCH Block Grant, which are women and infants, children and adolescents, and children with special health care needs.

The MDH operates a statewide network of local health departments and specialty clinics which serve the MCH population. Although the MDH provides services to all 82 counties, only 81 counties have county health departments. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

County level efforts are coordinated through nine public health districts. The District Chief Nurse oversees all public health nursing activities in the district and supervises the Maternal-Child Health/Family Planning Coordinator.

Children/Adolescent Health Services

Children's Medical Program

The Children's Medical Program (CMP) provides medical and surgical care to children with chronic or disabling conditions. Program services are available to state residents through 20 years of age. Conditions covered by the CMP include major orthopedic, neurological, and cardiac diagnoses, and chronic conditions such as cystic fibrosis, sickle cell anemia, and hemophilia. The program provides community-based specialty care through 19 clinics throughout the State, including a multi-disciplinary clinic centrally located in Jackson at the Blake Clinic for Children in the Jackson Medical Mall.

The CMP has a very strong link with the county health department system. This system is utilized to provide community based CMP application sites, screening and referral services, as well as a base of operations for central office staff when clinics are conducted at the community based level. The CMP has developed very effective lines of communication with the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis and Hemophilia parent and support groups, Division of Medicaid, the University of Mississippi Medical Center, and the Choctaw Indian Health Services to ensure that all support services are coordinated for the patients when and where appropriate.

The CMP utilizes the CMP Advisory Council to communicate with and receive feedback from health care providers and consumers. The Advisory Council includes specialty and sub-specialty physicians (pediatricians, pediatric orthopedic surgeons, pediatric cardiologists, etc.), dentists, physical therapists and other health care providers, and parents of CMP patients. Through this effort, providers are advised of program efforts such as the expanded effort to provide services to disabled children under sixteen years of age who receive SSI benefits under Title XVI, and the coordinated efforts to assist CMP patients in finding a medical home. CMP also receives input from the CMP Parent Advisory Committee composed of parents of CSHCN served by the program.

Genetic Services

The Genetics Services Program provides comprehensive services statewide for a broad range of genetic related disorders. Newborn screening is mandated by law and provides testing for PKU, hypothyrodism, galactosemia, and hemoglobinopathies. In March, 2002, congenital adrenal hyperplasia (CAD) was added. In June, 2003, newborn screening was again expanded to include

cystic fibrosis, biotinidase deficiency, medium-chain acyl-CoA dehydrogenase deficiency (MCAD) and 32 additional disorders detectable through tandem mass spectrometry. Mississippi now screens for a total of 40 genetic disorders and has one of the most comprehensive newborn screening programs in the nation. ***/2007/ The newborn screening program provided screening for over 99 percent of all newborns in the state during 2005. Also in 2005, there were 2,412 patient follow up visits made due to inadequate specimen collection, rejection of the specimen by the lab, and inconclusive test results. Follow up counseling, and referral for medical evaluation and treatment were provided by the program for 100 percent babies detected with a genetic disorder through the screening program. //2007//***

The Mississippi Department of Health added field staff in 2003, which created a Genetics Services team consisting of a nurse, social worker, and clerk in each of the nine public health districts. The genetics team works with county health department staff to assure adequate follow-up, case management, and continuity of care for genetic patients.

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

Early Intervention

First Steps Early Intervention Program (FSEIP) is Mississippi's early intervention system for infants and toddlers with special developmental needs and their families. The MDH is the lead agency that ensures an effective and appropriate implementation of IDEA, Part C. Other agencies such as the Mississippi Departments of Mental Health (MDMH), Education, and Human Services collaborate with the MDH and assist with the direct provision of early intervention services, referrals of potentially eligible infants and toddlers, and funding of the delivery of early intervention services.

First Steps is implemented through an interagency system of comprehensive developmental services for eligible infants and toddlers. The statewide system seeks to minimize the impact of a disabling condition on an infant or toddler and his or her family by identifying and utilizing, to the maximum extent possible, community based resources. The process of identification of an eligible infant to the provision of services and transition of the toddler into an appropriate educational setting is well orchestrated in keeping with the regulations of the Individuals with Disabilities Education Act (IDEA) Part C.

To be eligible for early intervention services through First Steps, a child must have a developmental delay of 25% or 1.5 standard deviations in any one developmental domain. Infants and toddlers with conditions known to cause developmental delays are automatically eligible for services. Additionally, a qualified provider through informed clinical opinion can establish eligibility for a child. Under IDEA's child find component, the identification, location, and evaluation of infants and toddlers birth to age 3 is a shared responsibility of the MDH under Part C and the Mississippi Department of Education (MDE) under Part B of the Act.

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

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

Early Hearing Detection and Intervention

Early Hearing Detection and Intervention in Mississippi (EHDI-M) functions as part of the First Steps Infant and Toddler Early Intervention Program for infants born with hearing loss. EHDI-M is the Mississippi Department of Health's designated program authorized to establish an early identification system. The EHDI-M implements a statewide family-centered comprehensive delivery system of developmentally appropriate services for infants and toddlers with hearing impairments, coordinated within the child's medical home. Universal newborn hearing screening is being implemented in all hospitals delivering more than 100 infants per year. Aggressive follow-up is provided for infants referred from hospital screens to ensure the completion of diagnostic processes and timely referrals into the early intervention system.

Oral Health

Weekly School Fluoride Mouth Rinse Program
/2007/ The School Fluoride Mouth Rinse Program is a voluntary program in which public elementary school children rinse weekly with 0.2 percent sodium fluoride solution, under the supervision of a teacher or school nurse. Eligible schools should be located in areas without water fluoridation and have fifty percent or more children who participate in free and reduced school lunch programs. During the 2003-2004 school year, about 20,000 children in 49 schools participated. During the 2005-2006 school year, over 32,000 children in 93 schools participated.

Community Water Fluoridation Program
Community water fluoridation remains the most cost effective, equitable and safe public health measure to prevent tooth decay. Prior to 2003, the proportion of Mississippi's population that received fluoridated water was 42%. Through a public/private partnership with the Bower Foundation to provide start-up funding to public water systems, Mississippi has 26 new public water fluoridation programs that serve over 150,000 people, increasing the proportion of population receiving fluoridated water to 50.5%. Funding from the Bower Foundation is expected to continue through FY 2008.

School-based Dental Sealant Program
In 2000, Public Health District III had ten percent sealant utilization, the lowest in the state. A school-based dental sealant program was initiated to provide preventive dental sealants to second grade children in public schools. From 2001-2003, over 3,700 dental sealants were placed. During the 2004-2005 school year, 32 schools and 1,863 children participated, with 6,532 dental sealants placed. 2005 MCH needs assessment data shows that District III continues to have the lowest sealant utilization (12%) followed by Public Health District IV (16%).

Oral Health Policy Task Force

In October 2001, Mississippi's Governor Musgrove hosted six states in Jackson for a third National Governors Association (NGA) Policy Academy on "Improving Oral Health Care for Children." The meeting focused on developing an action plan to address oral health care

needs in children and building alliances between the public and private sectors to implement the plan. The work done over the course of the Policy Academy meeting provided some vision for how policymakers should address poor oral health. For example, dental sealants were identified as a need during the Policy Academy, and as a result, the MDH developed a collaborative pilot project between the School of Dentistry at the University Medical Center and the Delta Hills Public Health District. The policy team also identified the need for a full-time Public Health Dentist in the state, and this position was created and filled in 2002.

In 2003, a Governor-appointed Oral Health Task Force (OHTF) was convened to develop a state oral health plan with strategies to improve oral health care. In 2005, the OHTF completed a five-year statewide oral health plan that was endorsed by Governor Haley Barbour.

The five-year statewide oral health plan proposes key actions in three primary public health areas: assessment, policy development, and assurance. Some examples of action steps include:

1) Assessment - Development of a statewide oral health surveillance system that contains a core set of measures that describe the status of oral health conditions to serve as benchmarks for assessing progress in achieving good oral health.

2) Policy Development -- Assure responsible leadership and oversight to address oral health problems by advancing legislation to mandate a state oral health program in Mississippi.

3) Assurance -- Develop a fluoride varnish program to work in conjunction with the existing dental sealant programs; target prevention activities at children 5 years of age and younger through programs such as Head Start. //2007//

Immunization Program

The purpose of the MDH Statewide Immunization Program is to improve the delivery of vaccination and other preventive services to infants, children and adolescents in Mississippi. The school- based immunization program makes immunizations available for sixth grade students not previously vaccinated with a booster dose of tetanus and diphtheria vaccine, a second dose of measles, mumps, rubella vaccine, the hepatitis B vaccine series and, if indicated, the varicella vaccine.

Abstinence Education Program

The purpose of the Mississippi Abstinence Education Program (MAEP) is to promote abstinence from sexual activity through education, mentoring, counseling, and adult supervision. Special emphasis is placed on adolescents 10 through 19 years of age who are most likely to experience untimely and unplanned pregnancies. MAEP funding through an Abstinence Education Grant under Section 510 in Title V of the Social Security Act is used to support community, school, and faith-based organizations in teaching social, psychological, and health benefits of abstaining from sexual activity outside of marriage.

State goals of the MAEP are: (1) to increase the number of middle school youth participating in an abstinence education program, and (2) to establish abstinence education programs among diverse racial and ethnic groups.

Organizations can receive financial support annually for a maximum of five years to provide

abstinence education. Initial applications are competitive. Continuation of funding is based on the program's performance, reporting, outcome evaluation, and availability of funds. Programs that have reached the five year funding threshold must wait for two years before reapplying for competitive funding through MAEP.

/2007/ Although the Mississippi Abstinence Education Program was officially removed from the MDH to the Mississippi Department of Human Services, the latest data collected by MDH revealed that a total of 21 abstinence education programs located in 15 counties throughout the state received financial support through MAEP during FY 2004. These programs enrolled over 21,000 youth and recorded approximately 113,937 encounters with these children. //2007//

In Mississippi, abstinence education programs have created a positive environment for youth development within communities by supporting adolescents in making healthy decisions to postpone sexual activity until marriage.

Health Promotion and Education

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

School Nurse Program

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

/2007/ Fifty-one (51) school districts have nurses that are supported by tobacco settlement dollars to reduce and prevent the use of tobacco products and other risky behaviors among youth. MDH provided oversight for this program from 1998 until recently. Due to a restructuring of funding resources, the Partnership for a Healthy Mississippi is now providing oversight. An additional twenty four (24) nurses are supported through the Bower Founation, a private funding resource, to conduct EPSDT in school-based health clinics. MDH works collaboratively with both organizations in order to benefit the health of all children. //2007//

Women's Health Services

The MDH Women's Health programs provide women with or assure access to comprehensive health services that affect positive outcomes, including early cancer detection, domestic violence prevention and intervention, family planning, and maternity services.

Breast and Cervical Cancer

The Breast and Cervical Cancer Early Detection Program works to reduce high morbidity and mortality caused by breast and cervical cancer in Mississippi. The target population for the program is uninsured, underinsured, and minority women. Women 50 to 64 years of age are the target group for mammography screening, and women 45 to 64 years are the target for cervical cancer screening.

Domestic Violence, Rape Prevention and Crisis Intervention

The MDH provides funding to 14 domestic violence shelter programs and nine Rape Crisis Center Programs. When requested, the MDH provides brochures, pamphlets and educational materials on a statewide basis.

Domestic violence shelters strive to meet the individual needs of every victim entering a shelter as a result of domestic violence. Program staff seeks to empower and enable through teaching life skills that promote non-violent responses which lead to a more peaceful life. Services include but are not limited to: temporary, safe housing; education regarding domestic violence; child care; transportation; job skills training; assistance in locating permanent housing; medical assistance; financial assistance; group and individual counseling; court advocacy; and transitional or second stage housing.

The rape crisis centers provide preventive services as well as direct crisis intervention services to victims of rape and other forms of sexual assault. Prevention services focus on education to decrease the number of sexual assaults that occur. Although it is the desired outcome, prevention is not always an option. Centers spend a great amount of time providing direct service to victims of sexual assault including: court advocacy; transportation; confidential counseling; family intervention and follow-up services.

/2007/ During FY 2005, a total of 1014 women and 1138 children received shelter services in Mississippi as a result of family violence. For Fiscal Year 2005, a total of 1358 sexual assault cases were reported to rape crisis centers in the State of Mississippi. //2007//

Family Planning

/2007/ The Family Planning Program promotes awareness and ensures access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives. More than 70,149 Mississippians received comprehensive family planning services in CY 2005, and approximately 20,002 of those were age 19 years or younger. //2007//

The target populations are sexually active teenagers and men and women ages 20-44 at or below 150 percent of poverty level. A fee system with a sliding scale is used. Under this scale, clients with an income at or below 100 percent poverty level are not charged for services. Reimbursement is sought for Medicaid eligible clients.

The family planning program provides:
1. Medical and non-medical counseling about methods of contraception,
2. Medical examination and provision of contraceptive method, and
3. Pregnancy testing and counseling

The family planning program also provides blood pressure screening, clinical breast exams, cervical cancer screening, follow-up of abnormal Pap smears and treatment, treatment for sexually transmitted diseases, preconception care, sterilization, and infertility services. Access to other MDH services such as WIC, immunizations, prenatal care, child health, and children's medical services is provided to family planning clients and their families as needed.

The Family Planning program demonstration waiver was requested from Medicaid in 1999, approved in December 2002, and implemented statewide in October 2003. The waiver was designed to increase the number of women served and the length of time services would be available to them. An evaluation of the program expanded the Family Planning baseline data by

examining inter-pregnancy intervals (IP) in the repeat birth population. In order to establish a comparison group for Family Planning, other MDH programs were included in the evaluation.

The Family Planning Waiver Program represents a collaborative effort between the Division of Medicaid and the Mississippi Department of Health to increase the availability of family planning services to all women of childbearing age (13-44) with incomes at or below 185% of the federal poverty level who would not otherwise qualify for Medicaid. Since the implementation of the Family Planning Waiver Program, approximately 46,386 clients statewide have been enrolled.

Maternity

MDH Maternity Services Program aims to reduce low-birth weight, infant and maternal mortality, and morbidity in Mississippi by providing comprehensive, risk-appropriate prenatal and postpartum care through county health departments.

During CY 2005, approximately 18 percent of the women who gave birth in Mississippi received their prenatal care in county health departments. Public health nurses, nurse practitioners, physicians, nutritionists, and social workers provide this cost-effective, comprehensive primary as well as preventive care. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a critical component of the maternity care effort.

A part-time, board-certified obstetrician/gynecologist continues to provide consultation statewide for the maternity and family planning programs. The public health team at the district and county level evaluates the maternity patient at each visit, using protocols which reflect national standards of care for maternity patients. Special emphasis is placed on the identification of high-risk factors and ensuring appropriate care to reduce or prevent problems. This includes arranging for delivery by an obstetrician at hospitals that provide the necessary specialized care for the mother and her baby.

Perinatal High Risk Management/Infant Services System

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) provides a multi-disciplinary team approach to high-risk mothers and infants. Targeted case management, combined with the team approach, establishes better treatment of the whole patient, improves the patient's access to available resources, provides for early detection of risk factors, allows for coordinated care, and decreases the incidence of low birthweight and preterm delivery. These enhanced services include nursing, nutrition, and social work. This team of professionals provides risk screening assessments, counseling, health education, home visiting, and monthly case management.

/2007/ Medicaid eligible postpartum women who were not eligible for traditional PHRM because they were not high risk, are eligible for postpartum PHRM due to their socio-economic status. In some districts, public health nurses visit postpartum women prior to their discharge from the hospital. In Fiscal Year 2005, the PHRM/ISS program provided services to 24,546 mothers and infants. //2007//

Perinatal Regionalization

Regionalization of perinatal services is an effective strategy for decreasing neonatal and infant mortality and morbidity, with pronounced effects on mortality among Very Low Birthweight (VLBW) infants (<1,500 grams). Perinatal regionalization is a system of care that involves obstetric and pediatric providers, hospitals, public health, and includes outreach education, consultation, transport services, and back-transport for graduates from the Neonatal Intensive Care Unit (NICU).

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

1. 40% of Very Low Birthweight infants born of Mississippi residents who delivered in-state were born in a level A hospital

2. As hospital levels decreased, mortality significantly increased (when controlling for <1,000 gram infants.) Exception: Large volume level B hospitals

3. Among infants <1,000 grams, mortality incrementally increased as the hospital level decreased

These findings were presented to the original steering committee associated with this study and to the Mississippi Perinatal Association. The MDH continues to work at developing a plan to address perinatal regionalization issues.

Closing the Gap on Infant Mortality: African American-Focused Risk Reduction

Closing the Gap is a three-year program funded by the Health Resources and Services Administration (HRSA) through the Bureau of Maternal and Child Health to accelerate the rate of change among African American populations to reduce significant disparity in infant mortality related to low birthweight, pretermaturity and sudden infant death syndrome (SIDS). A combination of medicinal, behavioral, educational, and service enhancement risk reduction interventions are being implemented in two target areas in Mississippi. These target areas include five counties in the Delta area (Bolivar, Coahoma, Leflore, Sunflower, and Washington); and three counties within the Jackson Metropolitan area (Hinds, Madison, and Rankin).

Considerable disparity exists between white and African-American infant mortality in Mississippi, which greatly affects the health of the state. Closing the Gap addresses this problem by maintaining three primary goals; (1) Decrease infant mortality related to low birthweight and preterm birth by implementing appropriate interventions in targeted regions; (2) Decrease infant mortality related to low birthweight and preterm birth by working to enhance the perinatal regionalization system, especially in targeted areas; and (3) Decrease infant mortality related to SIDS through enhanced African-Americans risk reduction education at both the community and professional levels in targeted communities.

Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is part of the Centers for Disease Control and Prevention (CDC) initiative to reduce infant mortality and low birthweight. It is an ongoing, population-based, state-specific source of information on selected maternal behaviors and experiences that occur before and during pregnancy and during a child's early infancy.

Since the start of data collection, PRAMS continues to successfully survey mothers throughout the state of Mississippi. PRAMS surveys approximately 176 mothers a month. ***/2007/ PRAMS received its first data batch for 2006 in March of this year. The state's response rate is required to be 70 percent of the total sample size as the epidemiologically valid threshold.***

All PRAMS reports and raw data for 2003 births have been submitted to CDC. Tabulation shows an overall response rate of 73%. The data analyses for 2003 data are complete.

Phase five (5) of the PRAMS survey began January 14, 2004 and will end December 2007. The mail and phone survey was revised and approved by CDC. PRAMS staff collaborated with the Dental and STD/HIV programs to ask state specific questions of concern to the survey. Also, the MDH's PRAMS staff submitted a poster presentation entitled "A Year in Review: Making the Program Work" at the Tenth Annual Maternal and Child Health Epidemiology Conference in Atlanta, Georgia.//2007//

Sudden Infant Death Syndrome (SIDS)

The purpose of the Mississippi Department of Health's Sudden Infant Death Syndrome (SIDS) program is to provide a statewide system for the identification of SIDS deaths, and to offer counseling and referral services as indicated for families with sudden unexplained infant deaths. The program also provides assistance in the campaign to educate the general public on SIDS risk reduction.

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

The Mississippi Department of Health partnered with different organizations, including the Mississippi SIDS Alliance and the Mississippi SIDS Coalition, to conduct outreach activities in 2005. ***/2007/ During CY 2004, SIDS remained the third leading cause of infant mortality in the state. Seventy-one infants died from SIDS in 2004.***

A SIDS database was develop in 2003 to effectively compile data on SIDS in Mississippi and to allow analysis of SIDS reports in an effort to identify trends and implement intervention strategies. This database has lead to the implementation of the following activities:

1. A survey for hospitals to determine their policies and practices regarding risk factors related to SIDS. The survey was mailed to 46 hospitals, of which 36 responded. Based on the results of the survey, educational in-services were conducted at two hospitals.

2. One-page SIDS fact sheets, a copy of the new American Academy of Pediatrics (AAP) recommendations, and an order form for the Back to Sleep campaign materials was mailed to all birthing hospitals. The program will continue to provide educational materials bi-annually and, a SIDS fact sheet that targets parents, caregivers, coroners, and child care workers. //2007//

An attachment is included in this section.

C. Organizational Structure

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

Health Services (HS) is responsible for all Maternal and Child Health (MCH) functions. HS administers programs that provide services to the Maternal and Child Health/CSHCN population. Each Office within HS, through the MCH Block Grant, supports services to women and infants,

children and adolescents and CSHCN through local county health departments and specialty clinics (see organization chart on agency as an attachment to "Agency Capacity").

In July 2004, HS added the Office of Preventive Health and selected epidemiologic surveillance systems related to chronic disease and asthma. In anticipation of the expansion, HS leadership conducted two meetings. During the first meeting, programmatic activities were discussed with HS staff leaders. At the second meeting, Dr. Donna Peterson from the University of Alabama at Birmingham facilitated strategic planning. HS created its vision "Leading and Empowering People for Healthier Lives" and identified strategic goals. Future strategic planning activities are slated to occur.

BIOGRAPHICAL SKETCHES

Daniel R. Bender, MHS, formerly the Director of the Office of Child Health, currently serves as the Director of Health Services. Mr. Bender was the Director of the Genetics Program from 1983 to 2000, where he worked toward the passage of laws mandating newborn screening for PKU, T4 (TSH), Hgb and Galactosemia. Mr. Bender started nine satellite genetic clinics in the state and started the first genetics database in Mississippi. He also developed the Mississippi Birth Defects registry. Mr. Bender's medical experiences include registered Emergency Medical Technician for Baldwin Ambulance and Director of Rankin County Emergency Medical Services. His education includes a Bachelor of Science Degree in Special Education and Master's Degree in Health Science. Mr. Bender has made many presentations which include Health Care for the Poor, the National Neonatal Screening Symposium, and the American Public Health Association.

LeDon Langston, MD, is a Board Certified OB/GYN physician currently serving as medical consultant to the Office of Women's Health in Health Services of the MDH. Recently retired from 25 years of private practice at Southwest Mississippi Regional Medical Center in McComb, Mississippi, he joined the MDH in February, 2001. He brings with him experience of 6000 deliveries and 3000 gynecological surgeries and hopes to serve as a bridge between private and public health practices. Dr. Langston is a former flight surgeon in the United States Air Force. He is a former member of the Mississippi Medicaid Medical Advisory Committee; President of the Mississippi OB/GYN UMMC Society; and the Medical Policy Advisory Committee for Blue Cross/Blue Shield of Mississippi. His present interests include the Teen Pregnancy Prevention and Breast and Cervical Cancer Programs.

Floyd Carey, MD, is a Board Certified Pediatrician currently serving as the medical consultant for the Office of Child Health within Health Services of the Mississippi Department of Health. Dr. Carey recently retired from private practice at Southwest Mississippi Regional Medical Center in McComb, Mississippi. He joined the Mississippi Department of Health in February, 2002. Among his varied projects, he has been actively involved in changes in genetic screening. ***/2007/ As of June 30, 2006, Dr. Carey retired as the Pediatric Consultant to MDH. His contribution to the MCH program has been invaluable. The MCH program will seek a replacement as soon as possible. //2007//***

Louisa Young Denson MS, MPPA, is currently the Director of the Office of Women's Health for the Title V program within the Mississippi Department of Health. Ms. Denson has served in various capacities of public health. Previously, she served as the Director of Disparity Elimination, Director of Minority Affairs, Office Systems Advisor for all clerical staff with the agency, Immunization Representative for 11 counties in District V, Hinds County Office Manager (which consisted of 11 clinics), Director of the Mary C. Jones Clinic, Public Health Advisor for the Sexually Transmitted Disease Program and a clerk in Vital Records and Statistics. Ms. Denson has a Master's in Public Policy and Administration, Bachelor's degree in Social Work, and is a licensed social worker. She has also completed the Certified Public Managers Program with the State Personnel Board.

Geneva Cannon RN-C, MHS, is Director of the Office of Child and Adolescent Health. Ms.

Cannon has over twenty years of experience as a pediatric nurse in critical care, public health, and administration. She was employed with the MDH in the late 1980's and early 1990's as a nurse with the Genetics Program and later as a nurse consultant with the Office of Child and Adolescent Health. Her career also includes working as Director of Licensure and Practice with the Mississippi Board of Nursing. Prior to her current position, she worked as the Program Coordinator in the planning and implementation of the separate insurance plan for the state's Children's Health Insurance Program.

Lawrence H. Clark is the Director of the Children's Medical Program (CMP), Mississippi's Title V Children with Special Health Care Needs (CSHCN) program. He has over 25 years of supervisory and management experience. He has worked with the Allstate Insurance Company's Regional Office in Jackson, Mississippi, and their corporate headquarters in Chicago, Illinois. He has 13 years of managerial experience with the Mississippi Development Authority, formerly known as the Mississippi Department of Economic and Community Development. Before joining the MDH staff, he was employed with the Mississippi Department of Education, Office of Special Education where he managed several statewide initiatives.

Kathy Gibson-Burk is the Director of the Office of WIC with the MDH. She came to the Department of Health in 1994 as the District Social Work Supervisor for the West Central Public Health District V. In 1997 she was promoted to the State Social Services Director; and in 1999 she received another promotion as the Deputy Field Services Director. She has over 22 years of service and management experience in state government, having worked 13 years with the Mississippi Department of Human Services. She earned a Bachelor's of Social Work degree from Mississippi University for Women, and a Master's of Social Work degree from the University of Southern Mississippi. She also received the Certificate of Achievement from the Tulane School of Public Health and Tropical Medicine for completion of the South Central Public Health Leadership Institute and is a graduate of the Certified Public Manager's Program through the Mississippi State Personnel Board.

/2007/ Juanita Graham, MSN, RN is the Health Services Chief Nurse. Juanita serves as a nurse consultant to the five offices of Health Services including WIC, Women's Health, Child & Adolescent Health, Preventive Health, and the Health Services Data Unit. Juanita participates in a variety of activities including grant writing, continuing education for nurses, logic modeling, and research. She holds both Bachelor's and Master's degrees in Nursing Science from the University of Mississippi. She teaches and develops online courses for several nursing and healthcare administration programs and holds a number of adjunct faculty appointments. Juanita is a member of the American Public Health Association, an officer and state delegate for the Mississippi Nurses Association, and a chapter board member and national delegate for the Sigma Theta Tau International Nursing Honor Society. She has given several state and national presentations on a variety of topics ranging from logic modeling to infant mortality. //2007//

Benny Farmer became the financial director of Health Services on May 1, 2003. He has considerable experience with grants and budgeting due to working in the MDH Bureau of Finance and Accounts for sixteen years, first as an accountant in various areas, and then as director of the Division of Budgeting/Purchasing/Grants. He holds a Bachelor's degree in accounting from the University of Southern Mississippi.

Virginia L. Green, MD, began working with Children's Medical Program (CMP), Mississippi's Title V CSHCN program, in 1986, as Pediatric Consultant. Other pediatric experience includes: private practice in Montgomery, AL, 1980- 1983; pediatrician for District V, Mississippi Department of Health, 1983-1986; pediatrician and Assistant Professor of Pediatrics, Department of Pediatric Gastroenterology, University of MS Medical Center (UMC), 1991 - 1993. She also served as a review pediatrician for Mississippi Disability Determination Services (DDS), reviewing childhood cases for eligibility for Supplemental Security Income (SSI) and Medicaid, 1991 - 1993. In 1994, she returned to CMP and recently replaced Dr. Marilyn D. Graves as the Program's Medical

Director. She has served on several committees relating to children with special health care needs and continues to serve on the UMC Visiting Teaching Faculty and on the Board of Directors for the Spina Bifida Association of MS.

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

/2007/ Charles E. Sledge, Jr., MS, is a research biostatistician currently assigned to the Maternal and Child Health (MCH) Data Unit. In addition to providing support to various programs within the MCH Title V program, he is a technical advisor/analyst for the Mississippi Pregnancy Risk Assessment Monitoring System (PRAMS) program.

Lei Zhang, MS, MBA, PhD, is the director of the Health Services Data Unit. He is the primary investigator of the Mississippi Asthma Program. In addition, he oversees all aspects of data collection and data analysis within Health Services. Dr. Zhang's research interests include health survey data analysis and spatial investigation using GIS. He has published several articles in peer-reviewed journals. In addition, he has given numerous presentations in national and local conferences. Currently he is a member of both the American Statistical Association and the American Public Health Association. //2007//

Laws and Authorizations:

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

An attachment is included in this section.

D. Other MCH Capacity

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

Office of WIC 43
Office of Women's Health 22
Office of Child/Adolescent Health, including CSHCN
and First Step Early Intervention System (FSEIS) 72

Each office, through the MCH Block Grant, supports services to women and infants, children and adolescents and CSHCN through local county health departments and speciality clinics. The MDH provides case management, childhood immunizations, well-child assessments, limited sick-child care, and tracking of infants and other high-risk children. Services are targeted towards women and children whose family incomes are at or below 185 percent of the federal poverty level. The MDH provides services to more than 120,000 children annually. Adjunct services such as the First Steps Early Intervention System (FSEIS), Genetic Screening, WIC, and the Children's Medical Program are important components of the comprehensive Child/Adolescent Health Program. Services are provided through a multi-disciplinary team approach including physicians, nurses, nutritionists, and social workers, and provide early identification of potentially disabling conditions and linkages with providers necessary for effective treatment and management. The MDH provides services to women and infants through its family planning, maternity, and Perinatal High Risk Management/Infant Services System (PHRM/ISS) programs.

Children and adolescents are targeted for periodic health assessments and other services

appropriate for their age and health status. Those services may include, but are not limited to:

(a) immunizations;
(b) genetic screening and counseling;
(c) routine and periodic screening, diagnosis and treatment for EPSDT eligible infants and children;
(d) well-child and sick-child care;
(e) vision and hearing screening;
(f) WIC services;
(g) counseling regarding: reproductive health issues, alcohol,tobacco, and substance abuse, and sexually transmitted diseases;
(h) comprehensive developmental services from child birth to age 3;
(i) dissemination of information on the benefits of protective dental sealants to families of children receiving health department services; and,
(j) referral and case management for treatment of conditions where services are not readily available; and,
(k) PHRM/ISS

Children and adolescents, including CSHCN, receive direct personal health care services defined as interventions for high risk individuals, case management, care coordination, primary and preventive care, health education and counseling.

The CMP has developed very effective lines of communication with the UMMC, the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis Foundation, and the local chapter of the Hemophilia Foundation to make sure that all support services are coordinated for the patients where and when appropriate.

The CMP also maintains a major link with health care providers through the CMP Advisory Council, which includes physicians, parents, hospital representatives, anesthesiologists, physical therapists, social workers and other health care providers. Through these resources, providers are advised of the expanded effort to provide services to disabled children under sixteen (16) who receive SSI benefits under Title XVI. The Children's Medical Program has led the way to coordinate communication between CMP, Social Security, and the State Disability Determination Office.

The CMP works to develop and strengthen lines of communication between all state agencies who provide assistance to CSHCN and to the blind and disabled population under sixteen (16) years of age. This includes invitations to CMP Advisory Council meetings, both parent and professional.

The Title V agency installed a toll-free telephone line in cooperation with the offices of WIC and Women's Health. The line provides assistance to clients seeking information about MCH services, family planning, Medicaid, WIC, and other services. This valuable tool encourages early entry into prenatal care and further links the private and public sectors. Information about the line is publicized through a newsletter of the Mississippi Chapter of the American Academy of Pediatrics, brochures, posters, and a Teen Help Card.

Toll-free numbers in the agency which are directly related to services for the MCH/CSHCN population include a Genetics/Early Intervention line, an HIV/AIDS line, and a CMP line.

E. State Agency Coordination

There are various organizational relationships that exist between the MDH and other human service agencies which work to enhance the capacity of the Title V program. Examples of MDH's coordination efforts with other human service agencies are as follows:

Substance Abuse Programs.
The Born Free project, which originated with the MDH, networks available community resources for the provision of services to substance-involved pregnant women and their infants. Other agencies involved in the Born Free network include: (a) the University of Mississippi Medical Center; (b) Marian Hill Chemical Dependency Treatment Center; (c) New Life for Women (housing); (d) Catholic Charities (provides direct primary treatment services and transitional program services); (e) community health centers; (f) Jackson Recovery Center; (g) state mental health centers and state hospital; (h) parole officers and the court system; and, (i) sexual assault and domestic violence shelters and other treatment centers. Born Free is now administered by Catholic Charities.

March of Dimes.
The MDH partners with the March of Dimes to increase the awareness of folic acid as it relates to birth defects. The March of Dimes launched a campaign to raise awareness of the growing problem of prematurity and to decrease the rate of preterm births. Premature infants are more likely to be born with low birthweight and suffer mild to severe disabilities and/or death. Prematurity is the leading cause of infant death before the first month of life. The March of Dimes partners with the Closing the Gap Initiative to provide professional education related to the prevention and management of low birth weight and prematurity.

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

First Steps Early Intervention System (FSEIS).
The FSEIS is structurally located within the Office of Child and Adolescent Health, and has established an Interagency Coordinating Council bringing together the State Departments of Mental Health, Education and Human Services, universities, parents of children with special needs, providers of services, and others, to develop a comprehensive system of family-centered, community-based, culturally-competent services. Local interagency councils support the planning, development, and implementation of the system at the community level.

Mississippi Statewide Immunization Program.
The MDH's Statewide Immunization Program is primarily funded by the Centers for Disease Control and Prevention, but MCH funds are used to support some staff in local health department clinics. A statewide coalition has been established, which is composed of health care professionals (organizations and individuals), immunization providers, community-based organizations, social/civic groups, lay people, and others with an interest in improving the

immunization status of Mississippi's children. This broad-based group provides the framework for promoting the implementation of the immunization monitoring and tracking system in non-health department clinics.

Department of Human Services (DHS).
DHS provides services that include case management, child care for the developmentally disabled, services for the chronic mentally ill, abstinence education, and treatment for alcohol and chemically dependent adolescents.

DHS Office of Children and Youth uses funds for day care, while the Division of Aging and Adult Services uses Social Services Block Grant (SSBG) funds for home health aides, ombudsmen services, transportation for elderly, case management for adults, adult day care, home delivered meals for adults, and respite care. The MDH no longer receives SSBG funds from the DHS to assist in its efforts to provide needed contraceptive services to teens, however, a representative of the MDH is a member of the DHS Out-of-Wedlock Task Force. A representative from DHS is an ex-officio member of the Infant Mortality Task Force and the Pregnancy Risk Assessment and Monitoring System (PRAMS) Advisory Committee.

DHS administers the federal Child Care Development Block Grant (CCDBG) which has two basic component areas. The provision of actual child care services comprises 75 percent of the budget. The Quality Child Care Development portion of the budget provides funds for training of child care providers, improvements to day care centers, and media centers. Some CCDBG funds are provided to the MDH for child care facilities licensure.

Division of Medicaid.
The Division of Medicaid is a key player in the reimbursement for services to patients seen in MDH clinics. In addition to a cooperative agreement, which allows billing for specific services provided to PHRM/ISS and other non-high risk patients, the MDH assists Medicaid in assessing pregnant women and children for Medicaid and CHIP eligibility using MDH staff and outstationed eligibility workers and a two-part eligibility form with 185 percent of poverty as a threshold, thereby preventing untimely delay for clients who need Medicaid coverage. Medicaid staff and MDH staff meet quarterly to discuss PHRM/ISS progress and concerns.

Community Health Centers/Primary Health Care Association.
A primary care cooperative agreement with the Bureau of Primary Health Care has been administered by the MDH since 1985. The cooperative agreement provides a mechanism for joint perinatal planning and provider education between the state MCH program and the 21 community health centers (CHCs). Perinatal providers are placed in communities of greatest need through a joint decision-making process of the Mississippi Primary Health Care Association (MPHCA) and the MDH Primary Care Development Program, making access to care available to many pregnant women and their infants. The Office of Rural Health (ORH) works closely with Primary Care Development to promote the recruitment and placement of providers in rural areas.

The MDH, through its Office of Rural Health, administers the Medicare Rural Hospital Flexibility (FLEX) Grant, which funds the Critical Access Hospital program. This program is designed to foster the growth of collaborative rural health delivery systems across the continuum of care at the community level with appropriate external relationships for referral and support. This should result in improved access to care, economic performance and viability of rural hospitals, and ultimately, health status of the community. The Office of Rural Health contracts with the Mississippi Hospital Association to provide staff support and programmatic assistance for the FLEX program.

The Mississippi Primary Health Care Association is the lead agency for the Mississippi Access to Rural Care (MARC) program, funded by the Robert Wood Johnson's Southern Rural Access

Program. The program supports work to increase the supply of primary care providers in underserved areas, strengthen the health care infrastructure and build capacity at the state and community level to address healthcare problems. To achieve these goals, MARC is focusing on rural health leadership development, recruitment and retention of primary healthcare providers, rural health network development, and revolving loan fund development. The MDH has a contractual arrangement with the Primary Health Care Association to provide staff support for recruitment and retention efforts. In addition, the MDH holds a seat on the MARC Board of Directors.

During the 1999 Legislative Session, House Bill 403 was passed that provided funding to the MDH for the purpose of contracting with Mississippi Qualified Health Centers (MQHC). These funds are used to increase access to preventive and primary care services for uninsured or medically indigent patients, and to create new services or augment existing services provided to uninsured or medically indigent patients. Services include, but are not limited to, primary care medical and preventive services, dental services, optometric services, in-house laboratory services, diagnostic services, pharmacy services, nutritional services, and social services.

The Mississippi Primary Health Care Association (MPHCA) is one of the 24 primary care associations funded by the Health Resources and Services Administration (HRSA) to implement a Medicaid/CHIP Outstation Demonstration Pilot. This Medicaid Demonstration Pilot has expanded on the foundation laid by the regional and national project TEAM (The Early Access Model for Integrated Health Care). The Medicaid/CHIP Demonstration has built these existing partnerships by including partners in "Train the Trainer" sessions on the Medicaid/CHIP application process and how to complete the one-page Medicaid/CHIP application.

The MDH HIV/AIDS Program maintains contractual agreements with a number of community agencies. The Jackson/Hinds Community Health Center provides AIDS education and information services to their clients in Hinds County and the Jackson public school system. Another agreement with the Aaron Henry Health Center in Clarksdale provides AIDS education and information to residents of Quitman, Tallahatchie, Tunica and Coahoma counties.

The Family Planning Program maintains six contracts with community health centers and four contracts with universities and/or colleges for the provision of contraceptive supplies and educational materials. These contracts have been formulated with the Aaron Henry Health Center, Arenia Mallory Health Center, G.A. Carmichael Health Center, Northeast Mississippi Health Care, Inc., Southwest Health Agency for Rural People, Access Family Health Services, Jackson State University, Alcorn State University, Tougaloo College, and Coahoma Community College.

The Breast and Cervical Cancer Screening and Early Detection program provides contracts to community health centers, health departments, private providers, and hospitals to conduct screening services, diagnostic services, referrals and case management. The target populations for the program are uninsured, underinsured, and minority women. Women 50 years of age and older are the target group for mammography screening, and women 45 years and older are the target group for cervical cancer screening.

The Bureau of Immunization located in the Office of Communicable Disease, provides vaccine to private physicians and community health centers that are enrolled as Vaccine for Children providers.

The Office of WIC has a contractual relationship with 19 community health centers for the purpose of certification of women, infants, and children for provision of WIC food and/or formula through distribution centers located throughout the state.

Marion County Health Department in Public Health District VIII and the Lawrence County Health Department in Public Health District VII work cooperatively with local community health center

staff, whereby community health center staff provide PHRM/ISS services to maternity patients receiving prenatal care at the county health departments.

Those community health centers that provide EPSDT services are also subject to the Division of Medicaid requirement for periodic lead screening. As the MDH expands its statewide program of lead screening and follow-up to improve access to this service for potentially vulnerable populations, the cooperation of community health centers continues to be critical to its success in implementing community based interventions. A representative from the MPHCA serves as an ex-officio member of the Infant Mortality Task Force.

Children's Medical Program (CMP).
CMP, the state CSHCN program, maintains an Advisory Council whose members include medical and other service providers and parents of CSHCN. Medical service providers of the Advisory Council include private physicians, a dentist, orthotics/prosthetics provider, and staff physicians of the University of Mississippi Medical Center, the only state funded medical teaching and tertiary care facility. A representative from the MDH also serves on the State Developmental Disabilities Council. CMP maintains a Memorandum of Understanding with the Mississippi Disability Determination Service providing for the exchange of respective program eligibility criteria in cross referral of CSHCN for services.

The Children's Medical Program now maintains a Parent Advisory Committee composed of parents of CSHCN who are covered by the program. Parents provide input regarding the services that their children receive from the CSHCN program.

Maternal Death Review.
In the past, the Mississippi State Medical Association's Committee on Maternal and Child Care reviewed all cases involving maternal deaths in the state. All maternal death certificates and matching birth certificates (if there was a live birth) or fetal death certificates were sent to the director of the Office of Women's Health. District and county health department staff were requested to gather information regarding prenatal care, labor and delivery, postpartum care and any other information surrounding the death. This information was used for both the in-house review and for the review by the Mississippi State Medical Association's Committee on Maternal and Child Care. The death certificates were revised in 1998 and a block added to check if the decedent had been pregnant within the last 90 days.

The MDH is currently in the process of developing the Statewide Maternal and Infant Mortality Surveillance System. Reviews of maternal deaths will be conducted under the auspices of the MDH, but with the collaboration of the University of Mississippi Medical Center (UMMC) and the Mississippi State Medical Association. A pilot program is currently being conducted in eight target communities including Bolivar, Coahoma, Leflore, Hinds, Madison, Rankin, Sunflower, and Washington counties.

Infant Mortality Task Force.
The Infant Mortality Task Force (IMTF), was created by the Mississippi Legislature. The Legislature directed the IMTF to work with the administrative heads of the Department of Health, Department of Education, Department of Mental Health, Department of Human Services, and the Division of Medicaid, to develop recommendations aimed at reducing infant mortality and morbidity in Mississippi. Members are appointed to the IMTF by the Governor, Lieutenant Governor, and Speaker of the House.

According to its statutory authority, the Task Force shall:
1. Serve an advocacy and public awareness role with the general public regarding maternal and infant health issues;

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

In 2003 and 2004 the IMTF went through a period of transition. Appointments are now based on the Mississippi Supreme Court Districts rather than Congressional Districts. The Mississippi Department of Heath staff continues to communicate with members of the IMTF and work to promote its recommendations. However, due to the 2006 legislative session, the IMTF is schedule to sunset June 30, 2006.

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

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

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

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

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

Rural Health Program.
The MCH program works collaboratively with the Office of Rural Health (ORH) in resolving access to care issues. This program is administered by the MDH Office of Health Policy and Planning. This program has been funded through a Federal Office of Rural Health Policy grant since August, 1991. There are four mandated functions under the grant: (1) to establish and maintain a clearinghouse of rural health issues, trends, and innovative approaches to health care delivery in rural areas; (2) to coordinate activities carried out in the state that relate to rural health

care in order to avoid redundancy; (3) to identify federal and state programs for rural health and provide technical assistance to public or nonprofit entities regarding participation in the programs and; (4) an option to provide technical assistance to rural hospitals and communities on recruitment and retention of health care professionals.

The Centers for Disease Control and Prevention and Health Resources and Services Administration provide funding for most services implemented through Health Services. Health Services houses the MCH and CSHCN programs and is reliant on federal funds. Less than 2% of total funding to Health Services is provided by the State of Mississippi. Therefore, many MCH programs funded through Title V work in cooperation with national resources such as CDC and HRSA/MCHB. Program staff are constantly in touch with project directors at the national level to ensure that needed services are provided to the MCH population.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	967.3	262.3	254.2	286.6	305.0
Numerator	9673	2623	2542	5869	6246
Denominator	100000	100000	100000	204815	204815
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2005
Unlike previous years, Mississippi asthma data for CY 05 were calculated per 10,000 children rather than per 100,000. Thus, the number reported this year represents the seriousness of asthma in our state.

Notes - 2004
An estimate for this measure was determined by using past reports.

Notes - 2003
The MSDH recently received funding from the Centers for Disease Control (CDC) and is in the process of developing a statewide asthma surveillance system, establishing collaborative partnerships, creating an asthma coalition, and developing a comprehensive State Asthma Plan.

2001 indicator data were calculated per 100,000 children living in the Jackson Metropolitan Area over a period of four years. However, the 2002 data were calculated per 100,000 children living in the same area, but over a one (1) year period, which accounts for the change between the reporting periods.

Narrative:
The Mississippi Department of Health has completed a five-year State Asthma Plan and established nine regional asthma coalitions and an Asthma Coalition of Mississippi. Mississippi continues to enhance its asthma surveillance system, and has recently completed a five-year surveillance report.

2001-2004 indicator data were computed per 100,000 children; however, the Centers for Disease Control (CDC) and other state asthma programs compute the hospitalization rate per 10,000.

2005 asthma data for Mississippi has not been analyzed, but an estimate has been provided per 10,000 children based on the steady increase in asthma hospitalizations in the state.

Asthma is not a reportable disease in Mississippi, however the Asthma Program, funded through the CDC, is working with individual hospitals to obtain hospital discharge data on a regular basis. Currently, the Asthma Program is recieving data from over 80% of Mississippi hospitals.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	76.0	97.0	60.9	68.6	71.4
Numerator	26742	34623	48990	54829	28286
Denominator	35194	35679	80456	79869	39618
Is the Data Provisional or Final?				Final	Final

Notes - 2004
An estimate for this measure was determined based on previously reported data.

Notes - 2003
2003 data were provided by the Mississippi Division of Medicaid.

Narrative:
According to the latest data available (CY 2005) from the Mississippi Division of Medicaid, of the 39,618 Medicaid enrollees whose age is less than one, 71% (28,286) received a screening service.

Although a well coordinated network of services are being provided on a statewide basis by the MDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	70.2	74.6	75.5	76.3	76.3
Numerator	191	554	542	546	546
Denominator	272	743	718	716	716
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2005

Due to difficulties in obtaining SCHIP data for 2005, 2004 estimates are used.

Notes - 2004
CY 2004 data is an estimate base on previous data provided from the Mississippi Department of Medicaid.

Narrative:
According to CY 2003 data from the Mississippi Division of Medicaid, there were 718 children enrolled in SCHIP who were less than one year of age at some point during the year, and of these children, 542 (75.5%) had a visit to a health care professional (physician, nurse practitioner, etc.) before one year of age.

A coordinated network of services are being provided on a statewide basis by the MDH, but there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. The SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	83.3	83.3	86.3	84.1	84.5
Numerator	35025	34407	36363	35831	35993
Denominator	42055	41284	42136	42595	42595
Is the Data Provisional or Final?				Final	Provisional

Notes - 2004
This measure was estimated based on projections developed by the MDH's Vital Statistics Department.

Notes - 2003
2003 data are currently unavailable. Data will be mailed to MCHB when available.

Narrative:
According to 2005 provisional data from the Office of Health Informatics, 84.5 percent of women (15 through 44) with a live birth during the reporting year had observed expected prenatal visits greater than or equal to 80 percent of the Kotelchuck Index.

There is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between internal

program and external program when possible. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	86.5	60.7	92.6	96.7	94.7
Numerator	312826	246960	363503	382511	347715
Denominator	361461	406847	392720	395621	367091
Is the Data Provisional or Final?				Final	Final

Notes - 2004
Data were estimated for this measure because actual 2004 data are unavailable.

Notes - 2003

Narrative:
Data from the Mississippi Division of Medicaid revealed that during CY 2005, there were 367,091 children 1 to 21 years of age who were potentially eligible for Medicaid. Of that number, 347,715 (95%) received a service paid by the Medicaid Program.

Although a well coordinated network of services are being provided on a statewide basis by the MDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	37.8	39.7	41.7	43.6	88.4
Numerator	31683	32808	34409	36421	69233
Denominator	83712	82666	82555	83629	78320
Is the Data Provisional or Final?				Final	Final

Notes - 2004

An estimate for this measure was determined from previously reported data.

Notes - 2003
2003 data were provided by the Division of Medicaid.

Narrative:
According to CY2005 data from the Division of Medicaid, 78,320 children age 6 through 9 were eligible for EPSDT services. Of that number, 88 Percent (69,233) received dental services.

Although, a well coordinated network of services are being provided on a statewide basis by the MDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	19601	17330	18366	18784	19084
Denominator	19601	17330	18366	18784	19084
Is the Data Provisional or Final?				Provisional	Final

Notes - 2005
These data are provided by SSI indicating the number of SSI beneficaries less than 16 years old in the state. The Children's Medical Program (CMP) staff maintains an ongoing relationship with the Social Security Administration and the State Disability Determination Services to facilitate the referral process to CMP for children and families potentially eligible for the program. The CMP collaborates with Medicaid, Social Security Administration and other third party payors to ensure access to needed services for children with special health care needs.

Each SSI beneficary is made aware of CMP, eligilibility criteria, and covered services. All beneficaries are encouraged to apply for CMP services. However, all SSI beneficaries may not directly receive rehabilitative services through the CSHCN program due to differences in eligibility criteria for program enrollment. CMP's eligibility criteria is based on family size, income, and diagnosis and is more exclusive than SSI eligibility criteria. Some degree of case management/care coordination is offered to all SSI beneficaries.

Notes - 2004
These data are provided by SSI indicating the number of SSI beneficaries less than 16 years old in the state. The Children's Medical Program (CMP) staff maintains an ongoing relationship with

the Social Security Administration and the State Disability Determination Services to facilitate the referral process to CMP for children and families potentially eligible for the program. The CMP collaborates with Medicaid, Social Security Administration and other third party payors to ensure access to needed services for children with special health care needs.

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Notes - 2003
These data are provided by SSI indicating the number of SSI beneficaries less than 16 years old in the state. The Children's Medical Program (CMP) staff maintains an ongoing relationship with the Social Security Administration and the State Disability Determination Services to facilitate the referral process to CMP for children and families potentially eligible for the program. The CMP collaborates with Medicaid, Social Security Administration and other third party payors to ensure access to needed services for children with special health care needs.

Each SSI beneficary is made aware of CMP, eligilibility criteria, and covered services. All beneficaries are encouraged to apply for CMP services. However, all SSI beneficaries may not directly receive rehabilitative services through the CSHCN program due to differences in eligibility criteria for program enrollment. Some degree of case management/care coordination is offered to all SSI beneficaries.

Narrative:
The Children's Medical Program (CMP) staff maintains an ongoing relationship with the Social Security Administration and the State Disability Determination Services to facilitate the referral process to CMP for children and families potentially eligible for the program. The CMP collaborates with Medicaid, Social Security Administration and other third party payors to ensure access to needed services for children with special health care needs.

Each SSI beneficary is made aware of CMP, eligilibility criteria, and covered services. All beneficaries are encouraged to apply for CMP services. However, all SSI beneficaries may not directly receive rehabilitative services through the CSHCN program due to differences in eligibility criteria for program enrollment.

There is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2005	payment source from birth certificate	65	35	11.4

Narrative:
Although a well coordinated network of services are being provided on a statewide basis by the MDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2005	payment source from birth certificate	63	37	9.8

Narrative:
In an effort to improve and/or target services to the more vulnerable populations in Mississippi. Mississippi's SSDI program is currently being used to promote the linking data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	payment source from birth certificate	49	51	85.1

Narrative:
Although a well coordinated network of services are being provided on a statewide basis by the MDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	payment source from birth certificate	51	49	84.5

Narrative:
Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with

the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2005	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	200

Narrative:
Mississippi's SSDI program is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2005	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2005	 200 200

Narrative:

Although a well coordinated network of services are being provided on a statewide basis by the MDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2005	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2005	200

Narrative:

Although a well coordinated network of services are being provided on a statewide basis by the MDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. The MCH Data Unit's plans are to continue its work with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. Progress in accomplishing these objectives has been made, but challenges exist in staffing and compatible data systems. Additional challenges also exist that are due to the MDH's quest to reconstruct the agency's current data collection systems to establish a more centralized integrated data system for improved data analyses. The establishment of this improved data collection system will also be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner?**	**Does your MCH program have Direct access to the electronic database for analysis?**

	(Select 1 - 3)	(Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2007

Narrative:
Although a well coordinated network of services are being provided on a statewide basis by the MDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey?	Does your MCH program have direct access to the state YRBS database for analysis?

	(Select 1 - 3)	(Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Pediatric Nutrition Surveillance System (PedNSS)	2	Yes
WIC Program Data	3	Yes
PRAMS	3	Yes

Notes - 2007

Narrative:
Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. Mississippi's SSDI is currently being used to promote the linking of data systems to better serve the MCH population. SSDI staff will continue working with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. The establishment of improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of Mississippi.

IV. Priorities, Performance and Program Activities

A. Background and Overview

In an effort to carry out the core functions of public health, the MDH relies on the work of public health team members across the state to assist every community in the state to achieve the best possible health status for its citizens. The MDH accomplishes this through the agency's goals of:

(1) Assessing health status indicators of the state's population to document each community's health needs and conduct epidemiological and other studies of specific health problems; (2) Developing, promoting, and supporting public policy and strategies that protect the state's citizens from unsanitary conditions related to the environment and that emphasize healthy lifestyles and the prevention of morbidity and mortality associated with disease and illness; and (3) Assuring access to essential health services.

The MDH's Health Services (HS) department, through the Office of Women's Health and the Office of Child/Adolescent Health Services, administers programs that provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs (CSHCN). Clinical and support services are provided to the target populations through local county health departments and speciality clinics. Services include prenatal and postnatal care, case management for high risk pregnant and postpartum women and infants, well child and sick child care, as well as restorative services for CSHCN. This network allows the MDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

The MDH Child Health and Prenatal programs serve all women, infants, and children but target services to women, infants, and children at or below 185 percent of poverty. Services are preventive in nature; however, treatment is often included for those whose need is greatest. Using a multi-disciplinary team approach, including medical, nursing, nutrition and social work, the Child Health Program provides childhood immunizations, well child assessments, limited sick child care, and tracking of infants and other high risk children. Services provided are basically preventive and designed for early identification of disabling conditions. Case management services are provided to high risk pregnant and postpartum women and infants by nurses, social workers and nutritionists. Services are provided in clinics and in the clients' home.

In areas where the MDH is not the primary provider of care, the MDH contracts and/or collaborates with private providers to care for the MCH and CSHCN population. Some of these providers conduct regular and/or screening clinics in health department facilities. Others are contracted for consultation and referrals. The MDH provides support services such as case management, nutrition and psychosocial counseling, education and nursing.

In some areas of the state, prenatal patients are seen in health department clinics until delivery and then return to MDH for postpartum and family planning services after delivery. High risk patients are sometimes co-managed by the health department and the private provider.

In other parts of the state, the health department has contractual agreements with private providers whereby the MDH manages the patient until a certain stage of gestation and then transfers the patient to the private provider for the remainder of her care. There are several areas of the state where, when a patient's pregnancy is confirmed, she goes immediately into the private sector or to a community health center or rural health clinic for care.

/2007/ The number of maternity clients seeking prenatal care at county health departments continues to decline. During FY 2003 only 9,738 clients received maternity services from county health departments, and from 7/1/04 through 6/30/05 (according to fiscal year data) 7,750 maternity patients received maternity services from county health departments.

//2007//

The MDH, in administering the Title V programs, has taken steps to integrate the private medical community into the system through contractual arrangements whereby local physicians provide limited clinical coverage at local health departments. These physicians enhance the continuum of care by becoming the client's provider of after-hours and weekend care when necessary and many times provide a medical home for families as the family's economic status improves.

B. State Priorities

STATE PRIORITIES

Mississippi's health priorities from the 2006 Needs Assessment are enumerated below:

1. Increase EPSDT/preventive health services for children on Medicaid and SCHIP.

2. Decrease smoking among pregnant women.

3. Decrease cigarette smoking among sixth through twelfth graders.

4. Reduce repeat teen pregnancies for adolescents less than 18 years old.

5. Address child/adolescent obesity/overweight issues.

6. Increase oral health care and preventive services for children.

7. Reduce child/adolescent unintentional injuries.

8. Decrease unhealthy behaviors, specifically alcohol and drug use and risky sexual behavior, for teenagers sixth through twelfth grades.

9. Maintain case management follow-up services for children with genetic disorders identified through MDH newborn screening.

10. Continue to improve and maintain developed data collection capacity for Title V population

These state priorities were derived through the needs assessment process in 2004 and 2005. Priorities were determined based on the needs of the MCH population in relation to current MCH Block Grant state and national measures. The priorities are designed to compliment national performance measures without duplicating any efforts that are currently being used to address the performance measures. Each priority, however, does relate in some way to the state and national performance measures as well as Healthy People 2010 goals. Eight state performance measures were derived from these priorities and are detailed in subsequent forms in this grant application/report. Below are summaries of each priority and why it was chosen.

EPSDT/Preventive Health Services: This priority was carried over from the previous cycle and enhanced. Little more than one-half of Medicaid eligibles receive preventive health screenings. One may reasonably assume a comparable percentage for SCHIP eligibles. Therefore, SCHIP was added to this priority and to the state performance measure that corresponds with this priority.

Smoking Among Pregnant Women: During the previous cycle, smoking among pregnant teenagers was selected as a priority to focus efforts on a specific age group of pregnant women. When revisited, it was agreed that this priority should be expanded to include all pregnant women. As data reflect, women who smoke during pregnancy are more likely to be low socioeconomic status, minorities, and deemed high risk. Smoking in itself makes pregnant women high risk due to the effects of smoking on unborn babies. In Mississippi, approximately 25% of pregnant women smoke. This statistic makes the size, seriousness, and scope of the issue appropriate for selection as a top priority.

Cigarette Smoking Among Sixth through Twelfth Graders: Cigarette smoking among youth continues to be a public health problem in Mississippi. Progress has been made to address youth smoking in Mississippi. However, according to 2003 YRBSS, the percent of children who report having smoked in the last 30 days or having ever smoked is well above the national average. Therefore, this priority was selected to remain in the top ten priorities. In the past, due to only having weighted data for ninth through twelfth graders, sixth through eighth graders were not included. Due to improved data resources, the priority will be enhanced to include sixth through twelfth graders, increasing the global scope of the priority.

Repeat Teen Pregnancy: Teen pregnancy remains a problem in Mississippi. Currently, over 40 per 1,000 births are to adolescent mothers. The rate of repeat teen pregnancies continues to be of special concern. Since a national performance measure to addresses teen pregnancy for 15-17 year olds exists, the workgroup desired to address the issue of repeat teen pregnancy. Repeat teen pregnancies remain around 140 or more per 1,000 live births to teens. This statistic accounts for approximately 25% of all teen births, above the national average according to the Kids Count Data Book 2004. Although it has declined in recent years, the rate is still a major concern due to implications for repeat teenage births. Adolescent mothers are at risk for LBW and preterm births, and a host of other health problems. This priority will remain in the top priorities for 2006-2010 so that more can be done to address this issue.

Childhood Obesity: Overweight or obese children, poor nutrition and physical inactivity have drawn public attention in recent years. Mississippi's children are becoming increasingly overweight, as is the adult population. Mississippi ranks among the most obese states in the U.S. According to 2003 YRBSS data, over 16% of youth self report as being overweight and another 17% as at risk for becoming overweight. With physical education at an all time low and education funding woes, little seems to be in progress to influence this growing problem. Childhood obesity must be made priority so that multi-agency combined efforts may collaborate to eliminate child obesity.

Dental Care: A 2000 MDH Oral Health clinical survey of 5,227 third-grade children showed that only 17% had at least one dental sealant on a permanent first molar tooth, over 70% demonstrated experience with dental decay, and about 15 percent of children were in urgent need of dental care, defined by pain and suffering, clinical inflammation, or loss of function. Several programs have been put into place to improve access to oral health programs. However, much remains to be done. Therefore, increasing oral health care and preventive services for children will be a 2005 Needs Assessment priority.

Unintentional Injuries in Children: Mississippi holds one of the highest rates of childhood unintentional injuries and deaths. Most childhood deaths and injuries occur before age 14 with the highest risk ages being 0-5 years. Adolescent injuries comprise the second highest risk group. Provisional data from 2003 show that 35.5 per 100,000 deaths will occur in children between ages one and 14 years. According to the 2004 Kids Count Data Book, 69 per 100,000 teenagers aged 15-19 die as a result of homicide, suicide, and accidents. This statistic is well above the national average of 50 per 100,000 deaths. These statistics support selection of this issue to be addressed during the next cycle.

Unhealthy Behaviors in Adolescents Sixth through Twelfth Grades: The Youth Risk Behavior Surveillance System shows that the state's data on teenagers in Mississippi consistently ranks above national averages for unhealthy behaviors. As an MCH program, the MDH will address unhealthy behaviors in hopes of lowering those averages to meet or fall below national averages in order to improve health status. STD rates for teenage males, drug and alcohol use, and injuries are a public health problem. Through the needs assessment, Mississippi has chosen to address unhealthy behaviors through other state performance measures, such as repeat teen pregnancy, obesity, and cigarette smoking.

Case Management Follow-up for Children with Genetic Disorders: The state leads in newborn screening and identification of genetic disorders and birth defects. Mississippi screens for over 40 genetic disorders and MDH follows identified cases through case management services. In 2000, this system was still in development. During the past five years, the MDH worked diligently to capture all families who have a newborn with a genetic disorder and offer case management, education, and support. Case management efforts are reaching close to 100% of families having a newborn identified through the newborn screening program. This priority will remain a top priority to support continued success within the program.

Data Collection Capacity: During the 2000 needs assessment cycle, a separate entity for data collection and capacity was a fairly new concept. A CDC assignee had been struggling to develop MCH data capacity. The workgroup determined the best way to address such an issue was to make it a top priority. Over the next five years a great amount of growth and strengthening occurred. Much has been done to address the issue of data capacity and infrastructure. However, data collection capacity should remain a top priority for this needs assessment cycle, but not as a state performance measure.

Summary: The Title V MCH Needs Assessment process consisted of several methodological principals to ensure the ongoing nature of the process and incorporate results and activities with other portions of the grant application and annual report. National and state performance measures were examined. Overall MCH health status was considered. Capacity indicators were used to develop the state's top ten priorities and develop new state performance measures based on needs assessment evidence. Steps involved the collaboration of a workgroup, conducting special analyses, analyzing health status and existing data, identifying current activities to address needs, and finally, assigning top priorities along developing with a plan to address the priorities and monitor progress over the next five years.

A different scientific method was used to determine the top priorities of the state during this needs assessment. To assess communities and MCH needs statewide, similar qualitative and quantitative methods were used. Surveys developed by ad hoc committees were based on surveys used during the 2000 needs assessment. The committees essentially built upon strengths of existing surveys and enhanced questions to meet the changing Mississippi climate. Other similarities consisted of the convening of the needs assessment workgroup and conferences to present data findings. The state's capacity to meet the needs identified by the 2005 needs assessment is adequate and provides room for growth and further capacity development.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			99.8	99.6	99.7
Annual Indicator	99.4	100.0	99.9	99.4	100.0
Numerator	42039	41511	41295	41219	100
Denominator	42277	41511	41316	41488	100
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
Data in the past had been entered by number of total screenings conducted over the number of total births, however, it was determined that MS needed to enter the number of follow ups to positive/presumptive positive screens over the total number of positive/presumptive positve screens. Therefore the numbers this year are different from other years.

Notes - 2004
Denominator is indicative of the genetics data base and the number of infants born in hospitals and screened. Therefore, the number of live births may differ from vital statistics information used in other areas of this report.

a. Last Year's Accomplishments
Last year during CY 2004, approximately one hundred percent (99.4) of all newborns in the state received at least one screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies, and Congenital Adrenal Hyperplasia (CAH). In June, 2003, newborn screening was expanded to include forty conditions. during 2003, a total of 105 genetic disorders (74 sickle cell disease, 20 congenital hypothyroidism, 7 galactosemia, 2 cystic fibrosis, 1 biotinidase deficiency, and MCAD) were detected in babies born in Mississippi. Each confirmed case received adequate follow-up, which included counseling, medical evaluation, diagnostic services, and treatment.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide screening of all births occurring in the state and follow-up on all inconclusive, adnormal, and presumptive positive results.			X	
2. Identify family counseling and arrange for repeat screens for all babies with inconclusive and abnormal results, and arrange for diagnostic evaluations for all babies with presumptive positive results.		X		
3. Identify all confirmed cases of genetic disorders detected through the screening process.		X		
4. Assure that infants diagnosed with a genetic disorder have a local medical home and are under the care of a physician.		X		
5. Continue to assist in coordinating the case management of effected children with local health departments and physicians.		X		
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Currently, one hundred percent (100) of all newborns in the state received at least one screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies, and Congenital Adrenal Hyperplasia (CAH). In June, 2003, newborn screening was expanded to include forty conditions. During 2005, a total of 136 genetic disorders (75 sickle cell disease, 33 congenital hypothyroidism, 8 galactosemia, 7 cystic fibrosis, 11 biotinidase deficiency, and 2 MCAD) were detected in babies born in Mississippi. Each confirmed case received adequate follow-up, which included counseling, medical evaluation, diagnostic services, and treatment.

c. Plan for the Coming Year

Mississippi's plan for the coming year is to continue screening 100 percent of all newborns and follow-up on those confirmed for genetic disorders. In addition to implementing activities necessary to maintain the percent of newborns screened and confirmed, monthly county newborn screening reports will continue to be monitored and evaluated based on the number of positive cases that remain in a system of care for at least 12 months.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			44.5	47.5	50.5
Annual Indicator		41.5	41.5	41.5	41.5
Numerator		147	147	147	147
Denominator		354	354	354	354
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	53.5	56.5	56.7	56.7	56.7

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain family participation through the program advisory committee		X		
2. Maintain CMP Parent Advisory Council		X		
3. Include patient and family subcommittee input in the MCH Block Grant Needs Assessment				X
4. Initiate a contractual program with the Mississippi Cerebral Palsy Foundation				X
5. Utilize a Family Satisfaction Survey tool to obtain information from families regarding the services they receive				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

c. Plan for the Coming Year

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

activities while attending conferences and retreats hosted by Living Independence for Everyone.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			46.2	48.2	50.2
Annual Indicator		44.2	44.2	44.2	44.2
Numerator		312	312	312	312
Denominator		706	706	706	706
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	52.2	54.2	54.2	54.2	54.2

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The SLAITS survey definition of children with special health care needs is much more inclusive than the eligibility criteria for the state's CSHCN program. Efforts are made to ensure that all CMP enrollees receive coordinated, ongoing, and comprehensive care within a medical home. Access to specialty services is facilitated as indicated.

a. Last Year's Accomplishments
According to last year's data collected by the most recent SLAITS Survey, 44.2 percent of Children With Special Health Care Needs (CSHCN)in the Children's Medical Program in Mississippi had a medical home. This percentage (44.2%) represents no change from the previous year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Include medical home information on CMP applications				X
2. Screen medical home status at all clinic encounters and make referrals as needed	X			
3. Collaborate with primary care physician groups to increase the availability of medical homes				X
4. Continue to coordinate with the University Medical Center to				X

provide care coordination				
5. Develop CMP case management positions (as funds allow) to provide care coordination services				X
6. Utilize district CMP/Genetics Coordinators to assist in care coordination at the community level				X
7. Collaborate with Coalition of Citizens With Disabilities on Healthy and Ready to Work grant				X
8. Continue to provide continuing education opportunities for primary care providers on topics related to CSHCN				X
9.				
10.				

b. Current Activities

Current data collected by the most recent SLAITS Survey shows that 44.2 percent of Children With Special Health Care Needs (CSHCN) in the Children's Medical Program in Mississippi had a medical home. This percentage (44.2%)represents no change from the previous year.

Telephone interviews to collect new SLAITS data are slated to occur between April, 2005 and December, 2006. The sample size will be 750 CSHCN, with at least 2,700 being non-CSHCN per state. More than 3,000 households with children will be screened. The next SLAITS data are expected to be released in 2007.

c. Plan for the Coming Year

The MDH's Children's Medical Program (CMP) will continue to partner with an organization entitled "Living Independence for Everyone of Mississippi" (LIFE) to implement a transition grant. LIFE has several activities directly related to MCH Children with Special Health Care Needs program efforts in developing access of CSHCN to medical homes.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			54.7	57.7	60.7
Annual Indicator		51.7	51.7	51.7	51.7
Numerator		370	370	370	370
Denominator		715	715	715	715
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	63.7	66.7	66.8	66.8	66.8

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
last year's data for this measure was generated from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions did not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include insurance information on CMP applications		X		
2. Verify insurance status at all patient encounters and make referrals to other sources		X		
3. Maintain CMP data system				X
4. Continue to work with Medicaid insurers and advocacy groups to promote adequate health coverage for CSHCN				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current data for this measure are from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions do not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Telephone interviews to collect new SLAITS data are slated to occur between April, 2005 and December, 2006. The sample size will be 750 CSHCN, with at least 2,700 being non-CSHCN per state. More than 3,000 households with children will be screened. The next SLAITS data are expected to be released in 2007.

c. Plan for the Coming Year
Until further notification, data for this measure will be generated from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			70.9	72.9	74.9
Annual Indicator		68.8	68.8	68.8	68.8
Numerator		245	245	245	245
Denominator		356	356	356	356
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	76.9	78.9	78.9	78.9	78.9

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Last year's data for this measure were generated from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions did not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provide and coordinate 19 community-based CSHCN subspecialty medical clinics throughout the state				X
2. Implement a medical home initiative for CSHCN				X
3. Maintain a collaborative relationship with community health centers to provide other needed services				X
4. Facilitate communication between specialty and primary care providers through care coordination initiatives				X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
Current data for this measure are from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions do not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Telephone interviews to collect new SLAITS data are slated to occur between April, 2005 and December, 2006. The sample size will be 750 CSHCN, with at least 2,700 being non-CSHCN per state. More than 3,000 households with children will be screened. The next SLAITS data are expected to be released in 2007.

c. Plan for the Coming Year
Mississippi's plan for the coming year relevant to this national measure is to continue its efforts to provide quality services that are accessible to Mississippians who need these services. Until further notification, data for this measure will be generated from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			9.8	13.5	13.8
Annual Indicator		10.6	10.6	10.6	10.6
Numerator		10	10	10	10
Denominator		94	94	94	94
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	17.8	21.8	21.8	21.8	21.8

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Last year's data for this measure were generated from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions did not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement the Healthy and Ready to Work initiative		X		
2. Develop a life-skills clinic for the transition of CSHCN to adulthood		X		
3. Develop a system at Blake Clinic to ensure that transition services are discussed with patients at every opportunity		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current data for this measure are from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions do not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Telephone interviews to collect new SLAITS data are slated to occur between April, 2005 and December, 2006. The sample size will be 750 CSHCN, with at least 2,700 being non-CSHCN per state. More than 3,000 households with children will be screened. The next SLAITS data are expected to be released in 2007.

c. Plan for the Coming Year
Mississippi's plan for the coming year relevant to this measure is to continue to support the Children's Medical Program's (CMP) partnership with Living Independence for Everyone of Mississippi an effort to help prepare CSHCN for transition into adulthood. Among services necessary to transition to adulthood will be transition to community life, employment and independent living skills, and individualized education plan support activities. CMP will continue to partner with LIFE to provide necessary training and support to transition children and youth to adult healthcare settings. Until further notification, data for this measure will be generated from a national telephone survey of families of children with special health care needs (CSHCN) that was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	86	87	88	89	90
Annual Indicator	85.5	89.9	84.1	85.8	87.6
Numerator		803	756	780	859
Denominator		893	899	909	981
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	89	89.5	90	90.5	91

Notes - 2005
Percentages, numerators and denominators are derived from a yearly survey conducted by the MDH Immunization department. MDH surveyed 981. Out of that we were able to locate and review 859 immunization records. 87.6% of those children were complete at 2 yrs of age. By sampling the immunization records of 19-35 month olds, the MDH is able to generate immunization rates consistently.

Notes - 2004
Percentages, numerators and denominators are derived from a yearly survey conducted by the MDH Immunization department. MDH surveyed 970 children born in 2001. Out of that we were able to locate and review 909 immunization records. 87.8% of those children were complete at 2 yrs of age. By sampling the immunization records of 19-35 month olds, the MDH is able to generate immunization rates consistently.

Notes - 2003
The current Immunization Survey used captures data of children immunized up to 27 months old. Percentages, numerators and denominators are derived from a yearly survey conducted by the MDH Immunization department. MDH surveyed 955 children born in 2000. Out of that we were able to locate and review 899 immunization records. 87.1% of those children were complete at 2 yrs of age. By sampling the immunization records of 19-35 month olds, the MDH is able to generate immunization rates consistently.

a. Last Year's Accomplishments
According to last year's 2004 immunization survey of children at 27 months of age, 85.8 percent completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to conduct annual immunization surveys to obtain statistical estimates of immunization rate				X
2. Continue to emphasize, through the Statewide Immunization Coalition, immunizations' significance				X
3. Continue to work with the Mississippi Chapter of the American Academy of Pediatrics (AAP)				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

According to the 2005 immunization survey of children at 27 months of age, 87.6 percent completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B.

c. Plan for the Coming Year

The results of the survey of two-year-old children suggests that the state of Mississippi is moving gradually toward achieving the 90 percent national goal. The MDH's plan for this measure is to continue to emphasize the significance of completing immunizations by two years of age. Also, professional and public education will continue to be a part of the state effort to increase immunization awareness.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	37	37.2	38.2	36.7	35.3
Annual Indicator	38.4	37.7	35.4	33.9	33.9
Numerator	2542	2385	2217	2126	2124
Denominator	66165	63321	62706	62661	62661
Is the Data Provisional or Final?				Final	Provisional
	2006	2007	2008	2009	2010

Annual Performance Objective	32.5	31.1	29.8	28.5	27.3

Notes - 2003
Annual performance objectives were based on previous five year trend, and, thus, may not appear linear.

a. Last Year's Accomplishments
The birth rate (per 1,000) last year for teenagers age 15 through 17 years was 33.9 per 1,000 live births, which represents a slight decrease from CY 2003 rate of 35.4 per 1,000 live births. In FY 2004, approximately 75,600 students attended 1,926 presentations about general and reproductive health. All nine public health districts were active in making presentations to schools.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support Statewide Abstinence Education Program				X
2. Meet with ministers and church organizations to solicit help in addressing teen pregnancy				X
3. Increase collaboration between adolescent pregnancy prevention programs that focus on minorities				X
4. Collaborate with community health centers in all medically underserved counties				X
5. During postpartum home visits, counsel teens regarding availability of family planning services		X		
6. Work with school nurses on counseling teens regarding risky behaviors and goal setting		X		
7. Counsel children ages 9-18 regarding postponing sex, reproductive health, and contraception.		X		
8. Develop partnerships between the State OB/GYN medical consultants and other providers				X
9.				
10.				

b. Current Activities
The 2005 birth rate (per 1,000) for teenagers age 15 through 17 years is 33.9 per 1,000 live births, which represents no change from the 2004 rate of 33.9 per 1,000 live births. During 2005, approximately 75,600 students attended 1,926 presentations about general and reproductive health. All nine public health districts were active in making presentations to schools.

Collaboration among public health districts will continue to take place with community health centers in all medically underserved counties regarding the provision of free contraceptives to teens. Through the EPSDT and Abstinence Programs, children and adolescents 9-18 years of age will continue to be counseled regarding postponing sex. Although the Abstinence Programs are no longer under the oversight of the health department, partnerships with those who operate the programs will continue to benefit the MCH population in Mississippi.

c. Plan for the Coming Year
Mississippi's plan for the coming year is to continue implementing activities aimed at reducing the birth rate for teenagers age 15 through 17 years of age, as well as maintaining collaborative efforts among public health districts and community health centers in all medically underserved counties. A new adolescent coordinator has begun focussing on teen issues such as births to teenagers. Through collaborative efforts, the state adolescent coordinator will promote healthy behaviors for all teens in Mississippi.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	17	17	17	25	30
Annual Indicator	17	17	17	17	17
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	30	30	30	30	30

Notes - 2005
Current data are unavailable; 17 percent represents an estimate based on data from a previous survey.

Notes - 2004
Data for this measure were provided from the latest (1999) Clinical Oral Health Survey.
No numerators and denominators are given due to that information not being released from the agency that originally conducted the oral health survey. This information will be provided in the future.

Notes - 2003
Data for this measure were provided from the latest (1999) Clinical Oral Health Survey.

a. Last Year's Accomplishments
Since the initiation of the school-based dental sealant program, over 3,700 dental sealants were placed between 2001-2003. Surveys and screenings were initiated to monitor sealant progress over future block grant cycles.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage increased utilization of dental services provided by Medicaid		X		
2. Continue to work with the University School of Nursing and		X		

Dentistry to facilitate access to protective sealant services in the Public Health District III area and plan to expand services as resources allow				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MDH's Dental program is involved in providing a variety of dental services. Namely, the program is currently promoting awareness about community water fluoridation programs in Katrina-devastated communities and the Mississippi Delta Region; training professional school nurses and Health Department nurses to properly perform oral health assessments as part of Medicaid EPSDT screening; delivering preventive dental sealants in Public Health District III; recruiting eligible elementary schools for the 2006-2007 weekly flouride mouth rinse program; and providing oral health assessments as an integrated component of adult health screening activities conducted by the Office of Preventive Health.

c. Plan for the Coming Year

The MDH's Dental Program will engage in the promotion of several activities aimed at improving oral health in Mississippi. In the coming year, the Dental Program will implement the use of oral health risk reduction assessments using MDH Web and Palm-application software to identify children at-risk for oral disease and provide early intervention; begin implementing state oral health plans (first year activity or a five-year plan) by engaging key state and community partners to form a statewide oral health coalition; and the development of oral health programming through WIC and Child Health Programs.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	9.1	8.6	8.4	8.2	8.2
Annual Indicator	8.5	8.9	8.8	7.9	8.2
Numerator	51	56	56	49	51
Denominator	598809	631139	633103	621884	621884
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7.9	7.7	7.6	7.4	7.2

a. Last Year's Accomplishments

The death rate last year of children aged 1-14 by motor vehicle crashes (per 100,000) is 7.9. This rate has slightly decreased from the 2003 rate of 8.8.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Safe Kids of Mississippi Coalition to initiate the passage of legislation				X
2. Partner with local health departments to provide child safety seats to residents of the state				X
3. Develop and implement an initiative to educate and provide information to parents on the proper use of child safety seats		X		
4. Utilize educational videos and informational TIPP sheets developed by the Ford Motor Company		X		
5. Maintain MDH participation with the Mississippi Association of Highway Safety Coalition				X
6. Work with school nurses and other school personnel to promote safety education related to motor vehicle crashes				X
7.				
8.				
9.				
10.				

b. Current Activities

Currently, 2005 data indicate that the death rate of children aged 1-14 by motor vehicle crashes (per 100,000) is 8.2. This rate has slightly increased from the 2004 rate of 7.9. The MDH has several preventive health activities aimed at reducing the death rate by motor vehicle crashes through collaborative efforts and promotions.

c. Plan for the Coming Year

Mississippi's plan for the coming year is to continue its collaboration with agencies and community-based organizations to develop initiatives to decrease death to children age 1-14 caused by motor vehicle crashes.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					16.2
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional

	2006	2007	2008	2009	2010
Annual Performance Objective	16.3	16.5	16.8	17	17.5

Notes - 2005
Data recorded from the latest Ross Mothers Survey report in November, 2005.
Currently, this measure has been changed to request breastfeeding data at 6 months instead of at hospital discharge requested by the previous measure. Thus, data from the latest Ross Mothers Survey revealed that 16.2 percent of mothers in Mississippi breastfed their infants at 6 months.

a. Last Year's Accomplishments
Last year, data from the Ross Mothers Survey revealed that 47.2 percent of mothers in Mississippi breastfed their infants at hospital discharge, which represented an increase of 2 percent from 2003. Of these mothers, approximately 20.2 percent continued to breastfeed at 6 months, up from 19.3 percent in 2003. Of the WIC population, 37.5 percent of mothers breastfed their infants at hospital discharge, up from 35.6 percent in 2003, and 12.2 percent continued to breastfeed at 6 months, up from 10.9 percent in 2003.

Mississippi has also recently passed legislation that allows for women to discretely breastfeed in public without
repercussion.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Certify and promote MDH clinics as breastfeeding-friendly facilities		X		
2. Continue the nationally recognized peer counselor breastfeeding program through the MDH		X		
3. Continue the implementation of USDA National Breastfeeding Promotion Campaign		X		
4. Distribute a promotional video to assist WIC clients, physician clinics and hospitals		X		
5. Provide technical training opportunities for health care providers on breastfeeding promotion				X
6. Conduct outreach activities with worksites employing large numbers of women in the childbearing age range		X		
7. Increase collaboration among MDH agency programs and private providers				X
8. Continue to partner with the March of Dimes to encourage providers to apply for funding to provide patient education				X
9.				
10.				

b. Current Activities
Currently, this measure has been changed to request breastfeeding data at 6 months instead of at hospital discharge requested by the previous measure. Thus, data from the latest Ross Mothers Survey revealed that 16.2 percent of mothers in Mississippi breastfed their infants at 6

months.

c. Plan for the Coming Year
Mississippi's plan for the coming year relevant to this national measure is to continue implementing initiatives to improve the incidence and duration of breastfeeding among women in Mississippi. These initiatives will include activities such as certifying and promoting MDH clinics as breastfeeding-friendly facilities, and distributing promotional videos to assist WIC clients, physician clinics and hospitals with ways to address breastfeeding barriers.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	98.5	98.5	99	99.3	99.5
Annual Indicator	96.0	96.1	96.4	96.7	95.5
Numerator	40599	39899	40778	40921	40898
Denominator	42277	41511	42321	42321	42809
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	99.6	99.7	99.7	99.8	99.8

a. Last Year's Accomplishments
During Calendar Year (CY) 2004 40,921 (96.7%) infants received hearing screening prior to hospital discharge. Extensive training was being conducted at all screening facilities to ensure competence of hospital staff in effectively completing the screening procedures and providing timely referral for infants not passing the screening.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Purchase and distribute 60 percent of supplies necessary to carry out universal screening		X		
2. Provide technical support to hospitals with regard to the screening process and upgrading equipment				X
3. Receive and review written, electronic and faxed reports from birthing hospitals and/or facilities				X
4. Review screening reports for risk factors		X		
5. Monitor referral of infants to diagnostic centers for confirmation of hearing loss		X		
6.				

7.				
8.				
9.				
10.				

b. Current Activities
Currently, 2005 data indicate that 40,898 (98.4%) infants were screened prior to hospital discharge. Extensive training continues to be conducted at all screening facilities to ensure competence of hospital staff in effectively completing the screening procedures and providing timely referral for infants not passing the screening.

c. Plan for the Coming Year
Plans for the coming year relevant to this national measure include the continued upgrading of screening equipment that will improve the accuracy and completeness in the reporting of screening results. Also, the MSDH plans to continue efforts to assure the implementation of universal screening at all hospitals for early detection of hearing impairments in newborns.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	14	15	11.5	14.5	10.5
Annual Indicator	15	15	12	10.8	10.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10.4	10.3	10.2	10.1	10.1

Notes - 2005
Data for this measure were taken from the Mississippi Profile Fact Sheet reported in the Childrens' Defense Fund's latest report.

Notes - 2004
Currently, data used to determine the number of children in Mississippi without health insurance are extracted from reports posted by the Children's Defense Fund.
Numerators and denominators are unavailable at this point in time.

Notes - 2003
CY 2003 data for this measure were provided from a 2003 report on health status of children in Mississippi published by the Childrens Defense Fund.

a. Last Year's Accomplishments
Last year's data to determine the number of children in Mississippi without health insurance was extracted from data published in the Children's Defense Fund's annual report.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Meet with DFA and Medicaid to discuss alternatives for determining the percent of children without health insurance				X
2. Assist DFA and Medicaid in marketing the availability of CHIP to eligible families and/or clients		X		
3. Assess health coverage status at every opportunity and provide assistance to families in the completion of applications		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Currently, data used to determine the number of children in Mississippi without health insurance is extracted from reports posted by the Children's Defense Fund.

c. Plan for the Coming Year
Mississippi's plan for the coming year relative to this measure is to collaborate with state agencies, advocacy groups, and other projects to identify uninsured children and increase awareness of available health coverage options.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					33.7
Numerator					13626
Denominator					40391
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	33.5	33.2	33	29.8	29.7

a. Last Year's Accomplishments
There are no data for last year on this particular measure because it is a new measure being reported for the first time. However, the percent of children ages 2-5 receiving WIC services with

a Body Mass Index (BMI) at or above the 85 percentile will be addressed under current activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct nutrition education and encourage WIC clients to make appropriate food choices and exercise				X
2. Tailor food packages to suit family needs			X	
3. Recommend and promote health lifestyle changes			X	
4. Continue to implement the Value Enhanced Nutrition Assessment			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In an effort to address childhood obesity, the MDH WIC program has implemented a new policy for children age 2-5 referred to as "VENA" or Value Enhanced Nutrition Assessment. Children 2-5 with a Body Mass Index greater than the 95 percentile are required to be placed on skim milk. Mississippi is the first state to implement this policy. The WIC program is also conducting nutrition education classes that encourage WIC clients to make appropriate food choices and exercise.

c. Plan for the Coming Year

During the coming year, the MDH WIC program will continue to implement VENA and promote nutrition education classes that encourage WIC clients to make appropriate food choices and exercise.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					21.9
Numerator					318
Denominator					1453
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	21.7	21.5	21	19.9	19.7

Notes - 2005

The most recent data for this measure is 2003. Data for 2004 are pending.

a. Last Year's Accomplishments
This is a new measure and has no prior history, however, the percentage of women who smoked in the last three months of pregnancy will be addressed under current activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with nurses and health educators to increase health education		X		
2. Continuing educating pregnant women receiving services of the dangers associated with prenatal smoking		X		
3. Provide training about smoking cessation and pregnancy to nurses, nutritionists, and social workers		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
According to the latest PRAMS data (CY 2003), the percentage of women who smoked in the last three months of pregnancy is 21.9.

c. Plan for the Coming Year
In an effort to address smoking during pregnancy, Mississippi will continue to implement and promote smoking cessation classes, Perinatal High Risk Management/Infant Services System (PHRM/ISS), Pregnancy Risk Assessment Monitoring System (PRAMS), and WIC.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	7.6	7.6	7.6	9.2	7.9
Annual Indicator	7.7	10.9	6.0	8.8	8.1
Numerator	18	24	13	19	18
Denominator	233188	219992	216778	216248	221500
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7.9	7.7	7.6	7.4	7.2

a. Last Year's Accomplishments
During 2004, the suicide death rate in Mississippi (per 100,000) among youths 15-19 was 8.8. This represents an increase from the CY 2003 rate of 6.0. Public health and school nurses were available to provide counseling and referral services to youth identified to be at risk by acting as a school and community resource for health education.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop strategies for utilization of school health nurses as a school and community resource for health education and to assist in bridging the communication gaps between adolescents and their families				X
2. Collaborate with the Department of Mental Health to explore initiatives for preventing suicide deaths among youths, such as suicide risk assessments and prevention				X
3. Review records to screen for high risk youth		X		
4. Through networks of the Suicide Prevention Coalition, provide information on available resources throughout the state		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Currently, CY 2005 suicide death rate in Mississippi (per 100,000) among youths 15-19 is 8.1. This represents an decrease from the CY 2004 rate of 8.8. Public health and school nurses will continue to be available to provide counseling and referral services to youth identified to be at risk by acting as a school and community resource for health education.

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

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005

Annual Performance Objective	34.3	33.2	33	33	34
Annual Indicator	33.7	33.2	34.9	31.2	32.8
Numerator	297	309	336	297	312
Denominator	882	931	963	952	952
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	32.7	32.6	32.5	32.3	32.2

Notes - 2003

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a. Last Year's Accomplishments

Last year, 31.2 percent of very low birthweight infants were delivered at tertiary centers. This represents a slight decrease from 34.9 percent reported for CY 2003.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to work with the Mississippi Perinatal Association, the Infant Mortality Task Force, and the March of Dimes to evaluate the regionalization system in the state				X
2. Evaluate the current system and develop a plan of improvement if needed				X
3. Continue to conduct annual hospital surveys to obtain status of available manpower for multiple medical services, including maternity and newborn		X		
4. Assess facility availability across the state for perinatal practices and statistics for use in state planning		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During 2005, 32.8 percent of very low birthweight infants were delivered at tertiary centers. This represents a slight increase from 31.2 percent reported for CY 2004.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this national measure is to increase the percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates by continuing to work with the Mississippi Perinatal Association, the Infant Mortality Task Force, the March of Dimes, and other partners to evaluate the regionalization system in the state.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	82.7	83.2	84.1	85.1	86
Annual Indicator	82.2	83.1	84.3	81.8	85.1
Numerator	34760	34501	35663	35036	36430
Denominator	42277	41511	42321	42809	42809
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	86	86.9	87.7	88.6	89.5

a. Last Year's Accomplishments
During CY 2004, approximately 81.8 percent of infants born were to women who had received prenatal care beginning in the first trimester. This represents a slight decrease from 84.3 percent reported for CY 2003.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with Medicaid and Department of Human Services to include AFDC checks and Food Stamp mailouts with information on prenatal care, WIC, and family planning		X		
2. Collaborate with Miss. Food Network to distribute information about prenatal care				X
3. Collaborate with the March of Dimes to develop media materials related to early prenatal care				X
4. Collaborate with the Healthy Baby Campaign, a multi-state campaign, to provide coupons for pregnant women who initiate and continue prenatal care				X
5. Collaborate with March of Dimes to implement Stork Nests for clients receiving continuous prenatal care				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During CY 2005, approximately 85.1 percent of infants born were to women who had received prenatal care beginning in the first trimester. This represents an increase from 81.8 percent

reported for CY 2004.

c. Plan for the Coming Year
Mississippi's plan for this national measure in the coming year is to increase the percent of infants born to pregnant women who received prenatal care beginning in the first trimester by partnering with other agencies and organizations to dissiminate information on the importance of prenatal care, WIC, and family planning.

D. State Performance Measures

State Performance Measure 1: *Percent of children on Medicaid and SCHIP who receive EPSDT and preventive health services well child visits.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					33.4
Numerator					134265
Denominator					401799
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	35	37	40	42	45

a. Last Year's Accomplishments
During CY 2004, of the 261,831 Medicaid eligible children (6-20 years old), 40,381 (15.4 %) received screening services. The MDH continues to work with the Division of Medicaid, Head Start, and other community partners to increase the EPSDT screening participation rate. Arrangements have been made to provide screening in non-traditional settings and after-hours to facilitate access to services.

This measure has changed to include Medicaid eligible children age 0-20, and will be addressed under current activities

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Encourage parents during postpartum home visits to take advantage of EPSDT screenings				X
2. Provide information about EPSDT in WIC Packets		X		
3. Remind parents at immunization visits about the importance of EPSDT and to seek health care		X		
4. Check whether EPSDT screenings are due on children being seen for WIC services and screen if needed				X
5. Develop a plan to provide and ensure EPSDT services to all eligible children in the state				X
6. Conduct mass EPSDT screening in select areas	X			
7. Support funding sources to school nurses to perform EPSDT screening				X
8.				
9.				
10.				

b. Current Activities

During CY 2005, of the 401,799 Medicaid eligible children (0-20 years old), 134,265 (33.4 %) received screening services. The MDH will continue to work with the Division of Medicaid, Head Start, and other community partners to increase the EPSDT screening participation rate. Arrangements have been made to provide screening in non-traditional settings and after-hours to facilitate access to services.

c. Plan for the Coming Year

The MDH's plan for the coming year relative to this measure is to continue its efforts to provide increased access to health care for children on Medicaid. The MDH will continue to encourage parents during prenatal care and postpartum home visits to take advantage of EPSDT screenings. Parents will also be provided information about EPSDT screening at immunization visits and in WIC packets. Mass EPSDT screenings will be conducted in selected area of the state as well.

State Performance Measure 2: *Current percent of cigarette smoking among adolescents grades 6-12.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator			21.0	21.0	21.0
Numerator			597	597	597
Denominator			2843	2843	2843
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	21	20.5	20.5	20	20

Notes - 2005
Q31 (HS) and Q20 (MS). During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day? MDH did not receive weighted data for 2005, therefore data are from 2003 YRBSS.

a. Last Year's Accomplishments
According to YRBS data last year, 25 percent of Mississippi's public high school students age 9 through 12 are current smokers. However, through EPSDT, family planning, and other adolescent visits, the MDH staff will continue to directly counsel youths concerning the hazards of tobacco use.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Through EPSDT, Family Planning and other adolescent visits, counsel youths about tobacco use		X		
2. Maintain community-based tobacco prevention programs in collaboration with the Partnership				X
3. Maintain use of tobacco prevention curricula in school through the School Health Nurses				X
4. Conduct site visits to at least 15 schools to assess tobacco prevention activities				X
5. Train staff on smoking cessation specifically targeted to adolescents				X
6. Make literature available to communities and schools on smoking cessation		X		
7.				
8.				
9.				
10.				

b. Current Activities
According to the latest YRBS survey data (2003 YRBS Survey), 25 percent of Mississippi's public high school students grades 9 through 12 are current smokers. Because weighted data for CY 2005 were not obtained, the latest data (CY 2003) are being reported.

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

State Performance Measure 3: *Percent of pregant women who smoke*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					11.8
Numerator					5067
Denominator					42809
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	11.7	11.5	11.2	11	10.5

Notes - 2005
This measure changed with the 5 year needs assessment. It was formerly the percent of pregnant teenagers who smoked, but was decided that all women should be targeted. Therefore, data are new beginning with this reporting year.

a. Last Year's Accomplishments
During CY 2004, approximately 13.4 percent of all pregnant women smoked cigarettes. However, in an effort to reduce smoking among pregnant women, the MDH staff continues to work with nurses and health educators to increase health education classes related to smoking cessation. Pregnant women are also informed and/or provided educational materials as they utilized other MDH services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Work with nurses and health educators to increase health education		X		
2. Continue to educate pregnant women receiving services on the dangers of prenatal smoking		X		
3. Provide training about smoking cessation and pregnancy to nurses, nutritionists and social workers		X		
4. Refer to PHRM/ISS		X		
5. Refer to Tobacco Quitline Mississippi for information on smoking cessation		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During CY 2005, 11.8 percent of all pregnant women smoked cigarettes. The MDH staff will continue to work with nurses and health educators to increase health education classes related to smoking cessation. Pregnant women will also be informed and/or provided educational materials as they utilized other MDH services.

c. Plan for the Coming Year

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

State Performance Measure 4: *Percent of children with genetic disorders identified through MDH newborn screening who receive case management services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	90	95	96	97	98
Annual Indicator	94.8	93.7	98.2	99.5	99.5
Numerator	4010	2749	3060	2977	2977
Denominator	4228	2935	3117	2992	2992
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	98.5	98.5	98.5	98.5	99

Notes - 2005
Current 2005 data are unavailable. Provisional data are based on 2004 data.

Notes - 2004
During 2004, procedures were installed by the Genetic Services program to ensure that babies who needed a repeat specimen were tested again before they were 6 months old and too old to be screened again. This raised our percentage from 98.2% in 2003 to 99.5% in 2004.

Notes - 2003
The difference in the percent of children with genetic disorders who received case management services between 2001and 2002, can be attributed to staff changes in the field coupled with the adding of additional screenings mandated by the Mississippi Legislature.

a. Last Year's Accomplishments
In CY 2004, approximately 99.5 percent of children with possible genetic disorders received case management services. All newborn screens with inconclusive, abnormal, or presumptive positive test results are reported to genetics field staff for follow-up. Field staff work with local health department nurses to contact the families of these babies by phone or home visits to arrange for counseling and case management. They repeat the screens or collect diagnostic specimens if needed, and arrange for medical evaluation and treatment or other intervention if indicated. Children diagnosed with genetic disorders receive medical care and case management through local physicians, county health departments, the University of Mississippi Medical Center, other treatment centers, and MDH satellite clinics. Case Management services are limited for some infants with inconclusive results at screening due to the inability to locate families or refusal of service by families.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Report all inconclusive, abnormal, and presumptive positive test results to genetics field staff for counseling, clinic appointments, and follow-up.		X		
2. Contact families of babies with inconclusive, abnormal, or presumptive positive test results by phone or home visit, and arrange for counseling or case management.		X		
3. Repeat newborn screens or collect diagnostic specimens as needed, and arrange for medical evaluation and treatment if indicated.		X		
4. Assure that children diagnosed with genetic disorders have a local medical home and are under the care of a physician.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In CY 2005, approximately 99.9 percent of children with possible genetic disorders received case management services. All newborn screens with inconclusive, abnormal, or presumptive positive test results are reported to genetics field staff for follow-up. Field staff work with local health department nurses to contact the families of these babies by phone or home visits to arrange for counseling and case management. They repeat the screens or collect diagnostic specimens if needed, and arrange for medical evaluation and treatment or other intervention if indicated. Children diagnosed with genetic disorders receive medical care and case management through local physicians, county health departments, the University of Mississippi Medical Center, other treatment centers, and MDH satellite clinics. Case Management services are limited for some infants with inconclusive results at screening due to the inability to locate families or refusal of service by families.

c. Plan for the Coming Year

Mississippi's plan for this measure is to ensure that children testing positive for genetic disorders receive appropriate case management services. This will be acheived by reporting all positive test results to genetic field staff for clinic appointments and follow-up, and conducting home visits on positive cases for case management.

State Performance Measure 5: *The Rate of Repeat Birth (per 1000) for Adolescents Less Than 18 Years Old*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	13.9	13.6	13.1	13.2	12.5

Annual Indicator	140.6	140.8	138.8	125.5	124.2
Numerator	385	363	329	289	286
Denominator	2738	2578	2371	2303	2303
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	120	116	112	108	108

Notes - 2005
Objective is listed as a percent, not rate. To interpret correctly, the objective RATE should be 125 per 1,000 births.

a. Last Year's Accomplishments
During CY 2004, the final data for the rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years was 125.5 per 1,000 births to teenagers. The MDH sponsored collaborative training such as conferences and male involvement workshops, and support training of MCH/Family Planning nurses to ensure their understanding of the problem of repeat adolescent pregnancies and the benefits of family planning and inter-pregnancy spacing.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to sponsor, through MDHs Family Planning Program, collaborative training				X
2. Continue to support the training of MCH/Family Planning (MCH/FP) Coordinators				X
3. Continue to work with staff to make prevention of repeat adolescent pregnancies a priority				X
4. Encourage health departments to provide enhanced family planning services to adolescents				X
5. Partner with March of Dimes to implement more Project Alpha Projects				X
6. Continue to collaborate with Delta Health Partners (Healthy Start Initiative)				X
7.				
8.				
9.				
10.				

b. Current Activities
During CY 2005, the rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years was 124.2 per 1,000 births to teenagers. The MDH will continue to sponsor collaborative training such as conferences and male involvement workshops, and support training of MCH/Family Planning nurses to ensure their understanding of the problem of repeat adolescent pregnancies and the benefits of family planning and inter-pregnancy spacing.

c. Plan for the Coming Year
The MDH will continue to sponsor, through MDH's Family Planning Program, collaborative training such as conferences and male involvement workshops, work with local health department staff to make prevention of repeat adolescent pregnancy a priority in care plans for teen clients,

and continue to partner with the Mississippi Chapter of the March of Dimes to implement at least one Project Alpha Program in the state to increase healthy lifestyle behaviors among adolescent males through education and responsible decision-making.

State Performance Measure 6: *Percent of children ages 0-5 on WIC classified as overweight*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					13.0
Numerator					5248
Denominator					40391
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	12.8	12.5	12.2	12	11.8

Notes - 2005
Because data were only available with a history of 1 year, we were unable to find the percentile data tables needed to provide statistics for ages o to 23 months. Thus, statistical data are being provided for for this measure using ages 2 through 5 years of age.

a. Last Year's Accomplishments
There are no data for last year on this particular measure because it is a new measure being reported for the first time. However, the percent of children ages 0-5 on WIC classified as overweight will be addressed under current activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage and/or promote breastfeeding of infants			X	
2. Tailor food package to suit family needs			X	
3. Encourage health lifestyle changes			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In an effort to address obesity in children ages 0 through 5, the MDH WIC program encourages and/or promotes breastfeeding of infants, and is currently implementing a new policy for children age 2-5 referred to as "VENA" or Value Enhanced Nutrition Assessment. Children 2-5 with a Body Mass Index greater than the 95 percentile are required to be placed on skim milk. Mississippi is the first state to implement this policy. The WIC program is also conducting nutrition education classes that encourage WIC clients to make appropriate food choices and exercise.

c. Plan for the Coming Year

During the coming year, the MDH WIC program will continue encouraging breastfeeding of infants and implementing VENA, as well as promoting nutrition education classes that encourage WIC clients to make appropriate food choices and exercise.

State Performance Measure 7: *Percent of adolescents in grades 6-12 who are overweight or at risk for becoming overweight*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			27.3	27.3	27.3
Numerator			809	809	809
Denominator			2961	2961	2961
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	26	26	26	25	25

Notes - 2005
Most recent data are from 2003 YRBSS. MS did not receive weighted data for the 2005 YRBSS.

Notes - 2003
Q66(HS) & Q38 (MS) How do you describe your weight? From YRBSS questionairre.

a. Last Year's Accomplishments
There are no data for last year for this particular measure because it is a new measure being reported for the first time. However, the percent of adolescents in grades 6-12 who are overweight or at risk for becoming overweight will be addressed under current activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and implement health education programs targeting adolescents in grades 6-12 who are overweight or at risk of becoming overweight				X
2. Identify and recruit contact persons within the public school system to assist the initiation of health education programs targeting overweight of at risk students.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Child and Youth Prevalence of Overweight Survey (CAYPOS) was conducted in April and May 2003 in Mississippi. Before beginning the study, institutional review board approval was received through the Human Subjects Protection Review Committee at The University of Southern Mississippi. The sampling frame consisted of all elementary and middle school grades 1 through 8 (N = 729) with fall 2002 enrollment numbers by grade. A sample of 57 schools was

selected using PC Sample software (28), which selects schools by probability proportional to enrollment with a random start. Overall, 24.0% of students in grades 1 through 8 were found to be overweight, and another 14.7% were at risk for becoming overweight. With the exception of sixth grade, there was a trend of increasing prevalence of overweight by grade (17.5% in grade 1 compared with 31.3% in grade 8). In the Child and Youth Prevalence of Overweight Survey, 25.2% of students in grades 6 through 8 were found to be overweight, compared with 18.5% in the Youth Risk Behavior Surveillance System.

Because this is a new state priority, efforts are now being discussed as to how to address this growing issue in Mississippi.

c. Plan for the Coming Year
In an effort to address childhood obesity, the MDH will work to develop and implement health education programs in Mississippi targeting adolescents in grades 6-12 who are overweight or at risk of becoming overweight.

State Performance Measure 8: *Percent of Medicaid eligible children ages 1-5 reported to have had at least one preventive dental service*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator				29.2	29.2
Numerator				33032	33032
Denominator				113311	113311
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	30	30.5	31	31.5	32

Notes - 2005
Data obtained from CMS website, 2003 participation report. Numerator is Total eligibles recieving preventive dental services (#12b) and Denominator is Totlal eligibles who should recieve at least one initial or periodic screen (#8).

a. Last Year's Accomplishments
There are no data for last year for this particular measure because it is a new measure being reported for the first time. A 2000 MDH Oral Health clinical survey of 5,227 third-grade children showed that only 17% had at least one dental sealant on a permanent first molar tooth, over 70% demonstrated experience with dental decay, and about 15 percent of children were in urgent need of dental care, defined by pain and suffering, clinical inflammation, or loss of function. Several programs have been put into place to improve access to oral health programs. However, much remains to be done. Therefore, increasing oral health care and preventive services for children will be a 2005 Needs Assessment priority.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Initiate at least two oral health questions in the WIC certification application			X	
2. Initiate more water flouridation programs in communities			X	
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The MDH's Dental program is involved in providing a variety of dental services. Namely, the program is currently promoting awareness about community water fluoridation programs in the Mississippi Delta Region; training professional school nurses and Health Department nurses to properly perform oral health assessments as part of Medicaid EPSDT screening; delivering preventive dental sealants in Public Health District III; and recruiting eligible elementary schools for the 2006-2007 weekly fluoride mouth rinse program.

c. Plan for the Coming Year
The MDH's Dental Program will engage in the promotion of several activities aimed at improving oral health in Mississippi. In the coming year, the Dental Program will implement the use of oral health risk reduction assessments using MDH Web and Palm-application software to identify children at-risk for oral disease and provide early intervention; begin implementing state oral health plans (first year activity or a five-year plan) by engaging key state and community partners to form a statewide oral health coalition; and the development of oral health programming through WIC and Child Health Programs.

E. Health Status Indicators

Health status indicators allow the MDH to provide services to all 82 counties in Mississippi. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care. County level efforts are coordinated through nine public health districts. The District Chief Nurse oversees all public health nursing activities in the district and supervises the Maternal-Child Health/Family Planning Coordinator.

Although a well coordinated network of services are being provided on a statewide basis by the MDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Risk Tobacco Survey and the Youth Risk Behavior Survey, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. The MCH Health Services Data Unit's plans are to continue its work with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files and; to conduct statewide need assessments when needed. Progress in accomplishing these objectives has been made, but challenges exist in staffing and compatible data systems. Additional challenges also exist that are due to the MDH's quest to reconstruct the agency's current data collection systems to establish a more centralized integrated data system for improved data analyses. The establishment of this improved data collection system will be used to aide the MDH in the sharing of quality data to assist its partners, and other health care providers throughout the state, in making and/or developing ways to better respond to the health concerns of the citizens of

Mississippi.

During FY 2005, the most significant achievement was the successful completion of the Title V Block Grant Needs Assessment. A workgroup of stakeholders was established consisting of office directors and district staff, Medicaid representatives, Human Services, Mississippi Systems of Care, and other social services agency executives. Data collection was initiated at state, district, and community levels. Secondary resources for state level data included vital statistics, national MCH performance and outcome measures, and state performance measures. Other specific topics investigated at the state level included: Perinatal Periods of Risk, Asthma Surveillance and Prevention, Prematurity and Infant Mortality, and the Mississippi National Evaluation of Camp Noah. Ad hoc committees were created to develop two survey tools for primary data collection within districts and communities. Both consumer and community survey tools were descriptive and qualitative in nature. The purpose of the consumer survey was to collect information regarding barriers to care, public health needs, and to determine if needs were being met. The second survey interviewed state MCH professionals to identify special subpopulations within the state to rate barriers of care, and to recruit feedback to help determine the best way to address challenges within communities.

Two conferences were held, the first occurring in August, 2004 to initiate the kick-off of the needs assessment process, to build collaboration among MCH professionals, and to provide health professionals with an opportunity to obtain more information on birth defects and developmental disabilities. The second conference was held in March, 2005 to present and/or report findings associated with the needs assessment to stakeholders, community leaders, and health professionals throughout the state.

Another major achievement during the FY 2005 period was the completion of an analysis of the Children with Special Health Care Needs SLAITS survey specific to Mississippi. A CDC ORISE Fellow assigned to Mississippi conducted analyses related to the CSHCN population. The findings were beneficial not only to the MCH Needs Assessment, but also to the Children's Medical Program (CMP), the state's CSHCN program. The analysis included information suggesting that consistency of health insurance plays a major role in access to care. The analysis also revealed that some CSHCN experience shortages in providers and access to oral health services.

F. Other Program Activities

TORT REFORM

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

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

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

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

G. Technical Assistance

The MDH is not requesting any technical assistance during this particular grant period. However, many MCH programs seek technical assistance from other sources and other state programs as needed. For example, simply by attending different professional conferences, such as YRBSS training, MDH staff gains valuable technical skills and are exposed to technical assistance in various MCH situations specific to their programs.

V. Budget Narrative

A. Expenditures

EXPENDITURES

The three components and the anticipated expenditure amounts are described below:

Component A, Services for Pregnant Women and Infants, is budgeted as follows for FY 2006: $3,161,223 for federal funds (30 percent of the total federal award), $2,702,753 for non-federal funds (34 percent of total non-federal funds).

Component B, Services for Child and Adolescent Health, is budgeted as follows for FY 2006: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for non-federal funds (33 percent of total non-federal funds).

Component C, Services for Children with Special Health Care Needs, is budgeted as follows for FY 2006: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for total non-federal funds (33 percent of total non-federal funds).

Administrative Costs are budgeted at $1,053,740 which is 10 percent of the total federal grant award. This amount will not exceed the allowable 10 percent of the total MCH Block Grant as mandated in OBRA 1989.

Personnel are employed to develop and implement standards of care as well as to directly provide services to clients. Typically, classes of employees include physicians, social workers, nurses, nurse practitioners, nutritionists, health aides and clerical staff. Employees are required to meet the standards for practice as specified by his or her professional organization.

Travel is reimbursed for official duty at the state authorized rate of $0.445 per mile. Government contract rates for lodging and per diem ceilings for subsistence are also utilized.

Equipment including minor medical and office, may be purchased in order to administer the program. The equipment items are minor parts of the budget. State regulations governing purchase of equipment are strictly followed.

Supplies include the necessary clinical and office materials to operate the programs and to deliver patient care. Supplies are purchased centrally and according to purchasing policy of state government.

Contractual reflects funds budgeted to purchase services from outside providers. Examples would be for high risk medical care for women and CSHCN.

Construction: none

Other includes telephone, copying and postage used on behalf of the block grant program.

B. Budget

BUDGET

The budget for Mississippi's MCH Block Grant application was developed by Health Services in cooperation with the Office of Administrative and Technical Support, Bureau of Finance and Accounts. The total program for FY 2007 is $18,486,681 of which $10,537,408 (57 percent) is Title V and $7,949,273 (43 percent) is match provided in-kind by the applicant. Sources of match

funds are state funds, Medicaid earnings (as allowed by the MCH Bureau), and other Third Party earnings. Other federal funds available to support the MCH objectives are listed on Form 4.

The MDH will expend funds for the four types of services (Core Public Health/Infrastructure, Population Based Individual Services, Enabling and Non-Health Support, and Direct Health Care Services). Services will target the three categories including pregnant women and infants, children and adolescents, and Children with Special Health Care Needs, specifically those in families living at or below 185 percent of the federal poverty level. This includes services to be provided or coordinated for individuals, by category of individual served and source of payment or for budgeting/accounting/auditing for each capacity building activity described in the Annual Plan (e.g., public health leadership and education, assessment, policy development, planning, technical assistance, standard setting, quality assurance, and the like).

Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2007 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989 as indicated in the attached chart.

Matching funds for the MCH Block Grant are identified by listing all direct program costs which have been paid from non-federal sources. These expenses include travel, medicine, medical services, clinical, and lab supplies. Funds used to match Medicaid or other grants are deducted. All salary and non-salary charges for the Children with Special Health Care Needs program are identified by budget. The agency time study provides a report of the value of staff time paid from state or county funds. Time coded to Family Health, Family Planning, Maternity, Perinatal High Risk Management and other Maternal and Child Health efforts is used to match the Perinatal Services category. Time coded to Child Health, Dental Health and School Nurse is used to match the Children and Adolescent category.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.