Maternal and Child Health Services Title V Block Grant

Missouri

Created on 8/11/2023 at 12:33 PM

FY 2024 Application/ FY 2022 Annual Report

Table of Contents

I. General Requirements 4

I.A. Letter of Transmittal 4

I.B. Face Sheet 5

I.C. Assurances and Certifications 5

I.D. Table of Contents 5

II. Logic Model 5

III. Components of the Application/Annual Report 6

III.A. Executive Summary 6

III.A.1. Program Overview 6

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts 10

III.A.3. MCH Success Story 11

III.B. Overview of the State 12

III.C. Needs Assessment FY 2024 Application/FY 2022 Annual Report Update 23

III.D. Financial Narrative 32

III.D.1. Expenditures 34

III.D.2. Budget 37

III.E. Five-Year State Action Plan 42

III.E.1. Five-Year State Action Plan Table 42

III.E.2. State Action Plan Narrative Overview 43

III.E.2.a. State Title V Program Purpose and Design 43

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems 50

III.E.2.b.i. MCH Workforce Development 50

III.E.2.b.ii. Family Partnership 58

III.E.2.b.iii. MCH Data Capacity 63

III.E.2.b.iii.a. MCH Epidemiology Workforce 63

III.E.2.b.iii.b. State Systems Development Initiative (SSDI) 65

III.E.2.b.iii.c. Other MCH Data Capacity Efforts 66

III.E.2.b.iv. MCH Emergency Planning and Preparedness 70

III.E.2.b.v. Health Care Delivery System 74

III.E.2.b.v.a. Public and Private Partnerships 74

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA) 77

III.E.2.c State Action Plan Narrative by Domain 79

Women/Maternal Health 79

Perinatal/Infant Health 103

Child Health 129
Adolescent Health 154
Children with Special Health Care Needs 172
Cross-Cutting/Systems Building 199
III.F. Public Input 215
III.G. Technical Assistance 219
IV. Title V-Medicaid IAA/MOU **220**
V. Supporting Documents **221**
VI. Organizational Chart **222**
VII. Appendix **223**
Form 2 MCH Budget/Expenditure Details 224
Form 3a Budget and Expenditure Details by Types of Individuals Served 230
Form 3b Budget and Expenditure Details by Types of Services 232
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated 235
Form 5 Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V 240
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX 245
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data 248
Form 8 State MCH and CSHCN Directors Contact Information 250
Form 9 List of MCH Priority Needs 254
Form 9 State Priorities – Needs Assessment Year – Application Year 2021 256
Form 10 National Outcome Measures (NOMs) 257
Form 10 National Performance Measures (NPMs) 298
Form 10 State Performance Measures (SPMs) 308
Form 10 Evidence-Based or –Informed Strategy Measures (ESMs) 312
Form 10 State Performance Measure (SPM) Detail Sheets 318
Form 10 State Outcome Measure (SOM) Detail Sheets 321
Form 10 Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets 322
Form 11 Other State Data 327
Form 12 MCH Data Access and Linkages 328

I. General Requirements

I.A. Letter of Transmittal

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 | Phone: 573-751-6400 | FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired and Voice dial: 711

Paula F. Nickelson
Director

Michael L. Parson
Governor

July 25, 2023

Shirley Payne, PhD, MPH, Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources & Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane, 18N100A
Rockville, MD 20857

Dear Dr. Payne:

I am pleased to submit Missouri's Department of Health and Senior Services Title V Maternal and Child Health Block Grant FFY 2024 Application and FFY 2022 Annual Report. The application and report have been developed in conformance with the Guidance and Forms for the Title V Application/Annual Report (OMB NO: 0915-0172, expiration January 31, 2024) and are being submitted through the HRSA Electronic Handbook (EHB) and Title V Information System (TVIS) web-based reporting systems.

Title V MCH Block Grant funds assure the provision of essential maternal and child health services in Missouri, and we look forward to continued partnership to improve the health of women, infants, children, adolescents, children and youth with special health care needs, and their families.

If you have any questions regarding any part of Missouri's annual application and report, please contact me at (573) 751-6435 or Martha.Smith@health.mo.gov.

Sincerely,

Martha J. Smith, MSN, RN
Missouri MCH Director

PROMOTING HEALTH AND SAFETY
The Missouri Department of Health and Senior Services' vision is optimal health and safety for all Missourians, in all communities, for life.

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Missouri's Title V MCH Block Grant is managed by the Department of Health and Senior Services (DHSS), Division of Community and Public Health (DCPH). Martha J. Smith, MSN, RN, is the state Maternal Child Health (MCH) Director and the interim Title V Children with Special Health Care Needs (CSHCN) Director. The Title V MCH Services Block Grant application is submitted by the DHSS as the designated state agency for the allocation and administration of these block grant funds. DHSS Title V MCH staff and programming are positioned throughout multiple divisions and organizational units. DCPH serves as the umbrella entity that facilitates access to numerous MCH-targeted programs and provides a majority of the services to the MCH populations. The capacity of Missouri's Title V MCH programming is large, encompassing DHSS programs and staff, programs and staff within the Office of Childhood at the Department of Elementary and Secondary Education, local public health agencies (LPHAs), and numerous private and community partners. It is through these programs, initiatives, and partnerships that a statewide system is supported to meet the needs of the MCH population. In 2021, Missouri's MCH population estimate, including women of childbearing age, infants, children, and adolescents, was 2,494,581, comprising 40.3% of the state's total population. This included 1,188,885 women of childbearing age (15-44 years; females 15-18 years are included in the women of childbearing age population estimate and excluded from the infant/child/adolescent total), and 1,305,696 infants, children, and adolescents (<1 to 18), 278,712 of which were CYSHCN.

Based on the Five Year Needs Assessment completed in the spring of 2020, the Missouri MCH leadership team identified the following FY2021-2025 state priorities and developed strategies and action plans to address these needs:

1. Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.
2. Promote safe sleep practices among newborns to reduce sleep-related infant deaths.
3. Reduce obesity among children and adolescents.
4. Reduce intentional and unintentional injuries among children and adolescents.
5. Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.
6. Enhance access to oral health care services for children.
7. Promote protective factors for youth and families.
8. Address social determinants of health inequities.

Five National Performance Measures (NPMs) and three State Performance Measures (SPMs) were chosen to align with the priority needs and are discussed below by population domain. Overall, Missouri retained six performance measures from the previous cycle and added two new measures. Progress will be monitored by tracking these performance measures. The needs assessment also identified two overarching principles to be applied across all priorities, performance measures, and strategies. These are to ensure access to care, including adequate insurance coverage, for MCH populations and to promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities.

Title V MCH resources are assigned and program activities are implemented to specifically address the identified priorities. Both budgeted dollars and expenditures are categorized and tracked by population served and across the three service levels in the MCH Pyramid: direct health care services, enabling services, and public health services

and systems. State and Federal MCH funding helps sustain the following programming:

- Community Health Services (injury prevention, adolescent and school health)
- Environmental Health (childhood lead poisoning prevention)
- Epidemiology (vital statistics, analytics, surveillance systems)
- Healthy Children and Families (home visiting, newborn health, TEL-LINK, safe cribs, MCH WarmLine, MCH Navigators)
- Genetics (newborn screening)
- Early Childhood (developmental monitoring, child care health consultation, inclusion services, parent advisory council (PAC))
- Oral Health (preventive services, community outreach)
- Special Health Care Needs (family partnership, care coordination, assistive technology)
- Women's Health (MCH services, infant & maternal mortality, maternal substance use and mental health, health services for incarcerated women)
- Nutrition & physical activity (breastfeeding, obesity prevention)
- Crosscutting (immunizations, communicable disease prevention, health equity)

Women/Maternal Health
Priority: Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.
NPM: Percent of women, ages 18 through 44, with a preventive medical visit in the past year

The health and wellbeing of the mother before, during, and after pregnancy is important not only for the woman but also for the newborn. Women who maintain a healthy lifestyle during the preconception period are less likely to experience adverse pregnancy and obstetric outcomes and are more likely to experience better health outcomes during the postnatal period and across the life span. According to data from the 2021 Behavioral Risk Factor Surveillance System (BRFSS), 72.4% of Missouri women between 18-44 years of age reported having a preventive health care visit within the past year. This was higher than the 2021 national prevalence of 69.7%. In Missouri, a higher percentage of insured women (76.5%) compared to uninsured women (41.3%) received a preventive visit in 2021. Title V MCH funds efforts to improve access to preventive health care for women, including: TEL-LINK which provides referrals to care for women of childbearing age and their families; the Newborn Health Program which partners with community providers to educate the MCH population on health resources (including preventive care); the Home Visiting Program which facilitates enrollment in MO HealthNet and/or Affordable Care Act marketplace insurance programs for participants; and MCH contracts with the LPHAs to build community-based systems and expand the resources those systems can use to respond to priority MCH issues, including providing and assuring mothers and children (in particular those with low income or limited availability of health services) access to quality MCH services.

Perinatal/Infant Health
Priority: Promote safe sleep practices among newborns to reduce sleep-related infant deaths.
NPM: A) Percent of infants placed to sleep on their backs.
B) Percent of infants placed to sleep on a separate approved sleep surface.
C) Percent of infants placed to sleep without soft objects or loose bedding.

Sudden unexpected infant deaths (SUID) combine infant deaths due to Sudden Infant Death Syndrome (SIDS), accidental suffocation and strangulation in bed, and deaths of unknown cause. In Missouri, the rate of SUID in 2020 was 102.6 per 100,000 live births, considerably higher than the national rate of 92.9 per 100,000 live births. In 2020, over half of SUID deaths in Missouri were attributed to accidental suffocation and strangulation in bed (56%). The

remaining SUID deaths, due to SIDS and unknown causes, contributed to 24% and 20% of SUID deaths respectively. Safe sleep recommendations have made marked contributions to the reduction of the national SUID rate since the early 1990s. In Missouri, 2021 PRAMS data showed that mothers in a younger age group, with less education, with lower household income, or who were African-American were significantly less likely to follow safe sleep recommendations. Safe sleep continues to be a priority for Missouri's Title V MCH Block Grant, which is the primary resource for the Safe Cribs for Missouri Program. The Safe Cribs Program provides safe sleep education and free cribs to eligible families. Title V MCH Home Visiting Program participants also receive intensive education on safe sleep for their infants. Title V provides supplemental funds to support operations of the PRAMS survey, which monitors safe sleep practices in the state, and supports printing and distribution of the *Pregnancy and Beyond* book, which includes information on safe sleep and infant care. The MCH Services Program contracts with LPHAs to promote safe sleep practices to reduce sleep-related infant deaths, and regional Safe Kids coalitions work closely with community partners to provide cribs and safe sleep education, trainings and events to reduce the risk of infant injury or death due to unsafe sleep environments.

Child Health
Priority: Reduce obesity among children and adolescents.
NPM: *Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.*

Priority: Enhance access to oral health care services for children.
SPM: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

In 2021, 17% of WIC-enrolled two-to-four year olds in Missouri were overweight, and an additional 15% were obese. Among older children (10-17 years), 14.8% were overweight (85th-94th percentile for age), and 18.9% were obese (>95th percentile for age) in 2020-2021. Overweight and obesity were more frequent among 10-13 year olds than among high-school-aged youth (Overweight 16% vs 13.6%; Obese 24.4% vs. 13.8%). Physical activity levels decline as children get older; while 34.3% of 6-11 year-old children were physically active every day, only 18.2% of 12-17 year-olds were physically active every day.

High levels of physical activity in early childhood are predictors of continued physical activity as children age into young adulthood—underscoring the importance of establishing healthy physical habits among youth. The School Health Program supports school nurses to engage with students and families in addressing overweight/obesity among children. The MCH Services Program contracts with LPHAs to promote physical activity and prevent and reduce obesity among children and adolescents, and the Building Communities for Better Health LPHA contract implements policy and environmental changes that increase opportunities for children to engage in physical activity across multiple settings.

According to National Survey of Children's Health (NSCH) 2020-2021 data, 75.1% of children ages 1-17 years old nationally had a preventive dental visit in the last year. This was a greater percentage than in Missouri (69.8%). A lower percentage of Missouri children age 1-5 years old (48.2%) had a preventive dental visit than their national counterparts (54.7%). This age group also had a lower percentage than Missouri children age 6-11 years old (76.5%) and 12-17 years old (80.7%). 17.4% of Missouri children age 6-11 years had some degree of tooth decay. Title V MCH supports Office of Dental Health efforts to promote cavity prevention and oral health for schoolchildren through literature and programs, including providing fluoride varnish.

Adolescent Health
Priority: Reduce intentional and unintentional injuries among children and adolescents.
NPM: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Priority: Promote Protective Factors for youth and families.
SPM: Suicide & self-harm rate among youth ages 10 through 19.

Intentional and unintentional injury continue to be the leading cause of preventable death and hospitalization among Missouri's children. Missouri continues to report higher rates of injury related death and hospitalization than the national average. In 2021, the leading cause of death for youths aged 10-19 was unintentional injuries (20.0 per 100,000). Homicide among Missouri adolescents between the ages of 10-19 replaced suicide as the second leading cause of death for this age group (9.9 per 100,000). In 2021, 71 Missourians aged 10-19 died of suicide (8.9 per 100,000), the third leading cause of death for this age group, making up approximately 6% of all suicides that year. Improving resiliency and mental health among children and youth of all ages will impact suicide and risk-taking behavior. Safe Kids Coalitions in Missouri work to provide unintentional injury prevention services to children aged 0-19 years, including addressing teen driver safety. The Adolescent Health Program (AHP) focuses on Social-Emotional Learning, and the Injury Prevention Program, in partnership with the AHP, provides a Mental Health Crisis Toolkit for families with youth experiencing a mental health crisis. The MCH Services Program contracts with LPHAs to prevent intentional and unintentional injuries, prevent child abuse and neglect, and promote motor vehicle, water, bicycle, and other general safety among children and adolescents. LPHAs also promote protective factors for youth and families to prevent adolescent suicide and self-harm.

Children and Youth with Special Health Care Needs (CYSHCN)
Priority: Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.
NPM: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

In 2020-2021, 48.5% of Missouri CYSHCN received care that met medical home criteria, a rate less than that of children and youth without a special health care need (50.4%). Data from the 2020-2021 NSCH showed that 14.7% of Missouri CYSHCN received care that met the criteria for a well-functioning system compared to 13.7% nationwide. This same survey indicated that among children without special health care needs nationally, 47.7% received care through a medical home, compared with 50.4% in Missouri. This rate is below the HP2030 target of 53.6%. The Bureau of SHCN provides targeted education to enrolling families on the importance of a medical home. Additionally, Title V MCH programs promote health insurance coverage to improve the likelihood that all children will have a medical home and services to address their needs.

Cross-Cutting/Systems Building
Priority: Address Social Determinants of Health inequities.
SPM: Percent of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Social Justice trainings.

Qualitative and quantitative data indicate that Missouri continues to experience concerning outcome disparities in maternal and child health associated with socioeconomic status, race and geography. Title V MCH core team members facilitate workforce development training on essential MCH content that is foundational for effective and equitable leadership, including topics such as the social determinants of health inequities, trauma-responsive care and services, cultural competence, health literacy, and effective multisector collaboration. Activities to address the social determinants of health inequities include reviewing training resources, such as the MCH Navigator trainings and MCH Leadership Competencies, establishing core training requirements for internal Title V MCH funded programs/staff and external contractors, and ongoing development and implementation of a progressive MCH Training Plan.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Federal Title V funds provide backbone funding for approximately 125 key staff positions in MCH programs across the Department of Health and Senior Services and the Office of Childhood in the Department of Elementary and Secondary Education (not including senior leadership, budget/financial support staff, procurement staff, and information technology support staff). This includes staff who serve children and youth with special health care needs (CYSHCN), such as the Family Partners; epidemiological staff who analyze data to identify priority health needs of the maternal/child population; and staff who focus on women's, newborn, children's, and/or adolescent's health. Staff also provide technical assistance to community partners, such as Safe Kids coalitions and the 115 Local Public Health Agencies (LPHAs). Contract funding to LPHAs comprises almost thirty percent of federal funds to help build community-based systems and expand the resources those systems can use to respond to priority maternal child health issues. The bulk of remaining contract funds are dispersed for home visiting, service coordination for CYSHCN, early childhood, and dental health contracts. The majority of state match supports newborn screening testing by the State Public Health Lab, newborn screening follow-up, and direct care for CYSHCN. State funds also support women's health services for incarcerated women and the Sexual Assault Forensic Examination – Child Abuse Resource and Education program. Federal Title V funds allow Missouri to coordinate public health services provided to the maternal child population by working across multiple state programs, engaging community partners and families, and collaborating with public health stakeholders throughout the state to address both ongoing and emerging issues.

III.A.3. MCH Success Story

The MCH Services Program is comprised of a Program Manager and four District Nurse Consultants (DNCs). Each DNC provides consultation and technical assistance to the LPHAs within one of four regions and serves as a liaison between the state and local levels. In 2022, the MCH Services Program was reorganized to the Bureau of Community Health and Wellness, enhancing collaboration with several other health promotion programs serving maternal and child populations.

During the pandemic, the MCH Services Program saw an unprecedented rate of turnover within LPHAs, including administrators, nurses, health educators, and administrative support staff. The resulting local public health workforce shortage significantly limited crosscutting and systems-building capacity. Many LPHA partners reported feeling isolated and requested a forum to communicate/collaborate with other LPHAs doing similar work, both within their respective regions and across the state. The MCH Services Program HUDDLE originated in November 2022 to strengthen LPHA knowledge, expertise and partnerships by facilitating dialogue about challenges and possible solutions and encourage mutual commitment to work together to realize improvements, specifically increasing MCH system-building capacity at the local level. The HUDDLE is convened quarterly in a virtual format and includes a presentation by a content expert on a MCH topic, followed by breakout sessions facilitated by the DNCs. Approximately 75-100 LPHA staff attend each quarterly meeting, and participants report increased feelings of comradery, support from peers and access to resources and tools for building capacity and supporting system-building.

HUDDLE presenters have included DHSS programs, LPHAs and other MCH partners. The Jefferson County Health Department presented how they use digital engagement to improve communication and drive success in health and safety programming for the MCH population. Many LPHA partners verbally expressed they learned something new and planned to apply the knowledge by creating branding for their social media, email signatures, and letterheads. These activities have helped them become more recognizable to their community members and partners that serve the MCH population. ParentLink presented the services offered for the MCH population, focusing on the WarmLine and the MCH Navigator program, and discussed how LPHAs can utilize ParentLink services to improve MCH outcomes at the local level. In a follow-up conversation, the ParentLink Executive Director shared that 12 LPHA requested ParentLink materials within the 20 minutes following the discussion. LPHAs verbally shared plans to share the materials widely and connect more families to ParentLink. Some LPHAs have reported placing the ParentLink brochures in laundromats, grocery stores and other local establishments to increase awareness of ParentLink's statewide resources for the MCH population and their families.

The MCH Services Program is 100% funded by Title V MCH Block Grant funding. The success experienced by the MCH Services Program is a direct result of Title V MCH Block Grant partnership, support and funding. The effectiveness of the LPHAs to address the needs of their local MCH population is largely dependent on the strong partnership between the MCH Services Program and the Title V MCH Block Grant.

III.B. Overview of the State

Geography

Missouri is comprised of 115 counties (114 counties and one independent city, St. Louis), covering an area of approximately 69,707 square miles, and ranks 21st in size among all states in the nation.[1] The state is centrally located in the heartland of the United States and shares borders with Arkansas, Kansas, Kentucky, Illinois, Iowa, Nebraska, Oklahoma, and Tennessee. The two largest rivers in the state are the Mississippi, which marks the eastern border of the state, and the Missouri, which flows across the middle of the state. Two large metro areas, Kansas City and St. Louis, are located on the western and eastern borders respectively, and are connected by the "I-70 Corridor."

Demography/Population Density

The 2021 U.S. Census state population estimate was 6,168,187 residents.[2] From 2010 to 2020, the state's population increased by 2.6%, including a 2.8% increase for males and a 2.5% increase for females. Missouri was ranked 29th among the 50 states and the District of Columbia for population density (89.7 people per square mile in 2021.[3])

The Missouri population has a noteworthy distribution pattern for its urban compared to rural areas. Missouri is a largely rural state, with 16 urban counties and 99 rural counties[*]. The City of St. Louis and 15 other counties are considered urban areas. Six other cities designated as Metropolitan Statistical Areas (MSAs) by the Census Bureau, listed in order of size: Springfield, Columbia, Joplin, Jefferson City, St. Joseph and Cape Girardeau. About 55% of Missouri's population falls within the MSA of its two major cities, St. Louis and Kansas City. The St. Louis MSA accounts for 35% of the state's population while the Kansas City MSA contributes almost 21%. Of Missouri's more than 6 million residents, roughly 2,063,000 (34%) live in one of the 99 rural counties.

The largest urban counties by population are St. Louis (997,187) and Jackson (716,862) counties. The greatest population density is in St. Louis City, with 4,778 people per square mile. The lowest population density at 7 people per square mile is tied between Knox, Reynolds, Shannon, and Worth Counties. The largest county in the state by area was Texas County, with an area of 1,179 square miles, and a population density of 20 persons per square mile. In total, 48 of Missouri's counties had a population density below 25 persons per square mile.[4]

Age

The estimated median age of Missourians for 2017 to 2021 was 38.8 years old.[5] For 2021, nearly 22.4% of the state's population (1,383,537) was less than 18 years old, and 17.6% of the population (1,084,768) was age 65 or older.[2] Missouri's MCH population including women of childbearing age (15-44), infants, children, and adolescents (under 1-19) was 2,535,028.[2] This accounted for 41.1% of the state's roughly 6.15 million population. Among this MCH population, 1,188,885 were women of childbearing age (15-44 years) and 1,540,293 infants, children, and adolescents (ages 0-19 years).[2] There was an estimated 278,712 children with special health care needs for the 2020-2021 time period.[6] In 2021, there were 69,269 Missouri resident live births, of which, 15.4% were African-American and 78.4% were White.[7] Hispanic births in Missouri increased by 11.8% from 2011 to 2021 (4,110 and 4,593 respectively).[7]

Diversity/Language

Based on population estimates from 2021, Missouri residents are predominantly White (84%) with a significant African-American (12.6%) population and smaller Asian/Pacific Islander (2.6%) and American Indian (0.76%) resident populations.[2] For 2021, the top three jurisdictions for proportion of population that is Black or African American alone or in combination are St. Louis City (46.1%), Pemiscot County (27.7%), and St. Louis County (25.9%).[8] The

Hispanic or Latino population comprises 4.7% of Missouri's population.[8] Population growth for Hispanics in Missouri was 30.5% from 2011 to 2021,[8] compared to 20.9% for Hispanics or Latinos nationally.[9]

The U.S. Census Bureau, via the American Community survey (ACS), provides 2016-2020 5-year estimate data, suggesting the degree of diversity in Missouri. The 5-year estimate of native-born United States citizens comprising the Missouri population was 5,867,824 (95.8%).[10] Furthermore, ACS data indicate 4.2% of the Missouri population was foreign born with an estimated population size of 256,336 for 2016-2020.[10] Of the residents that were not born in the United States, 39.8% were from Asia, 28.6% from Latin America, 18.4% came from Europe, 9.7% came from Africa, and 3.6% from other regions of the world.[11] Furthermore, 361,104 (6.3%) Missourians aged five and above spoke a language other than English at home. Of that group, 125,479 persons spoke English less than 'very well', which was 2.2% of the population aged 5 years and older. An estimated 149,698 (2.6%) Missourians 5 years and older spoke Spanish at home.[12] The Missouri Department of Health and Senior Services contracts with a vendor to translate program materials and health messages into a variety of languages and up to 17 different dialects to reflect the growing diversity of the state population.

Addressing factors related to diversity that lead to adverse maternal-child health outcomes represents an ongoing challenge for public health in the state. Examining data from 2021, the infant mortality rate (age <1 year) for African American babies (12.2 per 1,000) was more than double that of white babies (4.6 per 1,000).[13] Though minority populations tend to cluster near urban centers, granting better access to health services than many rural non-minorities, their ability to secure quality care is an additional challenge.

Education

The 2017-2021 ACS estimates 90.9%of Missourians over the age of 25 are high school graduates or higher.[14] This was higher than the national average of 88.9%.[15] However, the percentage of Missourians in this age group that have a bachelor's degree or higher (30.7%), was less than the U.S. average (33.7%).[14,15]

Economy

Missouri's metropolitan areas make up the largest portion of the state's economy. St. Louis and Jackson counties combined contribute nearly one third of the state's economy in terms of employment, personal income, and population. Regardless of population size, all regions of Missouri contribute to the state's economic resources. Missouri's rural areas are especially important for tourism and agriculture in the state. In 2021, agriculture, forestry, and related industries contributed approximately $93.7 billion and generated 456,618 jobs.[16] Missouri's median estimated household income for 2016-2020 was $57,290, which was $7,704 less than the national median household income of $64,994.[17,18]

Missouri's unemployment rate decreased from 2.7% in November 2022 to 2.5% in April 2023 (preliminary).[19] Due to the COVID-19 pandemic, many industries were forced to furlough and lay-off workers. Data from the Department of Labor and Industrial Relations showed the total number of initial unemployment claims for Missouri in the month of April 2023 to be 9,162, a significant decrease from 13,348 in July 2022 and 32,746 in July 2021.[20,21,22] Workforce development and economic stability were major focus areas of Missouri's COVID-19 response. Missouri's receipt of federal grants for responding to COVID-19 has a positive impact on the state's economic recovery and growth. The use of federal resources to surveil and control the spread of COVID-19 was essential in stabilizing Missouri's economy and preventing further economic decline, and grants still being implemented will be essential in bolstering the state's public health and healthcare infrastructure and workforce. These investments in infrastructure and workforce priorities provide short-term economic benefits and better prepare Missouri to protect from potential economic shocks due to future health crises.

Poverty

The ACS provides poverty data for the population for whom poverty status was determined. Among this population of Missourians, the estimated percent of those below the poverty level for 2016-2020 (13.0%) was lower compared to the estimated percent (13.7%) for 2015-2019.[23, 24] Furthermore, Missouri's estimated 2016-2020 poverty rate for children under 18 years old was 17.4%, which was higher than the state overall rate. Nearly 773,000 Missourians were living below poverty and nearly 234,000 of them were children.[23]

Food insecurity is an important issue that can affect children and families and may be affected by having poverty-level income. Current Population Survey Food Security Supplement data suggests Missouri's average 2019-2021 household food insecurity rate was 12.1%, which was higher than the national rate of 11.0%.[25] Additionally, the 2021 estimated overall child food insecurity rate for Missouri was 12.8%, a decrease from 14.1% in the previous year.[27] The 2018-2020 very low food security rate for Missouri was reported to be 5.1% compared to 4.1%, nationally.[25]

Homelessness

The 2022 Annual Homeless Assessment Report to Congress provides estimates of the number of people experiencing homelessness, homeless families with children, and unaccompanied homeless youth on any given night in 2022. Overall, 5,992 Missourians, 1,680 families with children and 446 unaccompanied youth, were reported to experience homelessness on any given night in 2022. Missouri experienced a substantial 29.8% (198 youths) decrease in the number of unaccompanied youth experiencing homelessness from 2020-2022.[28]

Environment

Lead mining and smelting has been an important part of Missouri's history since the early 1700's. Missouri has been the dominant lead-producing state in the nation since 1907. Though there are many possible sources of lead exposure, the most common sources of lead poisoning in Missouri are lead dust, lead in soil, and peeling, chipping or cracking lead-based paint. The highest risk of lead exposure for children comes from homes built before 1950, when most paint contained a high percentage of lead. Lead-based paint was banned from residential use nationwide in 1978. Any home built before 1978 may contain leaded paint. About 18.55% of existing housing in Missouri was built before 1950 and 55.38% was built before 1980.

The Childhood Lead Poisoning Prevention Program (CLPPP) was established in 1993. The program's mission is to assure children a safe and healthy environment through primary prevention, detection, surveillance, and case management for lead exposure. There is no "safe" level of lead in the body. Inhalation or ingestion of even very small amounts of lead causes neurotoxic health effects, and can affect nearly every other body system. Very high blood lead levels may cause death. Passed in 2001, 701.340 RSMo requires the promulgation of rules and regulations to establish a statewide lead screening plan. The rules and regulations define criteria for establishing blood lead testing and reporting requirements and for medical and environmental case management follow-up and treatment procedures.

The annual percent of Missouri's children younger than six years-old tested for lead exposure decreased from 20.4% in 2010 to around 14% in 2021.[29] Among this same age group, the percentage found to have blood lead levels of 10 µg/dL or greater declined from 0.97% in 2010 to 0.55% in 2021.[29] Children whose blood levels were greater than or equal to 3.5 µg/dL, the2021 CDC-recommended reference value, was 4.75% in 2021, compared to 6.5% of children whose blood lead levels were greater than or equal to 5 µg/dL, the 2012 reference value recommended by the CDC, in 2010.[29]

Transportation

In 2022, Missouri had the seventh largest highway system in the nation.[30] The transportation infrastructure has three key measures: airports, railroad and waterway mileage. The Missouri highway system is comprised of nearly 34,000 miles of highways and more than 10,000 bridges. Additionally, the county road system adds 97,000 miles and nearly 14,000 additional bridges. The extent of this infrastructure gives Missouri residents and businesses efficient accessibility to major markets for distribution needs and telecommunication. However, in both urban and rural areas access to public transportation can be cumbersome.

There was a 27% increase in vehicle fatalities from 2011 to 2021.[31] In 2020, 50% of motor vehicle crash deaths occurred in rural areas; and lack of seat belt use, distracted driving and driving too fast for the conditions continued to be common denominators in fatal crashes.[32] Between 2011 and 2021, 10,094 people were killed in motor vehicle accidents in Missouri, an average of about 918 fatalities per year.[31,33] For the first time since 2006, Missouri's 2021 traffic fatality total surpassed 1,000. According to preliminary data, 1,017 people were killed in Missouri traffic crashes in 2021, a 3% increase from 2020, marking the second straight year of growing fatality totals after nearly a decade of steady decline.

The Department of Transportation works with safety advocates across the state to reduce fatalities to 700 or fewer. The reported safety belt usage rate in Missouri (88.9%) in 2022 was below the national average of 91.6% for the same year.[34] Missouri has a secondary seat belt law, with primary enforcement of the seat belt requirement for children ages 8 to 15 years and secondary enforcement for those ages 16 and above in the front passenger seat.[35]

Health Infrastructure

There are five predominant schools that train new physicians in Missouri: Kansas City University of Medicine and Biosciences, University of Missouri–Kansas City, University of Missouri-Columbia, Saint Louis University, and Washington University. Missouri Professional Registration Directories include 3,463 Osteopathic and 25,388 allopathic Physicians.[36,37] Of these physicians, there are 922 Obstetrician/ Gynecologists and 16 specializing in Obstetric/Gynecologic surgery.[36,37] Additionally, there are 2,066 physicians certified in pediatrics and 621 specialized pediatricians (e.g. pediatric pulmonology, pediatric emergency medicine, pediatric cardiology, etc.).[36,37]

As of May 2, 2023, there were 169 hospital facilities in Missouri spread across 69 counties/jurisdictions.[38] The majority of hospitals are located in urban counties. There are also 49 total hospitals with psychiatric beds[39] and 29 trauma facilities in Missouri.[40] There were 838 licensed pediatric beds and 903 licensed NICU beds.[41,42] In addition, there are four VA Medical Centers and one VA Health Care System in the state of Missouri, not inclusive of 27 community based outpatient clinics, 1 outpatient clinic, and five veterans centers .[43] There are 343 Rural Health Clinics (RHC), which must be located in a non-urban area and in a federally designated or certified shortage area, and 28 Federally Qualified Health Centers (FQHC; 13 in rural areas only, 7 in urban areas only, 8 with sites in rural and urban areas, and 314 service delivery sites), which are community-based and patient driven care centers designed to help people with limited access to care.[44] Between 2022-2023, Missouri saw the closure of three birthing facilities: First Breath Birth and Wellness, Cox Monett Hospital, and Hedrick Medical Center.

Health Indicators

Missouri's three primary strengths, as identified in the 2022 America's Health Rankings Annual Report published by the United Health Foundation, were its low prevalence of high-risk HIV behaviors, low percentage of severe housing problems, and high supply of primary care providers.[45] Missouri ranks 39th overall among all states. Nearly 90% of students graduated from high school (ranked 9th), and Missouri ranked 10th for low rates of severe housing problems. Some of the most challenging issues facing Missouri are premature death

rates in years lost before age 75 (10,247 per 100,000 population), household food insecurity (12%), and prevalence of smoking in adults (17.3%). Obesity in adults increased from 34.0% to 37.3% between 2020 and 2021. Nationally, Missouri ranked 34th for low birthweight and 47th for low birthweight racial disparity.[45]

Health Insurance Coverage

Overall, Current Population Survey estimates indicate an increase in percentage of uninsured Missourians from 6.0% in 2018 to 7.5% in 2021.[46,47] Missouri's estimated uninsured percentage for 2021 is lower than the 8.3% national estimate for the same year.[48] Missouri's estimated percent of children under the age of 19 without public or private health insurance increased from 2018 (5.7%) to 2019 (6.9%) and this was higher than the national level (5.6%). An estimated 14.8% of Missouri women (ages 19-44) were without public or private health insurance in 2019 compared to 13.4% in 2018.[50] The estimated percentage for 2019 was higher than the national level for the same year (12.9%).[50]

The Uninsured Women's Health Services Program provides MO HealthNet coverage for women's health services to uninsured women ages 18-55 whose family's modified adjusted gross income does not exceed 201% of the Federal Poverty Level (FPL) for their household size. Covered women's health services include: approved methods of contraception; sexually transmitted disease testing and treatment, including pap tests and pelvic exams; counseling, education on various methods of birth control; and drugs, supplies, or devices related to the women's health services described above, when they are prescribed by a physician or advanced practice nurse.

Medicaid and the Children's Health Insurance Program (CHIP) provide no-cost or low-cost health coverage for eligible children in Missouri. Using CHIP funding, states can opt to provide coverage for pregnant women and/or services through the "unborn child" coverage option. Missouri provides coverage up to 300% of the FPL through the CHIP for pregnant women and unborn child options. Medicaid spending for state fiscal year (SFY) 2022 was approximately $12.6 billion in Missouri[51], and approximately 63% of Missouri Medicaid/MO HealthNet funds come from the federal government.[52] Non-disabled adults with children qualify for Medicaid if their income is below 21% of the FPL, meaning a family of four must earn less than $5,550 a year. Medicaid and CHIP enrollment in Missouri was 1,064,287 in May 2021, and 87.1% of all uninsured eligible children in Missouri participate in Medicaid/CHIP. Children represent the largest demographic served by Missouri Medicaid; 59% of all MO HealthNet enrollees are under the age of 19.[51]

The MO HealthNet for kids (Medicaid) program provides health insurance coverage for children under age 19 whose net family income does not exceed 196% of the FPL for children under age one, and 148% of the FPL for children ages 1-18. In SFY22, MO HealthNet covered a monthly average of 689,063 low-income children.[51] In SFY22, the MO HealthNet for Kids Program covered 650,967 low-income Missouri children, representing 57% of all MO HealthNet beneficiaries. Overall, Medicaid covered 48% of Missouri's children and paid for 39% of all births in the state for 2022.[51] Children represent the largest demographic group served by MO HealthNet, with 61% of all Medicaid enrollees being age 18 or younger.[51]

Using the State CHIP (SCHIP) funds, Missouri expanded its existing Medicaid program for low-income children in 1998. The expansion extended health coverage to low-income children with family income up to 300% of FPL.[51] The SCHIP program provides the same health services as those covered under Medicaid, except that children covered by SCHIP are not eligible for non-emergency medical transportation. Based on an income scale, some individuals covered under Missouri's SCHIP program must pay premiums. For families of six or fewer, premiums paid per family per month range from $15 to $324.[51] In June 2022, an average of 33,366 children had coverage under CHIP in Missouri.[51]

The MO HealthNet for Pregnant Women Program offers Medicaid coverage to pregnant women whose family incomes are up to 196% FPL. This program includes coverage up to 60-days postpartum even with subsequent

increases in family income. In SFY22, 57,892 women per month received benefits under the MO HealthNet for Pregnant Women Program.[51] Additionally, a monthly average of 101,109 low-income custodial parents were covered by MO HealthNet.[51]

Statewide-Managed Care

The MO HealthNet managed care system (formerly known as MC+) started in 1995 when Missouri Department of Social Services (DSS) first contracted with managed care plans in an effort to improve the accessibility and quality of health care services for Missouri's Medicaid populations, while improving predictability of the costs associated with providing care. Missouri expanded Medicaid managed care in 2017 to include all 114 counties and the city of St. Louis for children, families, and pregnant women. The MO HealthNet Managed Care Program operates statewide to provide health care services to enrollees through contracts between DSS-MO HealthNet Division (MHD) and managed care health plans. These include Home State Health, Healthy Blue, Show Me Healthy Kids, and United Healthcare Plans. Each managed care health plan has a network of doctors, hospitals and other providers across the state that coordinate care to help individuals and families stay healthy. All MO HealthNet recipients must enroll in a managed care health plan if they fit into one of the following eligibility categories:

- Parents/caretakers, children, pregnant women, and refugees;
- Other MO HealthNet children who are in the care and custody of the state and receive adoption subsidy assistance; and
- Eligible for CHIP.

Missourians who are elderly, blind or disabled, including those with developmental disabilities served through the Missouri Department of Mental Health, will not be included in the MO HealthNet Managed Care Program. They will continue to receive services through the traditional MO HealthNet Fee-for-Service (FFS) Program. Certain participants (including CSHCN) may also opt out of the Managed Care Program and choose the FFS Program.

Medicaid Expansion

Missouri experienced a long and complicated road to Medicaid expansion. In 2020, Missouri voters approved an amendment to the Missouri Constitution to expand Medicaid eligibility to persons 19 to 64 years old with an income level at or below 133% of the FPL (plus five percent of the applicable family size), effectively expanding Medicaid to those with incomes at or below 138% of the FPL as set forth in the Affordable Care Act. In 2022, that amounted to approximately $18,754 for a single individual and $38,295 for a household of four. Medicaid eligibility was previously set in state statute, but the amendment added Medicaid Expansion to Missouri's constitution effective July 1, 2021. However, following the passage of this amendment, the state legislature did not include funding for Medicaid Expansion in the SFY 2022 state budget. Governor Parson subsequently announced the state would not implement expansion because the ballot measure did not include a revenue source and the legislature did not provide sufficient appropriations for expansion in the state budget. Following this announcement, individuals who would be eligible for expansion coverage under the Missouri constitution filed a lawsuit against the state. The Missouri Supreme Court ruled the initiated amendment was valid under the state constitution, and the legislature's existing budget appropriation authorized the state to implement expansion coverage.

The amendment prohibits any additional burdens or restrictions on eligibility for the expansion population and requires state agencies to take all actions necessary to maximize federal financial participation in funding medical assistance under Medicaid Expansion. Federal law requires states to fund a portion of the program in order to receive federal funding (state match). This amendment does not provide new state funding or specify existing funding sources for the required state match. The federal government is paying 90% of the cost of Medicaid expansion in Missouri, just as they do in other states that have expanded Medicaid. However, since Missouri's expanded eligibility

rules took effect after the American Rescue Plan was enacted, the state is also receiving an additional 5 percentage points above the regular federal matching rate for the next two years for the traditional (non-expansion) Medicaid population, amounting to $968 million in additional federal funding over two years.

DSS began accepting applications for coverage in August 2021 and began processing applications after October 1, 2021. Coverage was backdated to July 1, 2021 for eligible applications submitted by November 1, 2021. As of October 21, 2022, 257,581 adults have enrolled in the Adult Expansion Group (AEG), including approximately 180,000 newly eligible adults.

Medicaid Extension

In 2018, Missouri lawmakers passed a provision to add some benefits, such as a year-long Medicaid extension, for low-income mothers with substance use disorder. DSS contacted the Centers for Medicare and Medicaid Services in February 2022 asking to pause those benefits. State officials cited two main reasons for not moving forward: voter-approved Medicaid expansion was expected to decrease the number of women who could be served under extended postpartum coverage, and lawmakers were considering an expansion of postpartum coverage to allow for full benefits to be provided through the full first year after birth.

Missouri currently provides coverage to low-income mothers during pregnancy and up to 60 days after childbirth. The Missouri Pregnancy Associated Mortality Review (PAMR) Annual Report recommends that the state extend Medicaid coverage to one year after childbirth for all conditions, including medical, mental health and substance use disorder. In an effort to improve maternal health and address racial disparities, the American Rescue Plan Act of 2021 allows states to extend postpartum Medicaid coverage up to a full year after birth. The new option is available to states for five years, starting April 1, 2022. The Missouri legislature passed SB 45 to extend MO HealthNet postpartum coverage from 60 days to 12 months postpartum for women who are either currently receiving or eligible to receive aid to families with dependent children, or eligible to receive benefits via the income eligibility standard. The Governor signed SB 45 into law on July 6, 2023. Pregnant women eligible for MO HealthNet and receiving mental health treatment for postpartum depression, related mental health conditions, or substance abuse treatment within sixty days of giving birth will remain eligible for benefits for those services for an additional 12 months. The extension of coverage for a full twelve months after delivery is estimated to cover more than 4,000 women who otherwise become uninsured two months after the end of pregnancy.

Department of Health and Senior Services (DHSS) Priorities

In Missouri, the Title V MCH Block Grant leadership is located within DHSS. Paula Nickelson was appointed as the Director of DHSS on June 01, 2023 and is responsible for the management of the Department and the administration of its programs and services. Ms. Nickelson had previously been appointed as the Acting Director of DHSS on March 1, 2022 and has served within DHSS for more than 22 years and been a leader in several program areas, including maternal-child health, chronic disease prevention, and emergency preparedness and response.

DHSS aims to achieve optimal health and safety for all Missourians, in all communities, for life by promoting health and safety through prevention, collaboration, education, innovation, and response while maintaining our values of excellence, collaboration, access, integrity, and accountability. DHSS has been accredited through the Public Health Accreditation Board since 2016. The new DHSS Strategic Map (attached) details the five strategic priorities, two crosscutting priorities, and objectives under each category designed to ensure progress towards achieving our vision.

Strategic Priorities

- Invest in innovation to modernize infrastructure
- Re-envision and strengthen the workforce

- Build new and strengthen existing partnerships
- Clearly and consistently communicate to educate and build trust
- Resolve access issues for underserved areas and populations

Premier DHSS Initiatives

Missouri State Board of Health and Senior Services

For the first time in many years, the Board of Health and Senior Services began operating again in November 2022. State law stipulates the Board advise DHSS on rules & regulations, budget, and planning & operation. The board is comprised of nine members that are Governor appointed and Senate confirmed.

Missouri Women's Health Council

The Missouri Women's Health Council is an advisory board comprised of thought leaders with expertise in women's health and the broad range of factors that affect health outcomes and wellbeing. Council members are appointed by the Department Director and reflect the geographic diversity of the state. The council is charged with informing and advising the Department Director regarding women's health risks, needs and concerns, and recommending potential strategies, programs, and legislative changes to improve the health and well-being of all women in Missouri. The Council consists of women from a variety of professions, including healthcare providers, researchers, healthcare administrators, social workers, and CEOs and executive directors of critical social services foundations serving women throughout Missouri. The following policy priorities reflect the shared vision of the Women's Health Council:

1. Improve access to healthcare for women in rural, suburban and urban Missouri, and
2. Ensure safety for Missouri women and their families.

Rural Maternal Health

Access to healthcare stands as another significant barrier for rural Missouri women. Of the 166 licensed Missouri hospitals, 76 are located in rural areas, and 35 of these are Critical Access Hospitals with a limited range of services. Additionally, 98 rural counties are Primary Medical Health Professional Shortage Areas (HPSAs). In addition to the existing variety of programs established to assist women in making informed decisions about their health and increasing their access to preventative, primary and specialist care, DHSS has convened a Rural Maternal Health Care Workgroup, along with partners from the Governor's Office, MO HealthNet, the Missouri Hospital Association, and the Missouri Primary Care Association, to engage stakeholders and strategize potential solutions and approaches to address the barriers and challenges.

Missouri's Title V MCH leadership is involved with many DHSS initiatives and priorities. Title V MCH efforts to provide positive health outcomes for the MCH population align with the DHSS goal to improve the health of all Missourians. The national and state performance measures and strategies identified in the MCH State Action Plan assist in achieving DHSS objectives. The MCH Director and relevant Title V MCH team members participate in the PAMR Board meetings and discussion to reduce maternal mortality. The Title V MCH team also works with local public health agencies, the majority of which are located in rural communities, to ensure access to healthcare services for women and children.

Revised Statutes of Missouri (RSMo) Relevant to Title V MCH

Title XII Public Health and Welfare, Chapters 191, 192, and 201 include laws in place to benefit the MCH population. A few examples are listed below.

- §191.323 (1985) gives DHSS the power and duty to prevent and treat genetic disease and birth defects and
- §191.331 (2007) allows infants to be tested for metabolic and genetic diseases. This chapter also addresses prenatal and postnatal care and education for women and children, breastfeeding, and prenatal

screening counseling.

- §192.002 (2001) and §192.005 (2018) established DHSS to supervise and manage all public health functions and programs. The department shall be governed by the provisions of the Omnibus State Reorganization Act of 1974, Appendix B, RSMo, unless otherwise provided in sections 192.005 to 192.014.
- §192.025 DHSS is designated as the official agency of the state to receive federal funds for health purposes.
- §192.067 authorizes DHSS to receive information from patient medical records for the purpose of abstracting data (i.e. PAMR).
- §192.070 (2001) states DHSS shall issue educational literature on the care of the baby and the hygiene of the child including, but not limited to, the importance of routine dental care for children; study the causes of infant mortality and the application of measures for the prevention and suppression of the diseases of infancy and childhood; and inspect the sanitary and hygienic conditions in public school buildings and grounds.
- §192.601 (2013) requires a toll-free telephone number established for the use of parents to access information about health care providers and practitioners who provide health care services under the Title V MCH Services Block Grant, the medical assistance programs, and other relevant health care providers, as required by 42 U.S.C. 705(a)(5)(E).
- §201.010 (2010) gives DHSS the authority to administer children's special health care needs service, a program of service to children who have a physical disability or special health care need and to supervise the administration of the services that are included in this program. The purpose of this service is to develop, extend, and improve services for locating such children, especially in rural areas, and for providing medical, surgical, corrective and other services and care and facilities for diagnosis, hospitalization, and aftercare (§201.030).
- §192.990 (2019) establishes the "Pregnancy-Associated Mortality Review (PAMR) Board" within DHSS to improve data collection and reporting with respect to maternal deaths.
- §160.077 (2022) establishes the "Get the Lead Out of School Drinking Water Act", requiring schools to provide drinking water with a lead concentration below five parts per billion (5 ppb); conduct an inventory of all drinking water outlets and outlets used for dispensing water for cooking or cleaning utensils in each school building, develop a plan for testing each outlet, and provide general information on the health effects of lead contamination to employees and parents on or before January 1, 2024; and conduct specified testing for lead before August 1, 2024.
- §217.940 (2022) establishes the "Correctional Center Nursery Program" to establish a correctional center nursery in one or more of the correctional centers for women to promote bonding and unification between the mother and child. The program allows eligible inmates and their children born while in custody to reside together in the correctional center for up to 18 months post-deliver.

Code of State Regulations (CSR)

- 19 CSR 20-60.010 establishes criteria and procedures for reporting standardized assessments and levels of maternal and neonatal care designations for birthing facilities.

Major Legislative Initiatives

Provided below is a list of bills and legislative decision items with potential impact for Missouri families that were passed during the 103rd General Assembly, 2023 Regular Session, and signed by the Governor:

In addition to extension of postpartum coverage, SB 45 also changed the requirements for blood lead testing for young children. Lead is a dangerous neurotoxin, and low doses of lead from paint dust and corroded water pipes

can cause lasting damages, including reduced IQ, behavior disorders and increased risk of mortality from cardiovascular disease. Previously, all Missouri children younger than six who lived in — or spent more than 10 hours per week in — areas deemed high risk were required to be tested for elevated blood lead every year. Children not at high risk were to be screened for potential lead exposure with a questionnaire and tested if necessary. With the passage of SB 45, all children under six will now be assessed with a questionnaire and tested, if necessary, with guardian consent.

SB 186 modifies the definition of a "missing child" in the context of law enforcement searches of missing children to include persons under 18 years of age, foster children regardless of age, emancipated minors, homeless youth, or unaccompanied minors. Any agency, placement provider, including the Children's Division, parent, or guardian, with the care and custody of a child who is missing shall file a missing child complaint with the appropriate law enforcement agency within 2 hours of determining the child to be missing. The law enforcement agency shall immediately submit information on the missing child to the National Center for Missing and Exploited Children (NCMEC). The law enforcement agency shall institute a proper investigation, search for the missing child and maintain contact with the agency or placement provider making the complaint. The missing child's entry shall not be removed from any database or system until the child is found or the case is closed.

HB 115 modifies licensing and collaborative practice arrangements for advanced practice registered nurses (APRNs). Under this act, an APRN may prescribe Schedule II controlled substances for hospice patients, as described in the act. Additionally, collaborative practice arrangements between the APRN and the collaborating physician may waive geographic proximity requirements, as described in the act, including when the arrangement outlines the use of telehealth and when the APRN is providing services in a correctional center. Collaborating physicians or designated physicians shall be present with the APRN for sufficient periods of time, at least once every two weeks, to participate in chart reviews and supervision.

HB 402 modifies the "Outside the Hospital Do-Not-Resuscitate Act" by expanding the provisions to cover persons under 18 years of age who have do-not-resuscitate orders issued on their behalf by a parent or legal guardian or by a juvenile or family court under a current provision of law. Such orders shall function as outside the hospital do-not-resuscitate orders unless specifically stated otherwise. Persons who are not subject to civil, criminal, or administrative liability for certain actions taken upon the discovery of an adult outside the hospital do-not-resuscitate orders shall not be subject to such liability in the case of a minor child's do-not-resuscitate order. Emergency services personnel shall be authorized to comply with the minor child's do-not-resuscitate order, except when the minor child, either parent, the legal guardian, or the juvenile or family court expresses to such emergency services personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire for the patient to be resuscitated.

SB 39 delineates what constitutes an acceptable official birth certificate and prohibits a private school, public school district, public charter school, or public or private institution of postsecondary education from allowing any student to compete in an athletic competition that is designated for the biological sex opposite to the student's biological sex as stated on the student's official birth certificate or other government record as described in the act.

SB 49 establishes the "Missouri Save Adolescents from Experimentation (SAFE) Act", prohibiting health care providers from performing gender transition surgeries or prescribing hormones or drugs for the purposes of gender transition to Missouri children under the age of 18.

SFY 2024 Budget Wins

The Missouri SFY24 operating budget is approximately $51.8 billion, including $15.2 billion in general revenue. .

Needed upgrades and investments in state government services to continually improve services provided to citizens and increase opportunities for Missourians' success:

- $300 million for a new mental health hospital in Kansas City;
- $33.3 million for reconstruction and reform at the Missouri Children's Division;
- $17 million for MO HealthNet eligibility redeterminations;
- $7.2 million for the construction of a new Division of Youth Services center in St. Louis;
- $4.35 million to implement the Maternal Mortality Prevention plan; and
- $4.3 million to increase the number of Youth Behavioral Health Liaisons statewide.

$248 million for broadband deployment in unserved and underserved communities.

$4.35 million to implement a Maternal Mortality Prevention Plan across the following domains of action:

1. Standardized maternal quality care protocols;
2. Perinatal Health access Project;
3. Standardized maternal care provider trainings;
4. Standardized postpartum plan of care; and
5. State Maternal & Child Health Dashboard (Improved maternal health data collection, standardization and harmonization).

$2.3 million for local public health agency core funding.

$3.8 million for local public health agency incentives funding (funding associated with completion of quality activities aimed at Administrator training, Board of Health Training, and Accreditation.

For references, please refer to the References attachment.

---

[*] Using the definition described in the Biennial Rural Health report (https://health.mo.gov/living/families/ruralhealth/pdf/biennial2020.pdf) which assigns counties as rural or urban primarily based on meeting a population density of greater or less than 150 persons per square mile.

Five-Year Needs Assessment Update

Ongoing Needs Assessment Activities
Ongoing work with the Missouri Pregnancy Risk Assessment Monitoring Surveillance System (PRAMS), Missouri Behavioral Risk Factor Surveillance Survey (BRFSS), and the Missouri Pregnancy Associated Mortality Review (PAMR) are significant components of ongoing MCH data collection and analyses. Missouri is also amongst a group of states participating in efforts to monitor emerging threats. These efforts are detailed in the Other MCH Data Capacity Efforts section.

Updates to MCH Data Collection and Analyses

1. Missouri conducted an adolescent health needs assessment in 2022. A variety of indicators were analyzed at the county level to help the program determine areas of highest need. Indicators included teen pregnancy, high school dropout rates, and poverty levels.
2. Missouri PRAMS collected social determinates of health (SDoH) data through the SDoH supplement.
3. The Missouri PAMR completed reviewing 2020 maternal deaths and is finalizing the report for public distribution. The PAMR board is currently reviewing maternal mortality cases that occurred in 2021.
4. Missouri is participating in the analyses of COVID-19 impact on pregnancy outcomes through the CDC "Surveillance for Emerging Threats to Mothers and Babies" (SET-NET) project. The team is also working to develop a means in this project to collect longitudinal data on infants over their first year of life.

Stakeholder Engagement
Ongoing MCH stakeholder engagement and input is sought through various opportunities and venues. Collaborative brainstorming and discussion related to the FFY 2021-2025 Title V MCH State Action Plan and other MCH priorities and initiatives for regional and statewide collective impact are ongoing as part of conversations with DHSS team members, other state agencies, local public health partners, for-profit and not-for-profit community organizations, faith-based organizations, family partners, and community members. Additional information regarding stakeholder engagement may be found in the Public Input section narrative.

MCH Population: Health Status and Needs
Data indicate improvements in health markers among the Missouri MCH population. The rate of inadequate prenatal care decreased from 21.3 in 2020 to 19.1 percent in 2021. Teen births (mothers under the age of 20) continued to decrease and moved from 3,591 births in 2020 to 3,342 births in 2021. This decrease in teen births is a 6.9 percent decrease from 2020 and a 56.7 percent decrease from the 2010 count of 7,739. Notably, the rate of mothers smoking during pregnancy decreased from 11.9 percent in 2020 to 10.1 percent in 2021, compared to 18.9 percent in 2010. The rate of out-of-wedlock births decreased from 41.2 to 40.0 percent from 2020 to 2021, respectively. It will be important to continue implementing ongoing strategies to promote further progress.

Data indicates other areas among the MCH population where markers have stayed consistent in the past year. Specifically, the infant death rate in 2021 did not change from the record low infant mortality rate of 5.7 per 1,000 live births set in 2020. This rate is 14 percent below the 2010 rate of 6.6. Of note, the rate of Medicaid and WIC births also remained unchanged in 2021.

Conversely, data indicate other areas where health markers among the MCH population are moving in the opposite direction. The percent of low birth weight in 2021 returned to a Missouri record high set in 2019, with a

rate of 8.9. This is an increase from the 2020 rate of 8.7. Specifically, the rate of births to obese (BMI>30) mothers increased to 31.8 percent in 2021 from 30.8 in 2020 and 23.8 in 2010. In addition, short spacing, defined as less than 18 months between births, increased from 12.3 percent in 2020 to 12.6 percent in 2021. The rate of cesarean births increased from 29.3 percent in 2020 to 30.2 percent in 2021. To effectively target resources and innovation in intervention and/or program development, further efforts are needed to understand the causation of maternal obesity, short birth spacing, and the increased rate of cesarean births.

Program Capacity

Additional information related to program capacity can be found in the MCH Workforce Development and MCH Epidemiology Workforce section narratives.

Maintaining a strong MCH system of care and ensuring seamless delivery of MCH services is vital for achieving desirable MCH outcomes. The COVID-19 pandemic presented new and exacerbated existing challenges in accessing and continuing MCH services. MCH programs remain committed to the provision of equitable, appropriate, and quality MCH services for Missouri's MCH population and continue to expand their knowledge, innovate and transition services to meet the needs of pregnant women, mothers, infants, children, youth, and CYSHCN, and their families. Additional detailed information related to the availability and access to and provision of health care services that impact the health status of the MCH population can be found in the MCH Emergency Planning Preparedness section narrative and State Action Plan narratives by domain.

Partnerships and Collaborations

To identify the priority needs of Missouri's MCH population, the Title V MCH needs assessment process sought input from community members and organizations, hospitals, non-profits, universities, LPHAs, and other state agencies. To address these priorities and implement effective strategies, MCH leadership continues to develop the relationships with these public and private entities as well as the specific organizations listed below.

Discussions with key partners identified the need for a comprehensive plan for Maternal Mortality Prevention, with targeted funding and initiatives. The Maternal Mortality Prevention Plan will be implemented through partnerships with internal and external maternal health partners, with the SDoH interwoven throughout all five domains. A robust Evaluation Plan will monitor progress, measure success, ensure accountability, and inform ongoing maternal mortality prevention efforts.

One of the largest partnerships is with the LPHAs who provide a strong local public health network of 115 city and county health departments. These agencies operate independently of each other and are independent of state and federal public health agencies. The LPHAs work directly with DHSS through contracts to deliver public health services to the communities they serve. These contracts include programs such as MCH Services, which comprises almost 30% of the Title V MCH Block grant annual budget; CYSHCN Service Coordination; Child Care Health Consultation; and Safe Cribs for Missouri. The LPHAs are typically the first point of contact for many Missourians seeking healthcare resources.

Adolescent Health Program partners include the Wyman Center, Teen Pregnancy & Prevention Partnership, Society for Prevention of Teen Suicide, and Council for Adolescent and School Health. The Injury Prevention Program supports Safe Kids coalitions and participates on Missouri's Injury & Violence Prevention Advisory Committee. Partners to support CYSHCN, include Assistive Technology, University of Missouri Kansas City-Institute for Human Development, and United 4 Children. The Office of Dental Health works with the Missouri Coalition for Oral Health, Missouri Dental Association, and Missouri Primary Care Association on community outreach efforts to increase access to oral health services. Newborn Health/Early Childhood initiatives connect with

child care providers, Children's Trust Fund, Home Visiting Implementation Agencies, Happy Birth Day, Inc. (Count the Kicks), and Local WIC Agencies. Statewide collaboration occurs with Missouri's Women's Health Council, Missouri's past and current Healthy Start grantees (Generate Health, Nurture KC, and Missouri Bootheel Regional Consortium), and the Missouri Hospital Association. Several Title V MCH programs work with local school districts and other state agencies, such as the Departments of Mental Health, Social Services, and Elementary and Secondary Education.

Missouri's Foundational Public Health Services (FPHS) model describes a minimum set of foundational public health services and measurable capabilities in identified areas of expertise that need to be available in every community in order to have a functional public health system. The Missouri FPHS model highlights Health Equity and SDoH as a lens through which all public health programs and services should be provided, and Maternal, Child, and Family Health is one of the Foundational Areas included in the model. DHSS has adopted the FPHS model as a guiding framework and is using the model to conduct a cost analysis of what it would cost to assure the provision of foundational services and capabilities at each local public health agency in Missouri. The cost analysis, anticipated to be completed in three years, will serve as a guide for a budgetary request to adequately fund public health services in Missouri.

The #HealthierMO Initiative led creation of Missouri's FPHS model, and the #HealthierMO Health Equity Design Team developed a Capacity Building Program and FPHS Workbook to help equip public health professionals to operationalize Missouri's FPHS model. (https://www.healthiermo.org/capacity-building)

Title V MCH team members facilitate internal discussions within these various units and partnerships to broaden their reach through program planning, development, and evaluation. In addition, MCH staff participate on various external boards, committees, councils, and coalitions to ensure initiatives meet the needs of the MCH population. Additional information regarding partnerships and collaborations is included in the Public and Private Partnerships section.

Organizational Structure and Leadership

Missouri's state government is organized into three branches: the Legislative, the Judicial, and the Executive Branch, which is headed by the Governor. Within the Executive Branch are 16 executive departments, including Health and Senior Services. The DHSS is the designated state agency for the administration of the Title V MCH Block Grant and allocation of grant funding. The Department Director was appointed in March 2022. DHSS is organized into the Office of the Director, including the State Public Health Laboratory (SPHL), and five divisions: Administration, Regulation and Licensure, Senior & Disability Services (DSDS), Cannabis Regulation, and Community and Public Health (DCPH). DCPH is the largest of the four divisions and is responsible for supporting and operating more than 100 programs and initiatives addressing public health issues.

DCPH is organized into bureaus, offices and units by types of programs and services provided and overseen by a Division Director, an Operations Director, two Deputy Directors and four Assistant Deputy Directors. DCPH serves as the umbrella agency that facilitates access to numerous MCH-targeted programs and provides a majority of services to the MCH population. Structurally, the MCH Director and the Title V MCH Services Block Grant are now located within the Division Director's Office, and the MCH Director oversees coordination of overarching MCH initiatives and administers the Title V MCH Block Grant. The new full-time CYSHCN Director role, which is currently vacant, is also organized with the MCH leadership team in the DPCH Director's Office. The CYSHCN Director role was previously housed within the Bureau of SHCN. This shift will increase the capacity of Title V MCH programming to address the needs of CYSHCN beyond the population served by the programs and services in the Bureau of SHCN, strengthen statewide efforts to promote a medical home for all children with and without SHCN in

Missouri, and implement family-centered, community-based, systems of coordinated care for all children with and/or at risk for special health care needs.

The functions of the Bureau of SHCN were transferred from the DHSS-DCPH to the DHSS-DSDS in November 2021. The transfer was formalized through the State FY 2023 budget process. The move to DSDS was a seamless transition for participants and families served through SHCN program and resulted in increased communication/coordination of Home and Community Based Programs (both Medicaid and the associated non-Medicaid services) and improved continuity of services. The work of the Bureau of SHCN aligns with the mission of DSDS, "to be the leader in advocating, partnering, protecting and supporting seniors and individuals with disabilities to be safe, healthy and independent."

State and Federal MCH funding supports the following programs:

- Community Health Services (injury prevention, adolescent and school health)
- Environmental Health (childhood lead poisoning prevention)
- Epidemiology (vital statistics, analytics, surveillance systems)
- Healthy Children and Families (home visiting, newborn health, TEL-LINK, safe cribs, WarmLine, MCH Navigators)
- Genetics (newborn screening)
- Early Childhood (developmental monitoring, child care health consultation, inclusion specialists, parent advisory council (PAC))
- Oral Health (preventive services, community outreach)
- Special Health Care Needs (family partnership, care coordination, assistive technology)
- Women's Health (MCH services, infant & maternal mortality, maternal substance use and mental health, health services for incarcerated women)
- Nutrition & physical activity (breastfeeding, obesity prevention)
- Crosscutting (immunizations, communicable disease prevention, health equity)

Core Title V MCH Leaders

- **Martha Smith, MSN, RN, Missouri MCH Director/Public Health Nursing Manager and interim CYSHCN Director,** has over 37 years of experience in nursing and MCH and has served in these roles since March 2019, previously serving as the Interim Director of the Center for Local Public Health Services and the MCH Services Program Manager. She has served as the interim CYSHCN Director since June 2023.
- **Lisa Crandall, Bureau Chief, Bureau of Special Health Care Needs (SHCN),** has worked for DHSS, Bureau of SHCN Needs since 2004 and has been the Bureau Chief since 2012. Lisa served as Missouri's Title V Children with Special Health Care Needs Director from 2016-2023 and will provide mentorship to the new CYSHCN Director.
- **Karen Harbert, MPH, Lead MCH Epidemiologist**, has worked for the DHSS, Office of Epidemiology since 2014 and has served as the lead MCH epidemiologist since December 2020. Previously, she was a Senior Epidemiology Specialist and served as the lead for data-related issues for the MIECHV, Title V, and Children's Trust Fund Home Visiting Programs.
- **Andrea Tray, MPH, Senior Research/Data Analyst**, has been with DHSS since 2021, serving in her current role since December 2022. She is currently conducting an analysis on racial disparities in breastfeeding as a benchmark for evaluating regional health equity initiatives.
- **Andra Jungmeyer, MPH, State Adolescent Health Coordinator,** has over 20 years of experience in public health, with over eight years in this position.
- **Jami L Kiesling, BSN, RN, Chief, Bureau of Genetics and Healthy Childhood,** has worked in state

public health over ten years, with a focus on maternal and child health. She has served in her current role since 2018, overseeing the TEL-LINK, Newborn Screening, Newborn Blood Spot Screening, Prenatal Substance Use Prevention, and Newborn Health programs.

- **Sara Gorman, MSN, RN, MCH Services Program Manager,** has over 15 years of state and local public health experience and served as the Central MCH District Nurse Consultant for two and a half years before becoming the MCH Services Program Manager in 2021.
- **Nina Nganga, MPH, MCH Program Coordinator,** has been with the DHSS in this role since August 2021. Her background includes a MPH in Global Health and a certificate in Global Women's, Adolescent and Children's Health and MCH-related research in the US and Kenya.

Family Leaders

The Family Partnership Program provides resource information and peer support to families of CYSHCN. The Program employs four part-time professional Family Partners who are parents of individuals with special health care needs. Each serves a region of the state to assist families as well as plan, schedule, and facilitate all Family Partnership events. These leaders have experience in their own communities working with agencies that provide services to at-risk families with young children and have demonstrated leadership skills.

Local Public Health Agency Workforce

LPHAs protect and improve community well-being by preventing disease, illness and injury and impacting social, economic and environmental factors fundamental to optimal health. LPHAs are the foundation of the local public health system, comprised of public- and private-sector health care providers, academia, business, the media, and other local and state governmental entities. In 2021, with 113 of 115 LPHAs reporting, 16 reported reducing the number of days open to the public, and 27 reported laying off staff and closing internal home health services due to decreased funding. The COVID-19 pandemic was cited as the primary reasons for changes in staffing, hours of operation, and provision of services. In addition, these LPHAs noted that recruitment of new staff has been significantly challenging due to the increasing demand for nurses across healthcare overall, as well as higher wages and sign-on bonuses available from other organizations.

Operationalizing Process and Findings

The Title V MCH Block Grant used the conceptual framework provided by HRSA/MCHB as part of its needs assessment process, and followed guidance for integrating the needs of stakeholders and Missouri's diverse population through a health equity lens. The needs assessment and its activities were guided by the social ecological model (SEM). Title V MCH leadership initiated the statewide Missouri Five-Year Needs Assessment in the fall of 2018. The needs assessment timeline included capacity for the DHSS contracting process (planning), qualitative and quantitative data collection and analysis (spring 2019 – fall 2019), and stakeholder input (winter 2019 – spring 2020) before identification of the final state priorities in spring 2020.

The needs assessment was designed to enable Title V MCH to assess its activities and services in relation to the state's MCH needs identified though qualitative and quantitative data sources. Selected MCH stakeholders participated in a virtual convening in April 2020, where they were briefed on the MCH Block Grant and an overview of findings. After reviewing additional fact sheets, stakeholders were invited to participate in an online discussion board segmented into each of the Title V domains (maternal, infant, child, and adolescent health and CSHCN), as well as cross-cutting/SDoH. Comments were recorded from stakeholders, particularly regarding the most pressing issues affecting each population domain and the MCH system's capacity to address those issues. After two weeks of discussion, stakeholders were invited to nominally rank each potential priority option in three ways: (1) by the number of individuals impacted, (2) by the capacity of existing resources to address the issue, and (3) by political and social will to address the issue. Additionally, nearly 100 indicators were reviewed and analyzed for the needs

assessment process. When numbers permitted, each indicator was broken down among multiple axes, including race, ethnicity, geography, and poverty. Trend analysis was performed on current national and state performance and outcome measures, as well as indicators of population/community health status and health system capacity. Qualitative and quantitative data in combination with the stakeholder meeting feedback led to the identification of 8 MCH priority needs for Missouri, including 5 National Performance Measures (NPM) and 3 State Performance Measures (SPM).

Emerging Public Health Issues
Four salient topics have been identified as public health issues of increasing severity and/or significance. These topics include the increased incidence of mental and behavioral health issues and suicide among adolescents, untoward impacts of children with and without a special health care needs without a medical home, the need for multipronged and innovative approaches to prevent maternal mortality and reduce severe maternal morbidity, and the need for a strong, reliable, resilient and well-prepared MCH workforce.

Suicide among Missouri adolescents between the ages of 10-19 is the third leading cause of death for this age group (9.1 per 100,000). In 2018, 94 Missourians aged 10-19 died of suicide, making up approximately 7.6% of all suicides that year. According to Missouri's Youth Risk Behavior Survey (YRBS), the percentage of high school students who say they seriously considered attempting suicide has increased from 15.4% in 2009 to 20.4% in 202021. The percentage of high school students who say they have made a plan about how they will commit suicide has also increased from 11.3% in 2009 to 16.8% in 2021. Addressing suicide among the adolescent population is of tremendous significance. The Adolescent Health Program (AHP) addresses various health topics such as positive youth development and teen pregnancy prevention, and is instrumental in addressing suicide prevention. The AHP team provides consultation, education, training, technical assistance, and resources for health professionals, school personnel, parents, adolescents, state agencies, and community organizations. The AHP team coordinates the Council for Adolescent and School Health (CASH) to help the DHSS identify health priorities for adolescents, promote strategies to reduce health risks, and promote healthy youth development. The AHP partners to provide evidence-based suicide prevention trainings to schools and has developed a crisis toolkit for distribution to families.

Well-child visits provide important opportunities to support the whole child and address physical, behavioral, mental and emotional wellbeing, as well as conduct routine screenings, administer routine immunizations, and make early referrals to needed specialized services. The rates of well-child visits and routine childhood immunizations decreased during the COVID-19 pandemic. A patient-centered medical home facilitates patient-provider relationships to provide comprehensive primary care. In collaboration with the Missouri Chapter of the American Academy of Pediatrics, the Show-Me School-Based Health Alliance, Missouri Managed Care, and other partners. The Title V MCH team is pursuing new partnerships and strategies to ensure every child in Missouri has an identified medical home. Establishing a full-time CYSHCN Director position will play a key role in ensuring all children with and without special health care needs have a medical home. Ensuring coordinated, comprehensive and ongoing health care services for children with and without special health care needs is addressed further in the State Action Plan CSHCN Domain narrative.

The Governor's final approved state fiscal year 2024 budget includes $4.35 million to implement a Maternal Mortality Prevention Plan and effect simultaneous transformation through the following five domains of action affecting maternal health:

1. Standardized, evidence-based maternal quality care protocols;
2. A Maternal Health Access Project with a single point-of-entry system for referrals to obstetrical and prenatal care providers and community agencies, resources, programs, and services and a hub and spoke model Perinatal Health Access collaborative, inclusive of perinatal mental health;

3. Standardized maternal care provider trainings, using creative modalities, on trauma--responsive and culturally and linguistically appropriate care and screening, referral, and treatment of mental health conditions during and after pregnancy; SUD during and after pregnancy; cardiovascular disorders associated with pregnancy; and gestational diabetes and other endocrinology disorders associated with pregnancy.
4. A Postpartum Plan of Care to plan for and optimize comprehensive postpartum care; and
5. Improved maternal health data collection, standardization, harmonization, transparency, and support to enhance data quality and access, identify poor outcomes during pregnancy and make improvements to support healthy pregnancy, delivery, and postpartum outcomes.

With the implementation of Medicaid Expansion in 2021, it is important to monitor and respond to any impacts on the MCH population. While increased access to health care may also increase the likelihood of preventive care visits among women, ensuring those eligible for care are enrolled and receive quality care are two separate issues of importance for consideration and monitoring. Medicaid Expansion also reinforces the importance of leveraging the Title V and Medicaid partnership to advance the patient-centered family medical home, ensure equitable access to care and address the SDoH and health inequities. It will continue to be important for Title V MCH leadership to be proactive in engaging with partners to facilitate expansion efforts.

With the end of the federal Public Health Emergency (PHE), all Medicaid enrollees, including children, must be re-determined for eligibility within a one-year period, beginning April 1, 2023 and ending March 31, 2024. More than 1.4 million Missourians have healthcare coverage through MO HealthNet and will be impacted by the return of annual renewals. Eligible individuals—especially pregnant and postpartum women, people of color and children—are at risk of losing coverage during the unwinding process. Despite remaining eligible for Medicaid or becoming eligible for other types of low-cost coverage, children and families may lose coverage due to procedural reasons (such as not responding to a mailed request for verification by the state that may have gone to the wrong address). The Title V MCH team is pursuing collaborative strategies to increase awareness and ensure that internal and external stakeholders can spread the word to keep Missourians informed about the unwinding process. This includes sharing resources highlighting practical ways that MCH professionals and advocates can support families through this uncertain time and ensure MCH populations have continuity of coverage through the Medicaid redetermination process. The MCH Director shared resources such as a letter from Dr. Michael Warren, Associate Administrator of the Maternal Child Health Bureau, a related AMCHP Fact Sheet and DSS outreach materials.

The MCH Director facilitated a discussion between DHSS, the Missouri Hospital Association and 8 hospital systems in rural Missouri. The meeting aimed to: 1) identify the challenges related to recruiting and retaining clinicians that provide maternal health services in rural hospitals and communities and 2) discuss practical solutions to address the challenges. A common thread from the discussions was that many rural hospitals are “a car wreck away” from closing their OB/GYN services. Closure of rural hospitals is an ongoing challenge in Missouri where 50% of rural hospitals do not provide maternity care services. Between 2022-2023, Missouri saw the closure of three more rural birthing facilities: First Breath Birth and Wellness, Cox Monett Hospital, and Hedrick Medical Center. One of the hospital partners posited that labor and delivery is the backbone of any community, and “closing obstetric services won’t only affect maternal and infant health and mortality - it will kill the soul of the community.” Additionally, rural hospitals in Missouri are responsible for most maternal health care services for incarcerated women, including labor and delivery. The challenges being faced were broken down into several themes:

1. Shortage of OB/GYN physicians available to work in rural hospitals (residency to attending physician pipeline, lack of support and mentorship for new physicians, lack of OB/GYN residency slots, etc.);
2. System-level/structural challenges (majority of rural patients are Medicaid recipients and associated lower reimbursement rates; lengthy Medicaid credentialing process for physicians - 90-120 days average; high rate

of turnover due to rural physician isolation, workload and on-call commitment; extended delays in Medicaid reimbursement for services; etc.); and

3. Non-physician related challenges (nursing workforce shortage, challenges in collaborating with LPHAs, etc.).

A Rural Maternal Health Care workgroup, led by the new DHSS Chief Medical Officer, has been formed, and discussions with rural maternal health partners have continued. The work group will identify barriers to care, including but not limited to provider/workforce availability, payment and coverage issues, supportive infrastructure, and patient trust, and strategize approaches, engage stakeholders, and identify appropriate entities to address barriers and design potential solutions. The goal is for Missouri mothers to have access to the continuum of care from pregnancy through one year postpartum that is: in hospital, outpatient, and/or community settings; within 50 miles of their home; inclusive of maternal health providers and workforce members with comprehensive and diverse educational backgrounds; centered on the needs of patients and communities, in a manner that authentically garners trust; and appropriate for all acuity levels of maternal health care needs.

Click on the links below to view the previous years' needs assessment narrative content:

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$13,002,609	$12,242,452	$12,971,226	$12,299,305
State Funds	$11,314,206	$9,987,230	$9,987,230	$9,987,230
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$24,316,815	$22,229,682	$22,958,456	$22,286,535
Other Federal Funds	$0	$0	$0	$0
Total	$24,316,815	$22,229,682	$22,958,456	$22,286,535

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$13,088,625	$10,199,806	$13,064,561	
State Funds	$9,987,230	$9,987,230	$9,987,230	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$23,075,855	$20,187,036	$23,051,791	
Other Federal Funds	$0	$0	$0	
Total	$23,075,855	$20,187,036	$23,051,791	

	2024	
	Budgeted	**Expended**
Federal Allocation	$13,186,864	
State Funds	$9,987,230	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$23,174,094	
Other Federal Funds	$0	
Total	$23,174,094	

III.D.1. Expenditures

The State of Missouri maintains the Title V Maternal and Child Health Services Block Grant (MCHBG) funding allocations and expenditures for reporting in the Statewide Accounting Management System (SAM) II. Total FFY 2022 expenditures reported for this application are from actual expenditures October 1, 2021 through June 30, 2023 and estimated expenditures July 1, 2023 through September 30, 2023. The MCHBG amount awarded to the state in fiscal year 2022 was $12,469,248, and $10,199,806 had been spent through June 30, 2023. Total actual expenditures from July 1, 2023 to September 30, 2023 will be included in the expenditures on the FFY 2022 Federal Financial Report.

Missouri expended $9,987,230 of state funds, thus meeting the state match requirement set in 1989. For the majority of the match amount, Missouri utilized the core public health funds that support the screening of all infants born in Missouri for over 70 disorders within the following categories: congenital adrenal hyperplasia, cystic fibrosis, primary congenital hypothyroidism, classical galactosemia, amino acid disorders including phenylketonuria, organic acid disorders, fatty acid disorders, lysosomal storage disorders, biotinidase deficiency, hemoglobinopathies, and hearing disorders. The state also utilized state funding expended for Special Health Care Needs programming, Community Health Services and Initiatives, Healthy Families and Youth programming (Genetics and Healthy Childhood and WIC programs), and the general funding expended by the Missouri Department of Corrections (DOC) for the health care costs for female offenders of childbearing age as match for the MCHBG.

The majority of the MCHBG expenditures focused on the following areas: access to care, family partnership, medical home, services for children and youth with special health care needs (CYSHCN), well women care, women's health initiatives, maternal and infant mortality prevention, newborn health, perinatal substance use prevention, breastfeeding, safe sleep, home visiting, oral health, WIC and nutrition services, physical activity and healthy lifestyle promotion, school health, mental health, adolescent health, child and adolescent safety/injury prevention, promoting protecting factors for youth and families, perinatal and childhood lead poisoning prevention, MCH epidemiology support, ongoing MCH Needs Assessment, and contracts with local public health agencies (LPHAs).

Missouri complied with the 30%-30%-10% requirement, as specified in the guidance. The FFY 2022 annual expenditures summarized in Forms 2, 3a, and 3b by Population Health Domain and Categories as stated in the guidance are as follows:

Form 2 Expenditure Details

Detailed expenditures as listed in Form 2:

- Preventive and Primary Care for Children $3,133,970 (30.7%)
- Children with Special Health Care Needs $3,098,518 (30.4%)
- Administrative Costs $756,875 (7.4%, which is less than the allowable 10%)

Form 3a Expenditure Details by Types of Individuals Served

Expenditures by the Types of Individual Served:

- Pregnant Women $1,730,078
- Infants < 1 year $1,478,777
- Children 1 through 21 years $3,133,970
- Children with Special Health Care Needs (CYSHCN) $3,098,518
- All Others $1,588

Form 3b Expenditure Details by Types of Services

Detailed expenditures by Types of Services:

- Direct Services $280,317
- Enabling Services $2,735,239
- Public Health Services and Systems $7,184,250

As illustrated in the table below, the MCHBG funding supported key programs within the Department of Health and Senior Services divisions of Community and Public Health (DCPH) and Senior and Disability Services (DSDS), the Office of Childhood (OoC) at the Department of Elementary and Secondary Education (DESE), and contracts with the LPHAs to improve the health and wellbeing of Missouri mothers, infants, and children, including CYSHCN.

DHSS	**Federal Expenditures (Title V)**	**State Match**
Special Health Care Needs	$966,192	$899,199
Community Health Services and Initiatives	$3,268,121	$12,078
Environmental Public Health	$2,062	
Epidemiology for Public Health Practice	$ 624,373	
Healthy Families and Youth	$935,406	$684,143
Office for Women's Health	$893,286	
Office of Dental Health	$602,604	
State Public Health Laboratory		$5,618,608
DCPH Director's Office	$613,522	
Vital Records	$128,282	
Administrative	$756,875	$394,758
DESE Office of Childhood		
Home Visiting	$940,803	
Safe Cribs	$2,195	
Child Care Health Consultation	$99,771	
Child Care Inclusion Services	$256,823	
Early Childhood Coordinated Systems	$5,399	
Contract Indirect	$46,849	
Office of Administration		
Information Technology Services Department	$57,243	$94,200
Department of Corrections		
Services for Incarcerated Women		$2,284,244
TOTAL	**$10,199,806**	**$9,987,230**

The expenditures above illustrate the breakdown of Missouri's FFY 2022 MCHBG funding to address the health and wellbeing of women of childbearing age, infants, and children, including CYSHCN. The expenditures support the MCH priorities selected by the stakeholders and partners to address the following population health domains:

Women/Maternal Health
Perinatal/Infant Health
Child Health
Adolescent Health
Children with Special Health Needs

A total of 47% ($4,751,612) of the funding was expended for contracts with the LPHAs and other community organizations. Contract funds supported the state priorities and associated activities listed in the FFY 2021-2025 State Action Plan, along with other initiatives/activities that improve the health of the MCH population and address local MCH issues.

A total of 34% ($3,508,136) of the funding was expended for personnel to provide program oversight and technical assistance (TA). TA was provided to contractors to assist with implementation of services and activities that impacted the MCH priorities and population. This amount also included the Section of Epidemiology for Public Health Practice staff who provide data to evaluate Missouri’s priorities, and the Title V MCH Program staff, who manage the Title V MCH Services Block Grant application and budget and provide state MCH leadership and lead implementation of MCH initiatives.

A total of 7% ($756,875) of the funding was expended for administrative costs. This was less than the maximum allowable amount of 10%.

The remaining 12% ($1,183,183) of the funding was expended for DHSS program Expenses & Equipment (E&E) and other special initiatives. E&E costs include travel expenses for meetings the MCH Director and CSHCN Director are required to attend as well as for other travel expenses, general office supplies and other costs necessary for program implementation and workforce development.

III.D.2. Budget

The Title V MCH Services Block Grant Federal Fiscal Year (FFY) 2024 application budget provides funds for maternal and infant health services, preventive and primary care for children and adolescents, and preventive and maintenance services for children with special health care needs (CSHCN). These services are managed by the programs within the Department of Health and Senior Services (DHSS) and through contracts with Local Public Health Agencies (LPHAs) and other community organizations. DHSS and its partners meet in the spring of each year to develop funding strategies for the upcoming grant application. Programs are required to submit a budget request based on the MCH priorities and initiatives they will be working on in the next grant cycle. After all budgets are submitted, the MCH Director, Title V MCH core team and Division of Community and Public Health (DCPH) leadership further review and approve the budget for the next fiscal year.

The FFY 2024 budget projections are based on the approved award amount for the Title V MCH Block Grant in FFY 2022. DHSS uses the two-year prior award amount since the total current year award is not known during the budget proposal phase and/or until after the initial grant application is submitted, typically in July. With the FFY 2024 proposed use of funds, every effort will be made to maintain Title V MCH support for essential MCH programs, services, and partnerships. This year, programs requested $13,186,864, which is $717,616 above the amount of FFY 2022 funding received. As state employee salaries have been increased to account for rising inflation, while Title V MCH Block Grant funding has remained relatively level, budget projections to maintain essential MCH programs and services has exceeded the anticipated award. The ongoing goal is to ensure maintaining or increasing services for the MCH population in Missouri, and any additional budget needs not covered by the FFY 2024 Title V MCH Block Grant award will be funded with lapses in FFY 2023 funding. Lapses in FFY 2023 funding are primarily due to personnel vacancies. If the FFY 2024 funding received and/or FFY 2023 lapsed funding is less than anticipated and/or needed, the MCH leadership will prioritize FFY 2024 activities and initiatives, while maintaining the core services provided for the MCH population in prior years. Similarly, any additional funding received beyond the anticipated award will be appropriately allocated to programs and initiatives serving the MCH population. Funding may also be redirected, as needed, to respond to evolving issues and assure the needs of the MCH population are addressed.

Requirements

Missouri complies with the 30%-30%-10% Title V legislative financial requirement (as indicated on Form 2) and program regulations. The budget is based upon a percentage breakdown by program, level of service, and MCH population domain(s) impacted by the services provided. The budget will meet/surpass the requirement that at least 30% of funds be used for preventive and primary care services for children and at least 30% for services for CSHCN. At 8.33%, the budget used to administer Title V MCH Block Grant funds is less than the 10% maximum amount allowed. The State uses its MCH Block Grant funds for the purposes outlined in Title V, Section 505 of the Social Security Act as follows:

Form 2 Annual Budget Details

The detailed budgets as listed in Form 2:

- Preventive and Primary Care Services for Children: $4,175,109 (31.66%)
- Children with Special Health Care Needs: $4,022,725 (30.5%)
- Administrative Costs: $1,098,528 (8.33%)

Form 3a Budget by Types of Individuals Served

Budget by the Types of Individuals Served:

- Pregnant Women: $2,087,013

- Infants < 1 year: $1,797,033
- Children 1 through 21 years: $4,175,109
- CSHCN: $4,022,725
- All Others: $6,456

Form 3b Budget by Types of Services

Detailed budgets by Types of Services:

- Direct Services: $282,022
- Enabling Services: $5,202,096
- Public Health Services and Systems (includes administrative costs): $7,702,746

Direct Services:

Direct services are preventive, primary, or specialty clinical services to pregnant women, infants and children, including children with special health care needs, where MCH Services Block Grant funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts. State reporting on direct services should not include the costs of clinical services that are delivered with Title V dollars but reimbursed by Medicaid, CHIP or other public or private payers. Examples in Missouri include, but are not limited to, the Kids Assistive Technology (KAT) project and Preventive Services Program (PSP). KAT projects include communication and mobility devices, hearing and visual devices, seating and mobility enhancements, and home and vehicle modifications for CSHCN. PSP is an evidence-based fluoride varnish and oral health education program that anticipates serving over 80,000 children in the 2023-2024 school year.

Enabling Services:

Enabling services are non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health care and improve health outcomes where MCH Services Block Grant funds are used to finance these services. Enabling services include, but are not limited to: case management, care coordination, referrals, translation/interpretation, eligibility assistance, health education for individuals or families, environmental health risk reduction, health literacy, and outreach. Examples in Missouri include contracts for Home Visiting, CYSHCN Service Coordination, Child Care Health Consultation, services provided by the LPHAs through the MCH Services contract, Child Care Inclusion Specialists, and the MCH WarmLine and Navigators at ParentLink.

Public Health Services and Systems:

Public health services and systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services. Examples include the development of standards and guidelines, needs assessment, program planning, implementation, and evaluation, policy development, quality assurance and improvement, workforce development, and population-based disease prevention and health promotion campaigns for services. Examples in Missouri include the injury prevention program, adolescent health program, comprehensive school health program, safe sleep program, obesity prevention program, breastfeeding program, prenatal substance use prevention, and the Maternal Health Multisector Action Network. Also included are MCH Epidemiological Services and program evaluation, MCH workforce capacity and technical assistance for program coordination and systems development, and LPHA community-based system building through the MCH Services contract.

TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT		
FFY 2024 PROPOSED USE OF FUNDS		
FUNDING	**PROPOSED FFY 2024**	
TOTAL FUNDS APPLIED FOR	$ 13,186,864	
FUNDING BY SERVICE LEVELS	**PROPOSED FFY 24**	**SUBTOTAL**
Direct Care Services		
Assistive Technology	$ 100,000	
Oral Health Services	$ 165,020	
Childhood Lead Poisoning Prevention	$ 17,002	
Total Direct Care Service		**$282,022**
Enabling Services		
DESE Office of Childhood	$ 1,846,516	
LPHA MCH Services Contracts	$ 878,518	
CSHCN Service Coordination	$ 1,268,614	
Family Partnership	$ 67,892	
Lead Hazard Reduction/Abatement	$ 46,757	
Oral Health Services	$ 143,632	
Total Enabling Services		**$4,251,928**
Public Health Service and Systems		
Adolescent Health	$ 89,000	
DESE Office of Childhood	$ 602,046	
Coordination and Systems Development	$ 2,980,760	
Epidemiological Services	$ 691,258	
Genetic Services	$ 23,120	
Healthy Families	$ 130,873	
Injury Prevention	$ 100,000	
LPHA MCH Services Contracts	$ 2,635,553	
Nutrition Projects	$ 17,485	
Obesity Prevention	$ 19,000	
Oral Health Services	$ 48,320	
Outreach and Education (TEL-LINK)	$ 36,419	
School Health	$ 20,000	
Women's Health Initiatives	$ 160,551	
Total Public Health Service and Systems		**$7,554,386**
Administration	$ 1,098,528	
		$1,098,528
Grand Total		**$13,186,864**

The budget supports the state's priorities to address all five population health domains:

Women/Maternal Health
Perinatal/Infant Health
Child Health
Adolescent Health
Children with Special Health Needs

A total of $6,669,094 (51%) of the funding is for contracts with the LPHAs and other community organizations. Contract funds support the state priorities and associated activities listed in the FFY 2021-2025 State Action Plan.

A total of $4,556,296 (35%) of the funding is for personnel to provide program oversight and technical assistance (TA). TA is provided to contractors to assist with implementation of services and activities that impact the MCH priorities and population. This amount also includes the Section of Epidemiology for Public Health Practice staff who provide data to evaluate Missouri's priorities, and the Title V Program staff, who manage the Title V MCH Services Block Grant application and budget.

A total of $1,098,528 (8%) of the funding is for administrative costs.

The remaining $862,946 (6%) of the funding is for DHSS program Expenses & Equipment (E&E). E&E costs include travel expenses, general office supplies and other costs necessary for program implementation and workforce development.

Maintenance of Effort/Match
The state's maintenance of effort level from 1989 is $9,987,230, and the state's calculated match requirement for fiscal year 2024 based on the planned budget total is $9,987,230. The total Federal and State Funds budget includes projected expenditures identified as benefitting the health of the Title V populations in Missouri. These funds come from the Title V MCH Services Block Grant and state general revenue. The Federal expenditures are within the DHSS, where the Title V MCH Program resides, though not specifically under the organizational authority of the MCH Director. The majority of State Funds are for newborn screening through the DHSS State Public Health Laboratory, direct care for CSHCN, and services provided to women of childbearing age (excluding those who are HIV positive) through the Missouri Department of Corrections. This program provides a critical public health service to the MCH population and is aligned with the National Performance Measures.

As illustrated in the table below, the MCH Block Grant and State funding supports key programs within the DHSS Division of Community and Public Health (DCPH) and the DESE Office of Childhood. Funding also supports maintenance for specific MCH data systems and providing health services to incarcerated women.

DHSS	Federal Funds (Title V)	State Funds
Special Health Care Needs	$1,437,506	$1,017,130
Community Health Services and Initiatives	$4,723,034	$34,552
Environmental Public Health	$85,012	
Epidemiology for Public Health Practice	$691,258	
Healthy Families and Youth	$1,041,761	$831,596
Office for Women's Health	$228,854	
Office of Dental Health	$ 602,604	
State Public Health Laboratory		$4,848,721
DCPH Director's Office	$593,352	
Vital Records	$129,437	
Administrative	$1,098,528	$242,953
DESE Office of Childhood		
Home Visiting	$1,419,437	
Safe Cribs	$153,271	
Child Care Health Consultation	$319,833	
Child Care Inclusion Services	$471,164	
Contract Indirect	$84,857	
Office of Administration		
Information Technology Services Department	$71,177	
Department of Corrections		
Services for Incarcerated Women		$3,012,278
TOTAL	**$13,186,864**	**$9,987,230**

*Information about the structure and programming of DHSS can be found in the Title V Program Capacity section of the application.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Missouri

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Partnership and Leadership Roles

Missouri has a rich history of providing support for and creating state partnerships that support the promotion and improvement of the health and well-being of the state's mothers, infants, and children, including children and youth with special health care needs (CYSHCN). The maternal child population is one of our most vulnerable populations, and Title V is the umbrella program that supports multiple programs targeting this population to coordinate activities and pool resources. A host of qualified health professionals oversee/implement the programmatic aspects of the Title V MCH Block Grant throughout the state. This includes a Core Team to provide Title V direction and carry out the daily and ongoing processes of the block grant with a focus on all five population health domains.

The MCH Steering Committee is comprised of Title V Core Team members (listed in the Workforce Capacity section of the application), the Title V Family Delegate, and other DHSS staff who lead and implement programs impacting the MCH population. This group provides leadership, accountability, and oversight to the state's MCH efforts; set a strategic direction for Title V programming; serve as the key decision-making body for program-wide activities; and identify and provide support to state and local level efforts. The Steering Committee ensures Title V efforts address the purpose of the MCH Block Grant and its Vision and Mission statements.

Formation of a MCH Advisory Council remains a Title V goal. The Division of Community and Public Health has convened a group of managers to discuss the process for board and committee appointments. Following agreed upon Division guidelines, an Advisory Committee will be formed, comprised of external partners such as local public health agency (LPHA) representatives, family/parent advocates, adolescents, and other state agency associates, and representative of the urban/rural and demographic composition of the state. The Advisory Council membership will include professionals with expertise in MCH care and services, consumers with an interest in the health of mothers and children, and individuals who can speak to the specific needs of the MCH population in Missouri. Members will provide ongoing guidance and support to Title V and MCH initiatives, informing strategies and measures for the Title V State Action Plan, identifying and responding to emerging MCH issues, and supporting ongoing needs assessment efforts and public input.

Missouri's Title V MCH Block Grant maintains active partnerships with local and state agencies including, but not limited to 115 LPHAs, Department of Social Services (DSS), Department of Elementary and Secondary Education (DESE), Department of Mental Health (DMH), Missouri Hospital Association (MHA), Missouri Foundation for Health, HealthierMO, Missouri Chapter of the American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), Show-Me School-Based Health Alliance, Community Health Workers Association of Missouri, Children's Trust Fund, ParentLink, University of Kansas City- Institute for Human Development, and schools of nursing and public health. Title V MCH team members participate on and lead various state committees and initiatives, such as the Healthy Start Collaborative, Early Childhood Coordinated Systems Steering Committee, Missouri Injury and Violence Prevention Advisory Council, and the Coalition for Adolescent and School Health, to collaborate with stakeholders and strategically align goals and activities. Through partnerships with federal agencies, Title V receives technical assistance, evidence-based resources, opportunity for creative thinking and constructive critique, and training to enhance Missouri's capacity to promote the health and safety of the MCH population.

Serving as a Convener, Collaborator, and Partner to Address MCH Issues

The unique needs of the MCH population are even more important in the midst of the chaos and uncertainty of an emergency, and the COVID-19 pandemic highlighted the special considerations for the MCH population that must be addressed to ensure the delivery of quality health care services to assure the health and safety of Missouri's

mothers, infants and children, including CYSHCN. During the COVID-19 pandemic, Title V continued to advocate with internal and external partners and supported partner efforts to promote: telemedicine and teledentistry for the MCH population, as appropriate; adequate prenatal care; well-child visits; routine childhood immunizations; health and safety of children and adults in the school setting; vaccination against communicable disease for women of childbearing age, pregnant women, fathers, infants, children, and adolescents; and strengthening social supports, assuring social services equity, and removing barriers to trauma responsive and culturally competent care. School Health Program staff funded through Title V leveraged other funding sources to contract for poverty simulations for school nurses, social workers, counselors and other staff, with six regional simulations planned for the 2023-2024 school year. Title V shares updated federal and state guidance with internal and external partners and encourages partners to share with additional partners and the individuals and families they serve. The Early Childhood Comprehensive Systems (ECCS) works with communities to improve early childhood outcomes by providing opportunities for implementation of the Office of Childhood Strategic Plan for Missouri's children and their families. The strategic plan was revised as part of the Preschool Development Grant: Birth to Five (PDG). The PDG is a federal grant awarded to DESE. The strategic plan focuses on four main goals: expanding access to high-quality programs and services, improving the quality of programs and services, strengthening community leadership, and modernizing systems and improving operations. The PDG Activity Team is a key partner in the coordinated enrollment plan for the early care and education systems and involves representatives from Title V funded programs such as Home Visiting, Child Care Health Consultation, ECCS, and MCH Services. Numerous organizations and services for young children and their families have existed for many years in the State of Missouri. Nonprofit organizations, government agencies, corporations, individual businesses, and informal groups have provided a wide range of supports to help young children thrive. ECCS has attempted to examine these services more comprehensively and link them into a more effective, unified system that aims to support families and communities in promoting optimal development of all young children in Missouri and ensure families are aware of the resources available to them.

As a key stakeholder in Missouri's early childhood system and a funder of programs serving young children and families, including programs in the Office of Childhood at DESE, Title V is centrally involved in the coordination of efforts to integrate early childhood programming, maximize the effectiveness of the early childhood services, and enhance family access to early childhood resources and services. The formal relationship between Title V and the Office of Childhood is established through an interdepartmental contract with a detailed Scope of Work.

The DHSS partnered with the University of Missouri Kansas City Institute for Human Development (UMKC-IHD) to organize, convene and facilitate a statewide Maternal Health Multisector Action Network (the Network). The Network is working to create a comprehensive statewide system to respond to the needs of women and families affected by mental health and substance use. Core team members from UMKC-IHD and DHSS convened a collaborative meeting with other key stakeholders (the Uplift Connection, Missouri Hospital Association, Generate Health, Missouri Foundation for Health, Missouri Bootheel Regional Consortium/Healthy Start Initiative, and the Nurture Kansas City/Healthy Start Initiative) who are also working on maternal substance use and mental health, specifically focusing on the mother-infant dyad. The aim of the meeting was to strategize how all groups could collaborate to leverage existing work by identifying any duplicating and/or overlapping efforts and discussing ways to collaborate for maximum collective impact to fill the existing gaps. The Network is also partnering with the Children's Division at the DSS and the Prison Nursery Program and Re-entry Team at the Department of Corrections to promote and facilitate systems change. Specifically, the Network is connecting and supporting Missouri-specific programs to add more prevention-based treatment and services for substance use disorder and mental health issues to the repository of available interventions. The Network is also connecting providers to the Prison Nursery program to build an equitable program inclusive of sober living homes, lactation consultants, peer support, and doula services.

The DHSS collaborated with the Association of State and Territorial Health Officials (ASTHO) to facilitate an

interactive MCH Boundary Spanning Leadership (BSL) Workshop. Forty-two participants, representing state agencies (DHSS, DMH, DESE, DSS), hospital systems (SSM Health St. Louis, Missouri Hospital Association), community-based organizations (Generate Health, Uzazi Village, Missouri Bootheel Regional Consortium, Missouri Foundation for Health) academia (University of Missouri-Columbia, University of Missouri-Kansas City), and other partners (March of Dimes, ParentLink, Children's Trust Fund), were in attendance. Participants examined boundaries and strategies to forge common ground and mobilized a plan to unify efforts across Missouri in order to achieve the shared vision of improving MCH outcomes. By shifting the focus from managing and protecting boundaries to boundary spanning, organizational leaders learned to create direction, alignment, and commitment. 100% of evaluation survey respondents indicated the event increased their knowledge of the major boundary types, increased their capability to explore the systemic and interpersonal factors contributing to MCH outcomes in Missouri, and strengthened their connections to key MCH partners to improve MCH outcomes in Missouri. One participant described the workshop as "mind shifting". Future follow-up BSL workshop meetings will focus on practical strategies to dismantle the boundaries preventing the development of relationships between agencies and power dynamics that could be contributing or restricting factors to collaborative partnerships.

Title V Framework

Like many Title V programs, the Life Course Perspective is a conceptual framework for understanding and addressing disparities in maternal and child health. The MCH Director facilitates *An Interactive Simulation, Application and Discussion of the Life Course Framework* for internal and external MCH programs and partners, including LPHAs, undergraduate and graduate students, and community organizations. To address the eight MCH priorities, apply the two overarching principles, eliminate health disparities, and create safe, stable, and nurturing relationships and environments for children and families in Missouri, the Title V MCH FFY 2021-2025 State Action Plan strives to integrate the Life Course Perspective throughout initiatives, strategies and activities and implement the following Association of State and Territorial Health Officials (ASTHO) recommendations to address and prevent adverse childhood experiences (ACEs) across the lifespan:

- utilize a population health approach that engages cross-sector partners, uses data to drive efforts and monitor progress, fosters resilience, and cultivates a trauma-informed workforce;
- support policy and environmental changes across sectors to strengthen household financial security and economic self-sufficiency and develop a trauma-informed state government, where all employees are trained in trauma-informed concepts and all agencies have a stake in addressing ACEs as a cross-cutting issue;
- cultivate a competent and trauma-informed MCH workforce that understands the underlying causes of health disparities;
- use data to inform prevention programs and policy and to identify at risk populations or geographic areas to implement context-specific prevention initiatives;
- engage cross-sector partners to support the social and emotional well-being of children and their families;
- work collaboratively with trusted family venues (e.g. faith based, barber shops, and other community centers) to influence family services that fall outside the realm of clinical practice;
- support centralized access points, care coordination efforts, and community leadership and infrastructure to link children and families to universal and targeted services;
- implement prevention approaches that promote prosocial and healthy behaviors at the individual and familial levels, such as evidence-based programs that support positive parenting skills, and foster resilience by enhancing social-emotional protective factors;
- support rigorous program evaluation to demonstrate effectiveness of programs, especially those designed to address and prevent ACEs;
- protect and increase investments in early childhood development, home visiting, and trauma-informed services for low-income children and families; and

- support and fund evidence-based home visiting programs to assess and address family needs and connect families to appropriate services.

Utilizing the Strengthening Families Protective Factors Framework from the Center for the Study of Social Policy, Missouri's Title V MCH Services Block Grant works to engage families, programs, and communities in building key protective factors to mitigate risks, promote positive well-being and healthy development, and help families successfully navigate difficult situations and improve outcomes. The Title V MCH Block Grant in Missouri will continue to fund contracts with LPHAs to support a leadership role for LPHAs at the local level to: build community-based systems and expand the resources those systems can use to respond to priority MCH issues; provide and assure mothers and children (in particular those with low income or limited availability of health services) access to quality MCH services; reduce health disparities for women, infants, and children, including those with special health care needs; promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for low income, at-risk pregnant women; and promote the health of children by providing preventive and primary care services for low income children. Local, regional and statewide initiatives and programs funded by the Title V MCH Block Grant will provide leadership for and enhance community capacity to address and prevent ACEs across the lifespan and build key protective factors that enable mothers, infants, children, and families to thrive.

Successes/Challenges/Emerging Issues
Missouri's Title V MCH Block Grant continues to anticipate and adjust to the ongoing impacts of the COVID-19 pandemic on the communities we serve. Executive Order 21-09, a targeted State of Emergency declaration, terminated on December 31, 2021. COVID-19 remains an ongoing public health challenge, and the DHSS continues to encourage individuals to stay up-to-date on vaccinations, use at-home COVID-19 tests when exposed or experiencing symptoms, and stay home if sick.

Foundation for Family and Community Health/Access to Care
Supporting Coordinated, Comprehensive, Family-Centered Systems of Care
The Tile V MCH Program supports service coordination through the Children and Youth with Special Health Care Needs and HCY programs to help families develop and obtain high quality supports and services to meet their needs. Early childhood home visiting programs are offered to ensure children have the opportunity to grow up healthy, safe, and ready to learn and be able to become productive members of society. Title V team members also work to develop meaningful partnerships with schools, child care providers, state departments/associations, local organizations, and community groups to promote systems of care that benefit the MCH population and overcome issues preventing access to care.

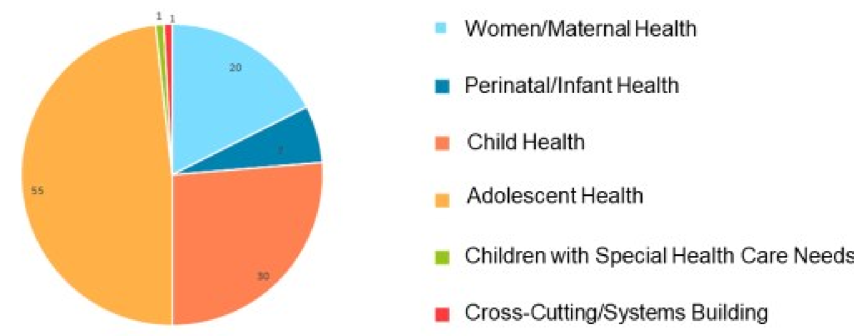
Innovative Approaches to Address Crosscutting Issues
Missouri's Title V MCH Block Grant works with partners to engage community stakeholders who work closely with the MCH population. Suicide remains the tenth leading cause of death for all ages among Missouri residents and the third leading cause of death among adolescents 10-19 years old. Youth suicide rates in rural counties are higher than more urban areas, Missouri is under-resourced with mental health professionals, and the gap in mental health resources is especially prominent in rural areas. Title V partnered with the Injury Prevention and Adolescent Health programs to form a workgroup with partners including DMH, DESE, the Association of Secondary School Principals, public school teachers and staff, Wyman, Inc., the DHSS School Health Program, LPHAs, parents, and adolescents. Led by the Injury Prevention Program, the workgroup developed the *Navigating Your Child's Mental Health Crisis Toolkit*, based on the Society for the Prevention of Teen Suicide (SPTS) toolkit for use in emergency room settings with families of youth experiencing a mental health crisis. The Mental Health Toolkit is a resource for schools to give parents/guardians who have a child experiencing a mental health crisis for the first time. The toolkit: 1) provides families with comprehensive resources and guidance on what to expect when they get to the hospital, 2) promotes

reduction of shame and prejudice around mental illness, 3) normalizes seeking mental health services, 4) recognizes the different experiences and unique needs of socially disadvantaged populations, and 5) provides equitable system-wide opportunities to help all students thrive. The DHSS partnered with stakeholders such as LPHAs, the Missouri School Board Association (MSBA), and school nurses working to address mental health to pilot the adapted toolkit to school districts with higher rates of suicide and self-injury. More than 900 toolkits were distributed to 14 school districts in FFY 2022. Additionally, the School Health Program partnered with the MSBA Center for School Safety to offer a 7-hour training for school nurses on triage and assessment of students after a fight and de-escalation strategies. This training was at the request of lead school nurses related to an increase in fights occurring at school. 100 individuals attended the training. In April 2023, the School Safety Task Force and School Health Program collaborated to provide another workshop on emergency medications and “stop the bleed” kits.

Implementing Core Public Health Functions
Assessment
Title V is supported by a robust data infrastructure, which includes the MCH epidemiology team that primarily supports the Title V block grant application and needs assessment processes and provides crucial data and analytical support for MCH programming and initiatives. Title V staff also provide technical assistance to both internal and external partners with respect to MCH data analysis and interpretation. Functions include: monitoring MCH indicators; presenting MCH-related data to internal and external stakeholders; leading the Five-Year Needs Assessment and ongoing needs assessment processes; updating and maintaining datasets; program planning, reporting, improvement, and evaluation; data dissemination; data analysis; and ensuring data quality, integrity, and processing. Data is gathered from the Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Survey (YRBS), Fetal and Infant Mortality Review, teen birth and pregnancy rates, Missouri Child Health Assessment Program Survey (MoCHAPS), Home Visiting programs, State Systems Development Initiative (SSDI), and Birth Defect Surveillance, among other relevant sources. The Title V core team sought technical assistance from the MCH Workforce Development Center and is in the process of revising the national and state performance measure objectives with the goal of making them specific, measurable, attainable, relevant, and time-based (SMART). Additionally, the Evidence-based or –Informed Strategy Measures (ESMs) will be revised to progress from process measurement to impact/outcome measurement. This will allow evaluation of whether Title V funded program activities are meeting the targeted goals.

Policy Development
Missouri communities perform the policy development and planning function when they use assessment information to set priorities. They work in collaboration with their governing bodies, or other local policy makers, to develop policy, allocate resources, and implement strategies to improve the health of their communities. Almost 30% of funds from the Title V block grant are distributed to the MCH Services Program, which contracts with 111 LPHAs to address the needs of their local MCH population. Each LPHA submits a five-year work plan with annual contract renewal. The MCH Services Contract priority health issues (PHI) are set to align with the Title V MCH Block Grant national and state priorities in order to focus on a more comprehensive statewide impact. Using local data and input from community members and partners, the LPHAs conducted focused local assessments of the priority MCH issues in their community and used the Title V MCH Block Grant priorities as a guide to identify their FFY2022-2026 MCH Services contract PHIs. Each work plan identifies targeted national, state, and/or local outcome measure(s); a statistically descriptive statement of the problem; goals for addressing the stated problem; and evidence-based strategies that will be used to address the problem. Also identified are system outcome(s) and multifaceted, progressive activities at each of the six levels of the Spectrum of Prevention, which includes influencing policy and legislation and changing organizational practices. The figures below show the breakdown of the FFY 2022-FFY 2026 MCH Services LPHA contractor work plans by population domain and PHI.

MCH Services Program LPHA Contractor Work Plan Focus by Population Domain (111 LPHAs)



MCH Services Program LPHA Contractor Work Plan Focus by Priority Health Issue (111 LPHAs)

Assurance

Missouri's Title V programming: assures communities have the information, resources, and strategies they need to maximize the health of their residents; assures the public has access to culturally appropriate, accurate, and current information that they need to make decisions about their health care options; provides health promotion, education, and disease prevention programs in the community; educates health providers about public health issues; helps assure access to care; and implements quality improvement processes to achieve measureable improvements in outcomes and other indicators of quality in services or processes, which contribute to increased equity and improved community health. LPHAs must establish a process for tracking and monitoring progress and analyzing performance trends to measure work plan effectiveness in achieving the targeted changes in the local community systems and revise work plan activities as necessary to improve effectiveness. The FFY 2021-2025 Title V State Action Plan was intentionally reimagined from the FFY 2016-2020 State Action Plan to identify general strategies to achieve the identified objectives and overall vision. FFY 2021 was intended to be a continued planning year with further identification and planning of shorter-term priorities, performance initiatives and specific action steps, detailing the "who, what, and when" related to the resources to be leveraged, and the establishing the "how" of achieving the objectives. The ongoing diverse, cross-sectional impacts of the COVID-19 pandemic necessitated continuing these processes into FFY 2022, while also maintaining work in progress. Internal MCH programs and external contractors

will continue to be challenged to identify evidence-based performance initiatives and action steps that align with the general strategies and will contribute to achieving the objectives and performance targets established in the ESMs (Evidence-based or –Informed Strategy Measures).

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Recruitment and Retention

Like most employers, the state of Missouri and the Department of Health and Senior Services (DHSS) have been affected by "The Great Resignation". The public health sector has been especially affected by people leaving the field due to the increased work-related stress created by the pandemic. The DHSS Office of Human Resources developed a retention strategies plan, which was shared with all supervisors and managers. Strategies include reviewing recruiting/hiring practices, understanding team effectiveness, exploring flexible scheduling, and utilizing stay interviews. The state Office of Administration launched the MO Appreciation website to show appreciation to colleagues and strengthen the culture of recognition. The website, which has been designed by state team members for state team members, is a one-stop shop to provide team members access to resources, ideas, and recognition opportunities.

Although Title V MCH supported programs have experienced numerous departures over the past two years, there has been a rebound in recent months. Many vacant positions have been filled, and the new team members have been trained and are actively contributing to MCH efforts. The Title V MCH Program works closely with multiple units throughout DHSS. Many DHSS staff have worked for the Department for many years, strengthening the knowledge base, needs assessment, and expertise both in public health and MCH. Managers and supervisors are responsible for ensuring that staff are qualified, properly trained, and informed on current public health issues.

MO Careers is the state hiring platform for finding a career in Missouri government, browsing state job listings, exploring job openings for individual state agencies, applying for posted positions, viewing state benefits, and more. Ongoing expansion to MO Careers (HireTrue) has continued to evolve and change how state agencies hire and onboard new team members. Expansion of MO Careers (HireTrue) requires less staff time to move positions and applicants through the hiring process and has increased consistency and efficiency in overall hiring processes.

The following Missouri Title V Workforce Information Sheet provides additional information regarding Missouri's Title V MCH Workforce.

Missouri Title V MCH Workforce Information Sheet

Title V MCH Program Workforce FTEs
1. **Title V MCH Funded Positions:** 125 positions/FTEs (not including ITSD) are funded in part or whole with Title V funding **Total Number of FTEs:** 52.868 Total FTEs
2. **New Title V MCH Funded Team Members On-boarded in Past Year** **Total Number of New FTEs:** 23 Positions representing 10.634 FTEs___ **Types of Positions:** 1) CYSHCN Director 1) MCH Research/Data Analysts 2) Program Managers 3) MCH Registered Nurses 4) Public Health Program Specialists 5) Administrative Support Staff 6) DHSS Chief Physician
3. **Title V MCH Funded Positions Currently Vacant** **Total Number of Vacant FTEs**: 12 Positions representing 3.78 FTEs **Types of Positions Vacant:** 1. CYSHCN Director 2. SHCN team members 3. MCH Registered Nurses 4. Project & Program Specialists 5. Program & Administrative Support Staff
Training Needs and Resources
1. **Current or Anticipated Title V MCH Professional Development and Training Needs** 1. Core MCH and Title V training for new Title V Team Members 2) Leadership Development ______ 3) Ongoing training, technical assistance, and education related to Core MCH and Title V concepts, new resources, new guidelines, emerging needs, innovative strategies, etc.______ 4) Training related to SDoH, trauma-responsive care, diversity, inclusion, cultural competence, and equitable care and services ______ 5) MCH Epidemiology training 6) Building program and policy evaluation capacity 7) Building needs assessment capacity
2. **Key Resources/Partners Needed to Meet Title V MCH Professional Development and Training Needs** 1. State of Missouri and DHSS Leadership Support 2. HRSA/MCHB 3. AMCHP: Leadership Lab, Annual Conference, Learning Collaboratives, Webinars, MCH Essentials Series, Resource Library, TA, etc. 4. MCH Navigator 5. National MCH Workforce Development Center

6. MCH Evidence Center
7. CityMatCH Webinars, Training, Conferences, Resources, etc.
8. State of Missouri and DHSS Training Resources & Offerings

Training and Growth Opportunities

The Missouri Way training series incorporates approaches proven successful in other high performing organizations in both the public and private sectors and was established to equip state team members with tools and techniques to become the best public servants possible and to drive change for the citizens of Missouri. The training was originally designed as an intensive 3-day training program to introduce senior leaders, managers, supervisors, and other emerging leaders to tools and approaches to solve basic management challenges and improve their team's performance. The training series has been transitioned to a new e-learning format available to all state employees. The new e-learning series is an essential part of the State of Missouri's plan to improve its performance and develop a culture of continuous improvement. The Missouri Way objectives are to:

- Accelerate participants professional growth through individual leadership development, building new skills to lead others and lead change
- Provide department leaders the skills and shared understanding needed to improve team performance and cultivate a strong, positive work environment
- Develop needed skills amongst team members across the State of Missouri to improve government performance for our citizens

The curriculum includes sessions on change management, continuous improvement, project management, customer experience, communications, performance measures and dashboards, and building and leading and provides common approaches, tools, and vocabulary in the following learning paths:

- Advanced Teams/Lead others
- Initiative Team Boot Camp
- Facilitation for Change Agents
- Lead Change
- Lead Self
- Performance Measures and Dashboards and
- Show Me Excellence

All state employees now have access to online professional development content through MO Learning, a world-class online training platform powered by LinkedIn Learning. State employees have access to an online library of over 16,000 high-quality courses that can be accessed through office computers or on a mobile device. A wide range of course topics pertinent to professional development is available, and a list of initial course recommendations is available for team members, supervisors, and managers.

Monthly 1:1 ENGAGE meetings bring supervisors and team members together to have meaningful professional development conversations. These conversations provide an opportunity to help team members improve in their current role and position themselves for future success. ENGAGE aims to help team members understand how they are performing against expectations and improve individually and collectively. Periodic ENGAGE evaluations measure a team member's performance in three areas; delivering excellent results, going above and beyond their day-to-day role and consistently demonstrating a commitment to grow and learn.

The Quarterly Pulse Survey (QPS) provides insight on the organizational health of state agencies and guides progress on major cross-department initiatives. Through the QPS, state team members asked for more investment in professional development. The Missouri Office of Administration rolled out the NEW Professional and Leadership

Development Award (PLDA) in late 2022, committing nearly $7 million dollars to reward and recognize the top performers amongst State of Missouri team members. The PLDA leverages ENGAGE to identify top performers who exhibit exemplary work in all three areas of ENGAGE performance evaluation, show dedication to State service and deserve to be recognized and rewarded. The top 10% of DHSS team members were selected to receive up to $1,500 for an approved professional development opportunity, and several MCH team members were among the recipients.

The FFY 2021-2025 Title V MCH State Action Plan includes the development and implementation of a Title V Core MCH, health equity, and racial justice training plan. The goal is to build core competencies of internal program staff and external contractors to increase knowledge and awareness of the basic principles of MCH, health equity, and racial justice. The trainings will impart practical skills to apply this understanding across all programs, practices, and interventions. The MCH Director provides presentations to internal and external partners on core MCH content. The MCH Director also serves as the state Public Health Nursing (PHN) Manager and facilitates public health nursing workforce development and other public health nursing initiatives. This includes providing PHN consultation and presentations and managing the PHN Discussion Listserv, which allows public health nurses to share messages, announcements, events, etc. and/or pose questions pertinent to public health nursing.

For many years, the Missouri Council for Public Health Nursing was organized within the DHSS and provided leadership, expertise, and advocacy related to public health nursing practice, standards, and issues. In 2022, the Section for Public Health Nursing (SPHN) was established within the Missouri Public Health Association (MPHA) to address issues that impact public health nursing within the public health system. The SPHN includes representation from the DHSS, local public health agencies (LPHAs), nursing academia, and other public health related organizations. The SPHN will continue providing leadership, expertise, and advocacy related to public health nursing practice, standards, and issues. The MCH Director serves as a member of the SPHN Executive Committee, and several other MCH team members are active members of MPHA and SPHN. The MPHA and the DHSS, along with other public health organizations, sponsor an annual public health conference, allowing program staff to network with LPHA and other public health partners and grow their expertise to serve as a resource in regards to issues that impact the MCH population. Two PHN awards are given annually during the conference to celebrate and acknowledge the great work of Missouri's Public Health Nurses and recognize a public health nurse and public health nursing leader.

The Family Partnership Parent and Caregiver Retreat provides an opportunity for families to network with one another, discover resources to assist their family, enrich their leadership and partnering skills, and plan a vision for their family's future. The retreat is a free event designed for Missouri parents, legal guardians, and caregivers of children, youth, and young adults with special health care needs. The Bureau of Special Health Care Needs plans to host a Retreat in FFY 2023. Related information can be found in the Children with Special Health Care Needs (CSHCN) Annual Report under NPM #11 Medical Home.

To improve capacity, Title V MCH Program partners attend national trainings such as the AMCHP conference, CityMatCH Leadership and MCH Epidemiology Conference, MCH Partnership Technical Assistance meetings, and other MCH conferences, summits, symposiums, etc. Participation in Collaborative Improvement & Innovation Networks (CoIIN) and National MCH Workforce Development Center Cohorts are encouraged, when applicable. Regional and statewide trainings, such as biannual regional public health meetings and the annual Missouri Public Health Conference, are available to program staff, LPHAs, and other community stakeholders to provide an opportunity to network and learn new information relevant to the MCH population. Program staff also attend trainings specific to their program areas. Although the merit of in-person convenings cannot be underestimated, the increase in virtual and hybrid conference and training opportunities allows a greater number and diversity of team members to participate and benefit.

Missouri was well represented at the 2023 AMCHP Conference, with 17 DHSS team members (15 in person, 2 virtually), three youth reps, and one mother with lived SUD experience attending, along with various other MCH partners. Some team members chose to use their PLDA to attend. A MCH community of learning, launched after the AMCHP Conference, will support individual and collective learning and provide an ongoing forum for MCH team members to share information and resources gained from conferences, webinars and other professional development opportunities.

Missouri participated in the 2022 MCH Roundtable hosted by the National Governors Association (NGA) Center for Best Practices. The roundtable consisted of state leaders, MCH organizations and federal partners. The MCH Director joined the roundtable to share strategies and lessons learned from impacts of the COVID-19 pandemic on Missouri's MCH programs, discuss MCH policy issues including workforce, community supports, mental health, child care, etc., and offer important insights for the development of a NGA publication with policy considerations for state leaders.

To address workforce development, the School Health Program is leveraging CDC Workforce Development funding to:

1) Offer an opportunity for 220 eligible school nurses to sit for the national exam to become Nationally Certified School Nurses (NCSN) during the 2023-24 school year;
2) Develop online learning modules to address the unique needs of medically fragile students attending school;
3) Offer 10 school districts an opportunity to: assess their school health policies and practices for physical and mental health using the CDC and AAP endorsed program, "Enhancing School Health Services through Training, Education, Assistance, Mentorship and Support," and then develop action plans to address the gaps identified (School districts are required to collaborate with their LPHA and a community health provider.);
4) Provide training and resources for school districts to participate in the MOKIDS TEAMS (Missouri- Keeping Infectious Diseases out of Schools Training, Education, Assistance, Mentorship and Support) so that parents, community members and school staff have an increased understanding of infection control and confidence in the school as a safe place to learn; this program is unique to Missouri - Missouri requested and received permission from the AAP to adapt the existing TEAMS framework to look at infection control and disease prevention;
5) Partner with ACIP to develop a Missouri KIDS TEAMs Tool kit with modules for a variety of stakeholders on infection control and communicable disease prevention; and
6) Provide funding for 60 small, rural public school districts without services of a registered professional nurse to have an in-depth assessment and virtual support for school health services.

Innovations in Staffing Structures and Workforce Financing

The SHCN Family Partnership is funded primarily through the Title V MCH Block Grant and secondarily through the HRSA Universal Newborn Hearing Screening and Intervention Program Grant. Title V MCH funds four Family Partners, and the HRSA grant provides funding to employ two additional Family Partners who are parents of children who are deaf or hard-of-hearing (FP-DHH) to support Missouri families involved in the early hearing detection and intervention (EHDI) process. More information on this can be found in the CSHCN NPM #11 Medical Home Annual Report.

Title V MCH team members serve as preceptors for undergraduate and graduate nursing and public health student intern experiences, with the students completing a capstone project in MCH and/or epidemiology. In addition to presenting to public health graduate students on Missouri's Title V MCH Services Block Grant Program and the Life Course Perspective, the MCH Director serves on the Advisory Council for the Saint Louis University Center of

Excellence in Maternal and Child Health Education Science and Practice. The Center of Excellence provides MCH scholars with exceptional academic, research, leadership and practical and real world public health training. The MCH Director collaborated with an assistant professor of nursing at Missouri State University and a doctorally-prepared local public health nurse leader and Community Outreach Specialist to query community/public health nurses about their experiences utilizing the Council of Public Health Nursing Organizations Community/Public Health Nursing Competencies during the Covid-19 pandemic. Study design and findings were presented at the 2022 Public Health Conference and have been submitted for publication in a peer-reviewed journal.

To conduct a comprehensive review of FTE linkages to grant requirements and assess staffing needs, available resources, and Personnel Services appropriations, DCPH leadership engaged managers across the Division to detail FTE linkages across a number of categories. Using a Linkage Tool, FTEs were categorically assigned to categories based on statutory and regulatory mandates, grant requirements, grant deliverables, grant objectives and strategies/activities, and requirements of subcontractors. The completed Linkage Tools were then used to prioritize FTEs to reflect grant needs and public health transformation efforts. Managers were also asked to forecast what each FTE may look like in 2023 and 2025 and to present ideas for how to decrease the number of FTEs needed through implementing contracts for services, new technology, and other operational innovations for human resource efficiency.

The FFY 2021-2025 Title V MCH State Action Plan priorities and national and state performance measures are forecasted to remain essentially unchanged through September 30, 2025, requiring adequate Title V MCH leadership as well as support and MCH program FTEs to accomplish the strategies and meet the objectives and evidence-based strategy measures included in the State Action Plan and to meet HRSA/MCHB Title V MCH deliverables. Many of the programs and FTEs supported by Title V MCH funding are also supported by other short-term grants, and, in many instances, those programs and FTEs are integral to the Title V MCH State Action Plan and will rely on Title V MCH funding for ongoing support.

Local Public Health Agency (LPHA) Workforce

In 2021, with 113 of 115 LPHAs reporting, 16 reported reducing the number of days open to the public, 27 reported laying off staff and closing internal home health services. Decreased funding and the COVID-19 pandemic were cited as the primary reasons for these changes in staffing, hours of operation, and provision of services. In addition, these LPHAs noted that recruitment of new staff has been significantly challenging citing increase in demand for nurses as well as higher wages and sign-on bonuses available from other organizations such as hospitals. From August 20, 2021 to May 5, 2023, 28 LPHA Administrators vacated their positions, representing 24% of the 115 LPHA administrator positions across the state.

Through Title V MCH funding, the MCH Services Program contracts with 111 LPHAs. Although many LPHAs experienced substantial turnover throughout the pandemic, the rate of LPHA workforce turnover had decreased in the earlier part of 2022. However, the turnover rate has increased again over the last year and remained consistent with an average of two to three MCH Coordinators resigning each month. TMCH Services Program staff provide MCH orientation for new LPHA MCH Coordinators. Orientation sessions include content covering core principles of public health, MCH competencies, Life Course Perspective, the Spectrum of Prevention, contract terms and deliverables, and available resources. Prior to the pandemic, MCH Services Program staff provided approximately 8-10 orientations per fiscal year. In FFY 2022, program staff provided 42 MCH Coordinator orientation sessions, and they have already provided 24 orientations so far in FFY 2023. Program staff also provide ongoing technical assistance to the LPHAs on the MCH Services contract and work plan, MCH initiatives/activities, and broad public health and public health nursing topics. LPHA requests for technical assistance have significantly increased related to and due to the unwinding of the COVID-19 pandemic and high rates of staff turnover.

In an effort to prioritize mental health in the work place, the Title V MCH Program partnered with the MCH Services Program in August 2022, to provide a one-hour virtual professional development opportunity titled, "*Managing Stress and Burnout and Increasing Resilience while Thriving at Work and in Life*." This opportunity was paired with a mental health initiative that was developed by Class #6 of the State of Missouri Leadership Academy to address prioritizing mental health wellness in the workplace for State employees. One of the solutions identified was implementing a Badge Buddy as a quick reference card attached to the employee ID. It provides a list of signs that a team member who may be struggling might exhibit and what to look for as a supervisor or peer. Resources and phone numbers are listed on the back of the card so team members can quickly and effectively provide support, even if they are not a mental health professional. After the completion of the meeting, a LPHA Badge Buddy Request Form was sent via email to all LPHAs, and 1500 Badge Buddies were provided to LPHA staff statewide. (*Below is a picture of the DHSS Badge Buddy*)

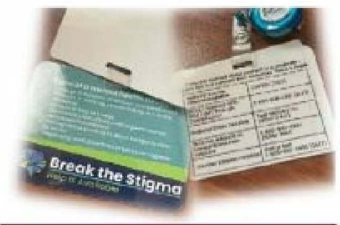
The DHSS Badge Buddy

Front

Back

If you are worried about yourself or a coworker - reach out and connect with resources. There is hope.

National Suicide Prevention Lifeline	Call 988 (24/7)
State Employee Only: SELF (EAP) through CompPsych®	1-800-808-2261 (24/7)
National Crisis Text Line	Text "MOSAFE" to 741741 (24/7)
National Alliance on Mental Illness Peer HelpLine	1-800-950-6264 (10AM-8PM)
Disaster Distress Helpline	Call or text 1-800-985-5990 (24/7)



In January 2023, the MCH Services Program team hosted four LPHA networking meetings. Meeting content included various topics identified from feedback reported on the Annual Program Evaluation Survey sent to LPHAs. Specifically, the survey asked about training needs that would help move MCH-related work forward and were aligned with the Spectrum of Prevention framework. The sessions featured content experts who shared the evidence behind what was working well and provided tangible strategies to realize improved outcomes.

- January 4, 2023 - Youth Engagement, Putting Education into Action (Dr. Sherri Miller, Tri-County Mental Health Services) – 83 in attendance
- January 11, 2023 - Driving Change through Policy and Social Norms Change (Jenny Dodson-Weihl, JD, Prevention Specialist, Missouri Kids First) – 76 in attendance
- January 18, 2023 - Community Engagement and Coalition Involvement that Leads to Change (Candace Rodman and Jim Meyer, MU Extension, Community Engagement Specialist) – 71 in attendance
- January 25, 2023 - Sowing and Growing Hope in Prevention (Amber Allen, MU Extension, Field Specialist in Human Development & Family Science)– 51 in attendance

The MCH Services Program began hosting MCH Huddles with LPHA partners in November 2022. The purpose of *Huddles* is to help individuals and organizations work together rather than alone. Participants talk about issues they have been struggling with and compare notes about possible solutions while making a commitment to work toward improvement, specifically working to achieve MCH contract deliverables and outcomes. MCH Huddles are convened quarterly in August, November, February and May and hosted in a virtual format. (LPHAs working on the same priority health issue may be located in different geographic regions across the state.) In addition to a presentation by a content expert, each MCH Huddle includes breakout room discussions facilitated by the MCH DNCs. The breakout discussions –alternate between Huddles, based on region or priority health issue and allow LPHAs to share wins and challenges and discuss potential solutions to those challenges. 83 LPHA staff attended the MCH Huddle in November 2022 and heard Jefferson County Health Department share successes they have had with branding and digital engagement among women of childbearing age and children in their community to improve health outcomes. In February 2023, 71 LPHA staff attended, and the Tobacco Prevention and Control Program presented about providing vaping and tobacco cessation and prevention resources for children and women of childbearing age.

In an effort to continue to build rapport and trust among LPHA partners, the MCH Services Program DNCs began sending a monthly email in December 2022 to provide resources and support as a way to “check-in” with LPHA staff. This is intended to serve as a warm reminder that the program staff are available to help and do not only care about the work but also the person doing the work. The monthly email is titled “MCH Exclusive”, and the MCH DNCs take turns compiling the email content. Sections of the MCH Exclusive include: Did You Know?, News You Can Use, Q+A, Reminders, and Something to Think On.

III.E.2.b.ii. Family Partnership

The Title V Program continues to develop relationships and engage with community members, parents, families, and organizations serving families to address the priorities and implement the strategies in the FFY 2021-2025 State Action Plan. As part of the 2020 statewide Five-Year MCH Needs Assessment, focus groups were held across Missouri to solicit feedback on the following topics: ability to access health insurance and insurance adequacy; ability to access care and care adequacy; barriers to and facilitators of good health; community and social issues; transportation; health literacy; mental health; substance use; and others. The social determinants of health inequities was a pervasive theme throughout the focus group discussions, and the need to intentionally promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities was identified as an overarching principle to be applied across all priorities, performance measures and strategies in the FFY 2021-2025 State Action Plan. Although the COVID-19 pandemic temporarily interrupted plans for more active and diverse partnership with families and family-led organizations, the Title V Program remains committed to engaging with families at all levels and in all aspects of the FFY 2021-2025 State Action Plan.

Special Health Care Needs Family Partnership

The Special Health Care Needs (SHCN) Family Partnership Program strives to enhance the lives of individuals and families impacted by special health care needs, providing resources and information to empower families to live a good life. The Family Partnership Program hosts events to benefit families through development of leadership skills, networking among peers, and staying current with trends and issues regarding special health care needs. The family partnership includes individuals with special health care needs as well as parents, legal guardians, or siblings. SHCN utilizes information from the family partnership to enhance the relationship among SHCN and the individuals and families it serves. This includes seeking input from Family Partners to ensure the family perspective is integrated in SHCN publications, educational/outreach materials, and the annual block grant application proposed use of funds. Family Partners are parents of individuals with special health care needs and provide information and peer support to other families. In addition to assisting families, the Family Partners plan, schedule, and facilitate all Family Partnership meetings, including the Family Partnership Parent and Caregiver Retreat. This ensures Family Partnership events are led by families for families. The retreat provides an opportunity for families to network with one another, discover resources to assist their family, enrich their leadership and partnering skills, and plan a vision for their family's future. The retreat also provides the opportunity for family input on various activities, such as the development of SHCN materials related to medical home and the Title V Five-Year Needs Assessment. While the retreat has not been held in recent years due to the COVID-9 pandemic, the retreats will resume in FFY23. This year's retreat will be held on August 25th and 26th, and the theme will be "Navigating Uncharted Waters".

Each Family Partner is well equipped to help explore options and solutions in the following topic areas:

1. Daily Life - What your family members do as part of everyday life: school, employment, volunteering, communication routines, and life skills;
2. Social and Spirituality- Building friendships and relationships, leisure activities, personal networks and faith community;
3. Community Living - Housing and living options, community access, transportation and home adaptations;
4. Advocacy and Self-Determination – Developing advocacy skills, transition planning for the future, fostering independence and interdependence;
5. Healthy Living - Managing health care and staying well: medical needs, exercise, therapy services, locating physicians and specialists, medical home;
6. Safety and Security - Emergency planning, well-being, community support, guardianship options, legal concerns;
7. Services and Supports - Using an array of integrated supports to achieve a good life, including mentor

programs.

The objectives of the Family Partnership Program are to provide families with the opportunity to offer each other support and information; give families the opportunity to provide input based on lived experience on the needs of individuals with special health care needs; and build public and community awareness of the unique needs and issues facing families of individuals with special health care needs.

The Northeast (NE) Family Partner helped a family secure housing by connecting them with the State Assistance for Housing Relief (SAFHR) Program. A code enforcement officer from the City of Manchester condemned their house due to unsanitary living conditions. The home was a multigenerational household occupied by a grandfather in his 70s, experiencing early stage dementia; a grandmother in her 70s; a son in his 50s with a foot amputation; a daughter in her late 40s to early 50s with an intellectual disability; and two grandchildren: a male in his early 20's with autism and a female in her early 20's with multiple complex medical needs (including having no limbs, being non-verbal and requiring tube fed). The code enforcement officer and a police officer called the NE Family Partner as a known resource for families of children with complex medical needs. The Family Partner worked with several agencies to help the family secure temporary housing and clean up their property so they could have a safe and healthy home. After two months of living in a hotel, the family moved back into their home. Meanwhile, the mother of the two young adults was not aware they could continue receiving benefits after turning 21, and the Family Partner helped the family get them re-enrolled on Medicaid and Supplemental Security Income (SSI). The family continues to call on the NE Family Partner for help as needed.

Since 2015, SHCN has employed four hourly and intermittent Family Partners who are parents of children and youth with special health care needs. Family Partners serve as the parent representatives for SHCN. In addition, Family Partners provide information, training, technical assistance, and peer support to families of children and youth with special health care needs (CYSHCN) so they can make informed decisions about their children's health and serve as family leaders at the state level to improve services for CYSHCN. Family Partners receive training on Bureau programs and services and often work with other DHSS program staff. They developed an improved referral process to enhance communication and efficiency of referrals made to Family Partners from Service Coordinators. This internal electronic referral form includes: referring staff member information; participant and family demographics; a section to document the need, diagnosis, and other concerns identified at the time of referral; and a section for Family Partners to document follow-up actions, including informing the referring Service Coordinator of the outcome. Family Partners are also able to provide education to Service Coordinators on the services provided by the Family Partnership Program and the unique issues facing families of CYSHCN. A streamlined referral process and education to Service Coordinators increases the number of referrals for SHCN families to Family Partnership. In collaboration with the Newborn Hearing Screening Program, SHCN expanded the Family Partnership Program by adding two additional Family Partners. These Family Partner positions are funded by the Health Resources and Services Administration Universal Newborn Hearing Screening and Intervention Program Grant and specifically serve families of children who are deaf or hard of hearing. Additional information regarding the SHCN Family Partnership can be found in the State Action Plan for Children with Special Health Care Needs.

Missouri Parent Advisory Council (PAC)

The Missouri PAC, composed of selected parent leaders from across the state, exists to engage and empower families, identify and train family leaders to be a voice for families in their community, and bring issues facing families to a higher level with the goal of improving access to programs for young children and families. PAC members work in their communities to bring issues facing local families to a higher level to improve access to services and increase family engagement within programs. PAC meetings have been held virtually since 2020. The Department of Elementary and Secondary Education is the lead in Missouri for the Preschool Development Grant: Birth to five (PDG B-5), and this funding has been used to further family engagement and leadership. PDG B-5

funding was used to develop a PAC facilitation toolkit and recruitment guide. PAC members and others across the state can use these resources to engage families and develop leaders. The PAC provides in-person trainings, typically held in the spring and fall, for specific projects that members may become involved with at the state level. Training may also include attending out-of-state conferences that would benefit both the individual member and the PAC as a whole. PAC members receive training in Strengthening Families™ and the Protective Factors Framework through Strong Parents, Stable Children: Building Protective Factors to Strengthen Families training and facilitative leadership training. Many members have experience and training on how to host and implement Parent Cafés and are participating in these within their communities. One member is a trained facilitator in the "Darkness to Light: Stewards of Children" prevention of child sexual abuse training. Next steps for the PAC include scaling up regional parent advisory groups to two more communities, coordinating one in-person meeting with regional and state PAC members, providing additional training on the Parent Café model, and connecting and involving community leaders with PAC and Parent Café activities.

Home Visiting Family Engagement

The MCH funded Home Visiting programs have a formalized three-tiered continuous quality improvement (CQI) process in which family engagement is an integral part. One or more current or former home visiting family participant(s) are required to be included as member(s) of each Level 1 CQI Team. Level 1 meetings are face-to-face quarterly meetings held by each individual Local Implementing Agency (LIA) implementing a specific home visiting model. It is the fundamental base at which changes to improve services to families occur. As of October 2019, every LIA had successfully incorporated the inclusion of family participant(s) as team member(s) who are recognized as a vital element in helping the LIAs determine what processes work and what needs adapting to implement and achieve CQI. Having successfully achieved family engagement in CQI efforts at Level 1, the Missouri Home Visiting CQI Handbook was formally revised in October 2019 to fully outline the required inclusion of families at Level 1, and the mechanism to include families as representatives at Level 2.

Since 2012, Missouri has been obtaining family input regarding their experience with the LIAs and the Home Visiting services they receive through an annual survey. The survey results are returned unopened from each LIA to the Home Visiting Program, analyzed, and then shared in aggregate form back to the submitting LIA. These results can identify trends that need to be addressed with technical assistance from the Home Visiting Program to the LIAs.

Newborn Screening Family Engagement

The Newborn Screening team produces a quarterly newsletter called *Behind the Screens* that is distributed to over 250 healthcare providers. Each edition includes a patient spotlight that features a child that has been diagnosed through newborn screening. Parents are invited to share their experiences of how newborn screening has impacted their child's and family's lives. Through their stories, parents provide personal feedback to the frontline healthcare workers who are collecting the screens, which reinforces the vital role they have in improving the lives of Missouri babies.

On December 1, 2021, the Missouri Newborn Screening Program launched the implementation phase to screen all Missouri newborns for adrenoleukodystrophy (ALD), ensuring all newborn specimens received by the Missouri State Public Health Laboratory are screened for ALD. ALD is a genetic disease that most severely affects males. This disease mainly affects the nervous system and the adrenal glands, and often causes progressive loss of the myelin sheath, which acts as an insulator and surrounds the nerves in the brain and spinal cord. This can cause a variety of neurological problems including cognitive, mobility, and sensory issues. ALD may also cause a deficiency of certain hormones due to damage to the adrenal glands. This adrenal insufficiency may cause weakness, weight loss, skin changes, vomiting, and coma. If left untreated, the severe form of ALD can lead to critical and irreversible disabilities that can ultimately lead to death. Early diagnosis through newborn screening allows for proactive care, consistent

monitoring, and lifesaving treatment. The Missouri Newborn Screening Program established an ALD Task Force to provide expert guidance and feedback during the implementation phase to ensure a comprehensive, evidence-based, and family centric approach to screening. In addition to clinical specialists, laboratory staff, and follow-up staff, two parent advocates were invited to participate in the ALD Task Force. These two individuals have been invaluable in the development of educational materials, review of resources, and ensuring the family perspective is kept in the forefront.

The Newborn Hearing Screening Follow-up Coordinator from the Bureau of Genetics and Healthy Childhood Newborn Hearing Screening Program and a Family Partner from the SCHN Family Partnership Program were chosen from a large pool of applicants to participate in the “Impact of Family Support and Engagement Learning Community (IFSE-LC)” developed and led by the National Center for Hearing Assessment and Management and The Family Leadership in Language and Learning Center. They will participate with six other state programs and their corresponding family-based organizations to learn the key domains of family support, survey methods, and evaluation processes. The IFSE-LC will create a survey tool to assess the impact of family support to families with infants and children newly diagnosed with hearing loss and evaluate how family support is making a difference, as well as identify areas of improvement.

Family Partnership through Contracts

The Child Care Health Consultation (CCHC) Program encourages family engagement via program services. Parents/guardians of children in child care are invited to attend children’s health promotion and participate in health and safety trainings and consultations provided to child care providers. Content for health promotion works to include handouts and other evidence-based informational resources for children to share with parents at home, to help improve parent/guardian health and safety knowledge for their child outside of the child care setting. Frequently, training for child care providers includes how to communicate and work closely with families of the children they care for, promotes resilience in children and families, and provides resources on these topics for child care providers and for distribution to parents/guardians. Parents/guardians are also invited to participate in specialized consultation(s) alongside the child care provider(s) when the purpose of the consultation pertains to their child. CCHC Program services also provide opportunities for parent/guardian involvement for the development of Individualized Health Plans (IHPs), referrals to outside resources, such as MO Health Net, developmental screening, and WIC, and notification of the child not being up to date on routine immunizations, and to create dialog between the child care provider, the parent/guardian, and the child’s health care provider, as necessary. Child Care Health Consultants work with child care providers to develop and implement procedures, and provide trainings that promote optimal family partnerships for the health and safety of children in child care.

The MCH Services Program contracts with 111 LPHAs whose efforts include addressing risk and protective factors that influence health disparities within families and communities through the Life Course Perspective. The MCH Services contracts requires LPHAs to identify strengths, weaknesses, and needs of the community’s MCH population. LPHAs are also encouraged to engage families in work plan development, implementation and outcome evaluation, programming efforts, and the local MCH needs assessment process.

The Inclusion Services (IS) project intertwines family engagement through values, policies, and practices that support the right of every child and their family, regardless of ability, to participate in a broad range of activities as members of a child care program, community, and society. The desired result of inclusive experiences for children with or without disabilities and their families include a sense of belonging and membership, positive social interactions and friendships, and development and learning to reach their full potential. The Inclusion Specialist provides outreach, technical assistance, and training to child care professionals and families of children with special needs. They provide inclusion training and training with a social-emotional component

based on the research-based Pyramid and Conscious Discipline models. They provide program outreach by promoting inclusion services to facilities licensed, regulated or registered by the Department and community awareness through newsletters, calendars, websites, and other media. They promote inclusion services at community events such as child care conferences and through local agencies that support and assist with placement of children in child care settings through phone calls, emails, and in-person contact.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Data Capacity & Epidemiology Workforce

Data Capacity
The Missouri Department of Health and Senior Services (DHSS) has a great deal of MCH epidemiology capacity built into its organizational structure. All components, including programmatic and data, which impact MCH practice in the state are organized within the Division of Community and Public Health (DCPH). The integration of data collection, analysis and program services provides great flexibility in terms of the flow of information and information exchange with minimal challenges. The integrated DCPH organizational structure can be hailed as one of Missouri's strengths in terms of cross-sectional partnership building and collaboration.

In addition to core MCH programs, health promotion and chronic disease prevention programs, communicable disease prevention programs, WIC and Nutrition Services, and the Center for Local Public Health Services are housed within DCPH, as is the Office of the State Epidemiologist. The Office of Primary Care and Rural Health, Office of Minority Health, Office of Dental Health, Office on Women's Health, and the Bureau of Genetics and Healthy Childhood are also located within the DCPH. The centralized location of all these units catering to Missouri's MCH populations and receiving support from the Missouri Title V agency within one Division underscores the need for a MCH epidemiology workforce that can provide data and analytical support in a coordinated manner.

Epidemiology Workforce
The Division of Community and Public Health houses the core MCH epidemiology and data analysis capacity for the DHSS. The Office of Epidemiology (OOE), which includes the MCH and Chronic Disease epidemiology teams, is the Division's principal link between information science and public health, conducting much of the Division's secondary data analysis and supporting program evaluation, planning, survey design and interpretation, and data dissemination. The OOE works closely with the Bureau of Health Care Analysis and Data Dissemination (BHCADD) and the Bureau of Vital Statistics (BVS) to perform primary data collection, validation, analysis and dissemination. The MCH epidemiology team is centrally located to provide data and analytical support to a wide variety of MCH programs across the Division and Department. In addition to the team lead, a Senior Epidemiologist, the MCH Epidemiology unit within the OOE has several epidemiologists and research analysts with the capacity and access to analyze data from a variety of population-based surveys and data systems, such as the Behavioral Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Assessment Monitoring System (PRAMS), maternal mortality, vital statistics, reportable conditions data, and program specific data.

Missouri's Title V MCH Block Grant provides funding support for 7.555 full-time equivalent (FTE) positions for data, analytical, and dissemination needs within OOE and BHCADD, with an additional FTE supported through the SSDI grant. These FTEs are split across 15 different individuals, as most staff in this area have braided funding through Title V MCH and other individual program grants.

The core data team supporting Title V includes Karen Harbert, Lead MCH Epidemiologist, Andrea Tray, Senior Research/Data Analyst, and Andrew Schnabel, Research/Data Analyst. Their qualifications and duties include:

Karen Harbert: Karen has a Master's of Public Health from the University of Missouri – Columbia and 12 years of public health experience. She is also pursuing a Doctor of Public Health degree at Johns Hopkins. She has served as the Lead Maternal-Child Health (MCH) Epidemiologist since 2020 and leads a team of seven full time staff members. This team provides data management and analysis support for a variety of MCH-related programs, including Missouri Pregnancy Risk Assessment Monitoring System (PRAMS), Pregnancy Associated Mortality

Review, Pregnancy Mortality Surveillance System (PMSS), and the Title V MCH Block Grant. This team is also responsible for dissemination of MCH data to support program planning and evaluation. This includes grant reporting, program evaluations, scholarly publications, fact sheets, and dashboards.

Andrea Tray: Andrea has a Master's of Public Health from the University of Missouri-Columbia and 2 years of public health experience. Andrea works full-time on epidemiological support of Title V. She is involved in needs assessment, data requests, program evaluation, and data dissemination.

Andrew Schnabel: Andrew has a Bachelor of Science in both political science and economics. He has 1.5 years of public health experience. His position is fully paid through the SSDI grant, and he works full-time on epidemiological support of Title V. His responsibilities include needs assessment, data requests, program evaluation, and data dissemination.

DHSS currently has an appropriately staffed epidemiology team. Despite significant staff turnover during the Great Resignation, the Department has rebounded and filled vacant positions with well-qualified individuals.

There are limited opportunities for local training given the highly specialized nature of the work, so DHSS relies on virtual and out of state training for epidemiological staff. This includes resources provided by CityMatCH, Association of Maternal and Child Health Programs (AMCHP), CDC, and HRSA. In particular, the program applies to send one or two staff members each year to the CityMatCH MCH Epidemiology training. Additionally, staff have access to on-demand virtual training on specific tools such as Tableau or SAS. All epidemiologists and analysts in the Office of Epidemiology are trained in SAS. Training on other tools, such as Tableau, REDCap, Qualtrics, and ArcGIS, is provided to specific staff based on program needs.

Data Modernization and Interoperability

The new Bureau of Data Modernization and Interoperability (BDMI) was formed to enhance existing data infrastructure through modernizing old data systems while increasing interoperability across various data sources. The work of the BDMI will have significant on MCH data analyses and dissemination. Some of the highlights include:

1. DHSS is in the process of implementing a new reportable disease management system that will greatly automate data collection and management of sexually transmitted infections such as chlamydia, gonorrhea and syphilis – diseases that have been associated with adverse pregnancy outcomes such as low birth weight and preterm birth. Increasing the timeliness of data ingestion, and timely management of these conditions during the prenatal period could potentially reduce the associated adverse birth outcomes.
2. The BDMI is also responsible for managing vaccine data that is collected through the ShowMeVax (SMV) data system. Enhancements to data management and interoperability of the SMV system will greatly enhance the ability of MCH programs to monitor childhood vaccination data for timely program interventions.
3. The DMI team is also collaborating with the Bureau of Health Care Analysis and Data Dissemination to upgrade MOPHIMS (Missouri Public Health Information Management System) – the public access web query data system operated by the State of Missouri. This is a centralized data dissemination platform for all perinatal, chronic and hospital data. Upgrading this tool will greatly enhance local public health agency staff capacity to customize data to meet their community needs.
4. Upgrading the various data systems will provide the MCH epidemiology team with tools to analyze MCH data from a health equity perspective and better understand and address the social determinants of health influencing health and health disparities. It is anticipated that the efforts of the BDMI will fill the gaps needed for MCH leadership to plan programs and initiatives from a more holistic and synergistic perspective.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The Missouri State Systems Development Initiative (SSDI) project serves four overarching goals:

1. Build and expand State MCH data capacity to support Title V program efforts and contribute to data driven decision making in MCH programs;
2. Advance evaluation and development of health equity and social determinants of health metrics;
3. Advance the development and utilization of linked information systems between key MCH datasets in the state;
4. Support surveillance systems development to address data needs related to emerging MCH issues.

Missouri's SSDI project is located within the Office of Epidemiology and is led by the Lead Maternal Child Health Epidemiologist. The strategic organization of the SSDI project with other data collection programs, such as vital statistics, chronic disease epidemiology, reportable diseases, and the Patient Abstract System, allows for easy access to a variety of datasets that support Title V programming.

The Missouri SSDI project provides data support for the Title V MCH Block Grant annual application and both the five-year and ongoing MCH needs assessment processes. SSDI project staff continue to work closely with local public health agencies (LPHAs) to provide data and assist with development of effective work plans to address ongoing challenges affecting maternal and child health, including providing data to assess social determinants of health, smoking among women of childbearing age, and healthcare access.

The SSDI project continues to provide valuable support to identify and integrate Title V performance measures with other data sources, including vital statistics, the Pregnancy Risk Assessment Monitoring System (PRAMS), the Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Associated Mortality Review (PAMR, reportable conditions data, and program-specific data. The Missouri SSDI project has also contributed data to enhance the ability of LPHAs receiving Title V MCH funding to conduct local- and regional-level MCH needs assessments. Integrating many different data systems, the SSDI project continues to assist with the MCH needs assessment by developing fact sheets using data pulled from a variety of sources. SSDI project staff continue to enhance the DHSS' ability to accurately capture the circumstances surrounding severe maternal morbidity (SMM), including updating programming code and improving the quality of and methods for linking cases of SMM to birth and death records.

SSDI resources are utilized for MCH projects of special significance to the state and Title V Agency and to address any emerging issues that develop during the project cycle. The SSDI project supports initiatives including, but not limited to:

- Maternal mortality initiatives, including PAMR data analyses and dissemination;
- Data collection and analysis related to long-term effects of COVID infection during pregnancy for mother and baby; and
- Development of new data on social determinants of health in new mothers.

The SSDI project provides data support for the ongoing MCH needs assessment efforts, including continuous efforts to streamline data collection processes related to Title V MCH structural and/or process measures. In addition, the SSDI project will assist with evaluating program outcomes.

Additionally, the SSDI project focuses on data dissemination to support MCH efforts. This includes creation of dashboards, fact sheets, infographics, scholarly articles, and other products.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

County Level Study (CLS)
The Office of Epidemiology (OOE) is currently collaborating with the University of Missouri-Columbia Health and Behavioral Risk Research Center (HBRRC) to conduct the 2022 Missouri County-level Study (CLS). The last CLS in Missouri was done in 2016 and was well received across the state because of its ability to provide county level data on a variety of chronic disease and MCH indicators. This project has finished data collection and the data is being prepared for analysis and public dissemination.

The Missouri Behavioral Risk Factor Surveillance System (BRFSS) has been in existence for over 35 years and is the primary surveillance system that combines demographic information as well as social and environmental factors (e.g. health care access) with information on chronic diseases (e.g. diabetes) or other related health conditions (e.g. obesity) and behaviors associated with health outcomes (e.g. smoking or physical activity). The Missouri BRFSS survey is conducted annually with partial funding from the Centers for Disease Control and Prevention (CDC). One of the major limitations of the Missouri BRFSS is that the current budget can only fund approximately 7,000 surveys per year. This sample size is insufficient to address county-level health questions. The Missouri BRFSS Program recommends enhancing data collection by adding up to 10,000 additional survey responses per year.

The CLS is modelled after the Missouri BRFSS. Earlier versions of this study were successfully conducted in 2007, 2011, and 2016 using funding sources that are no longer available. Since many public health interventions are implemented at county or sub-county levels, an estimated 50,000 surveys are required to provide detailed data to inform prevention and planning at the local level. The CLS is similar to the Missouri BRFSS in terms of following the CDC’s best practices for sampling, data collection, and weighting methodologies; however, the DHSS has greater control over the survey design and the opportunity to collect a sample size sufficient for county- and sub-county-level analyses. The intended target of the study is approximately 50,000 Missouri adults ages 18 and older, distributed across all 114 Missouri counties and the City of St. Louis. The interviews were conducted via randomly selected landline and cell telephone numbers using a standard questionnaire that was developed in collaboration with internal and external public health partners. The questions are tailored to address data collection needs surrounding COVID-19. Collecting comprehensive, granular information through state and local needs assessments enables data-driven intervention planning and allocation of resources to more effectively target populations for public health interventions.

Pregnancy Risk Assessment Monitoring System (PRAMS) – Social Determinants of Health Supplement
The Council of State and Territorial Epidemiologists (CSTE) partnered with the CDC-Division of Reproductive Health (DRH) to provide technical assistance to state, local and territorial public health agencies for the implementation of routine population-based data collection to inform public health’s understanding of the effects of Social Determinants of Health (SDoH) on the experiences and attitudes of pregnant and postpartum women. The project supports jurisdictions to collect SDoH information about participants’ experiences with housing instability, food and transportation insecurity, barriers to mental health access, and race or ethnic discrimination among women with a recent live birth before, during and immediately after pregnancy. Participating jurisdictions have implemented the SDoH questionnaire supplement as part of the Pregnancy Risk Assessment Monitoring System (PRAMS) to collect population-based data on the impact of SDoH on pregnant and postpartum women and infants. Missouri PRAMS has been implementing the SDoH supplement and collecting data since May 2022. Data collection has been completed and data will be accessible in the fall 2023.

The PRAMS project is also beginning data collection for a new phase of the core survey. The survey is updated approximately every five years. The new survey includes new questions related to emergency preparedness, respectful maternal and infant care, and maternal mortality warning signs. This additional data collected from these new questions will provide baseline measures and inform Title V initiatives.

Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET)
Missouri receives funding from the CDC to participate in Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) through the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) cooperative agreement. SET-NET supports states and other jurisdictions to adapt and expand existing surveillance systems to monitor for emerging infectious diseases and health threats during or around the time of pregnancy through the child's first year of life. SET-NET collects data on mothers, and infants and the impact of various health threats including Zika, Hepatitis C, Congenital Syphilis, and COVID-19. SET-NET also tracks birth defects, developmental problems, and other disabilities as these children age. Epidemiologists use these data to:

- Monitor and improve the health of pregnant people and infants;
- Link families to medical and social services to get recommended care;
- Strengthen laboratory and clinical testing to find emerging health threats quickly; and
- Ensure public health is ready and prepared to meet the needs of pregnant people and infants during emergencies.

This surveillance builds upon the US Zika Pregnancy and Infant Registry. The Registry collected health information on pregnant people and their infants who had laboratory evidence of Zika infection during pregnancy. A key part of this unique surveillance is the ability to find exposures during pregnancy and link them with health outcomes of pregnant people and infants. This innovative and nimble approach enables CDC and state, local and territorial health departments to monitor exposures of concern during pregnancy and collect follow-up data on affected infants over time.

Missouri is currently only funded to collect and report information related to COVID-19 and pregnancy. For COVID-19 surveillance, Missouri identified pregnancies of interest and collected necessary information through linking COVID-19 testing data with other data sources including: birth certificates, fetal death certificates, death certificates, COVID-19 vaccination data, and the Patient Abstract System (PAS). Key COVID-19 surveillance questions include: demographics and risk factors of pregnant people with COVID-19, timing of illness onset, presence of symptoms, severity of illness, reinfections, genetic variants (e.g. Delta), complications with pregnancy, birth/neonatal outcomes (such as infant death, low birth weight, and preterm births), infant COVID-19 testing status, severity of post-natal infection, infection and reinfection in infants, infant growth patterns, and other concerns. In order to be considered a record of interest for mother-baby surveillance of COVID-19, the mother must be a Missouri resident and have had at least one lab-confirmed positive SARS-CoV-2 RNA test result at any point during pregnancy up to and including the day of delivery. The positive test result must have occurred between January 20, 2020 and December 31, 2021. The program is currently working to develop a means of collecting longitudinal data on the baby to allow for analysis of events that occur after mother and baby are discharged from the hospital after delivery.

Levels of Care Assessment Tool (LOCATe) Process Improvements
The CDC developed the Levels of Care Assessment Tool (LOCATe) to help states and other jurisdictions create a standardized assessment of levels of maternal and neonatal care. Assessing these levels using a consistent methodology allows jurisdictions to ensure pregnant women and their babies are receiving risk-appropriate care. Missouri initially implemented this tool as a paper-based survey. In subsequent years, the program has evolved to be fully electronic with automatic notifications of a hospital's status.

In FY23, the LOCATe team added a map of facility locations and levels to the website for Risk Appropriate Care at https://health.mo.gov/riskappropriatecare. The map shows both maternal and neonatal levels of care.

Additionally, the data collected through LOCATe is being used to update two measures on the publically available

Missouri Information for Community Assessment (MICA) database at https://healthapps.dhss.mo.gov/MoPhims/MICAHome. The Birth MICA includes the ability to query data on very low birth weight births delivered in a level 3 facility and high-risk deliveries in a level 2 or 3 facility. These queries previously relied on self-reported levels from the hospitals, so the meaning of a specific level was not standardized as it is in LOCATe.

Data Dissemination Activities

In additional to the LOCATe dashboard previously mentioned, a number of publically available dashboards have been developed to support MCH programs. The MCH program dashboards that are currently available include:

- Missouri Pregnancy Risk Assessment Monitoring System (PRAMS): Available at https://health.mo.gov/data/prams/prams-dashboard.php. This dashboard includes data from the PRAMS survey and allows a variety of customization for data queries. Data is available on topics such as prenatal care, contraception, intimate partner violence, breastfeeding, and pregnancy intendedness. Users can select custom data ranges, and data may be cross-tabulated by age, education, geography, income, race/ethnicity, and WIC enrollment.
- Pregnancy-Associated Mortality Review (PAMR): Available at https://health.mo.gov/data/pamr/dashboard.php. This dashboard displays maternal mortality data from the state's Maternal Mortality Review Committee. Counts are available at the county level, and causes of death, timing, and demographic statistics are available at the state level.
- Early Hearing Detection and Intervention (EHDI): Available at https://health.mo.gov/living/families/genetics/newbornhearing/dashboard-ehdi.php. This dashboard includes information from the newborn hearing program. It includes information about pass/fail rates, timing of diagnostic testing, and number of children receiving intervention services.
- Newborn Blood Spot Screening: Available at https://health.mo.gov/living/families/genetics/newbornscreening/blood-spot-screening.php. This dashboard reports annual data on counts of positive tests for each disorder included in the panel. It also includes information on the number of tests performed.

The Title V team is in the early stages of developing a general Maternal-Child Health dashboard for Missouri. This dashboard will be funded through state general revenue and will be used to provide a broad picture of MCH in the state rather than focusing on one specific program.

The MCH Epidemiology team also produces fact sheets on various MCH topics, available at https://health.mo.gov/living/families/mch-block-grant/. Some examples of fact sheets available include adolescent suicide, infant death and injury, breastfeeding, and pregnancy and delivery care.

Data Modernization and Integration

In early 2022, the Department of Health and Senior Services (DHSS) organized a new team, the Bureau of Data Modernization and Interoperability (BDMI), to focus on modernizing and integrating data systems. The national Centers for Disease Control and Prevention (CDC) has initiated a multi-year, billion-plus dollar effort to modernize core data and surveillance infrastructure across the federal and state public health landscape. This initiative is focused on putting the right people, processes, and policies in place to help solve problems before they happen and reduce the harm from any problems that do occur. (https://www.cdc.gov/surveillance/data-modernization/index.html) The goal of the Bureau of Data Modernization and Interoperability (BDMI) is to modernize and ensure interoperability of public health data systems with other relevant systems to reduce inefficiencies, provide more timely and accurate public health responses, and better serve Missouri residents and visitors.
This includes:

- Working with data submitters at laboratories, hospitals, clinics, local public health agencies, long term care facilities to transmit data electronically;
- Engaging with other DHSS programs, local public health agencies, and other stakeholders to identify necessary system improvements to increase staff efficiency and improve the timeliness of public health actions;
- Routine reporting of data to stakeholders at all levels; and
- Automating processes when possible.

There are a number of projects in BDMI that will impact MCH programs. First, the communicable disease system is undergoing a major upgrade. MCH populations are particularly affected by issues such as the increased incidence of sexually transmitted infections like chlamydia and syphilis. There has also been an increase in the number of cases of congenital syphilis in infants. The new system will facilitate easier case management, contact tracing, and linkages to other data systems. There are also upgrades planned for the database that hosts newborn hearing test data, as well as hospital data. BDMI also works with school nurses who assess and report the number of school-age children who have received their recommended immunizations. Additionally, BDMI works with healthcare providers to establish automated electronic reporting of immunizations to properly assess the vaccination coverage among children and adolescents.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The MCH population has unique needs during an emergency, and Missouri works to enhance emergency preparedness planning and response activities to assure MCH population needs are considered in state, regional, and local planning. The MCH Director serves as a branch manager in the DHSS Emergency Response Center (ERC). Many Title V team members serve in the DHSS ERC, including serving on the Local Public Health Management team. The State Emergency Operations Plan (SEOP) is reviewed annually and considers a variety of vulnerable populations, including at-risk and medically vulnerable women, infants, and children, in planning elements. Missouri actively includes vulnerable populations in exercises and has sponsored multiple statewide conferences focused on emergency planning issues specific to children and families, such as reunification and pediatric medical surge planning. Missouri maintains an interdisciplinary Children and Youth in Disasters (CYD) Subcommittee as part of the statewide Access and Functional Needs Committee. The committee has six standing work groups that address needs across the systems where children live and receive care and support, by focusing on several key aspects of children's environments including: public health/medical disaster planning; schools; child care; foster care and congregate care; children's mental health; and emergency services (e.g., sheltering, feeding).

Work began in early 2020 to systematically integrate MCH knowledge, expertise, and populations into our emergency preparedness risk assessment, training, and exercise planning processes, and the state, regional, and local emergency operations plans. The COVID-19 pandemic interrupted formal integration of MCH into Emergency Preparedness and Response (EPR) processes but presented opportunities to strengthen existing and build new partnerships between Title V, EPR and MCH programs across state agencies, local public health partners, and community organizations. Lessons learned through COVID-19 response are informing the work to build EPR capacity for mothers and infants and increase capacity to adequately assess and respond to MCH needs in a future disaster or public health emergency. Knowledge gained will inform MCH leadership participation in future development of EPR training, communication plans and tools/strategies to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population.

Addressing the needs of Missouri's children and youth with special health care needs (CYSHCN) and their families presents unique challenges and requires special considerations in EPR. Missouri is a largely rural state, with greater population concentrations surrounding the larger urban areas. Comprehensively meeting the needs of CYSHCN and their families in rural areas is more difficult due to transportation barriers and limited access to providers with specialized experience in treating complicated health issues. During times of emergency, MCH team members work to ensure CYSHCN and their families continue to receive high quality services in their local communities and have help to identify resources for additional support. Additional information regarding EPR for CYSHCN can be found in the CYSHCN Population Domain narratives.

Missouri has a variety of MCH surveillance systems that have the ability and flexibility to collect timely data during public health emergencies. The following is an overview of the various MCH surveillance systems that can gather data with respect to EPR among Missouri's MCH populations:

1. National Vital Statistics System (NVSS) –Birth and death certificate data is compiled by the Missouri vital statistics team in conjunction with CDC-NCHS to assign death codes and compile an annual birth file for pregnancy outcomes. The data can also be compiled monthly to provide real time estimates for adverse pregnancy and neonatal outcomes.
2. National Syndromic Surveillance Program (NSSP) – ESSENCE, Missouri's syndromic surveillance program, collects real time data from hospitals across the state, including information on chief complaints and ER visits. ESSENCE continues to be a critical resource for timely public health action for a range of issues including suicide attempts, communicable disease outbreaks, opioid overdose visits and emergency department visits

during natural disasters.

3. Pregnancy Risk Assessment Monitoring System (PRAMS) – Missouri PRAMS continues to be a key MCH surveillance system during public health emergencies, such as the COVID-19, H1N1 and opioid epidemics. The program added new questions to the survey in 2023 to capture data about emergency preparedness activities for families with infants. The first batch of data from these new questions will be available in late 2024.
4. Behavioral Risk Factor Surveillance System (BRFSS) – The BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS is a population-based surveillance system that has the ability to add modules, such as the COVID-19 module, during public health emergencies for assessment of emergency preparedness among all Missourians, including MCH populations.
5. Reportable Disease Data Collection System (EpiTrax) – The EpiTrax system collects and compiles COVID-19 case data on a real time basis, and the data is disseminated to the public on a daily basis through dashboards.
6. Show Me Vax (SMV) Data Application – Show Me Vax collects vaccine data in Missouri. While it is not mandated to report vaccines in Missouri, it is mandatory for providers to report COVID-19 vaccine uptake. COVID-19 vaccine data is available in real time, is compiled on a daily basis and is made available to the public through dashboards.

COVID-19 Response

Throughout the COVID-19 pandemic, Title V MCH programs were relied on to provide leadership and support in delivering critical MCH services and assisting local communities to respond to emerging threats and needs. Title V coordinated with MCH partners to develop and implement EPR plans to address MCH population needs. Highlights of COVID-19 response activities supported by Title V during FFY 2022 are summarized below.

- Numerous program staff supported by Title V funding provided ongoing assistance in the state's COVID-19 pandemic response efforts such as: participating in operational briefings with state and local leaders and partners; community education and engagement; provision of accurate and reliable information to partners, health care providers, parent networks, etc.; partnerships with other state agencies, medical providers, and health care organizations to help educate the MCH population about COVID-19; support for local emergency preparedness efforts to represent the needs of the MCH population; and providing information to partners and community members regarding COVID-19 vaccination.
- SHCN team members collaborated with MO HealthNet on Medicaid waivers and state plan amendments and provided one-on-one education with families and providers on COVID-19 precautions, testing sites, vaccinations, resources, etc.
- The State School Nurse Consultant provided ongoing support and guidance to schools and school nurses, including hosting virtual learning opportunities for school nurses to assist with implementing best practices in schools, developing guidance for schools, participating on the Hub team for the COVID and Kids ECHO, and communicating best practices for developing and implementing school health plans and determining appropriate mitigation strategies.
- At the request of the Association of State and Territorial Dental Directors, the Office of Dental Health contributed to the creation of a toolkit for schools on how to respond to the pandemic and manage, coordinate and provide a school-based preventive oral health services program.
- Title V funded local implementing agencies (LIAs) continued to providing virtual or tele-home visiting (HV) services, engaging families in HV services within the limits of social distancing recommendations. LIAs supported HV families in the following ways:
    - Healthy Families America (HFA) LIAs used local diaper banks for supplies and referred families to

local resources for support. Staff helped families complete forms for utility assistance. Diapers and wipes were delivered to families through no contact delivery, with additional community resource information included. Resources were also texted to families.

  - Nurse Family Partnership (NFP) LIAs stayed connected with clients through tele-visits to provide services and ensure families had access to available community resources. Collaboration between agencies was particularly apparent in the St. Louis region where weekly virtual webinars were sponsored by Generate Health to allow information and resource sharing among different community organizations that serve families. Diapers and wipes were distributed to enrolled moms by either no contact home drop-off or by in-person pick up.
  - Information was sent out in the private DHSS HV Weekly Update email to LIAs regarding free data and cellular minutes from SafeLink Wireless for families receiving unemployment benefits.

The local public health system was significantly impacted by the COVID-19 pandemic, and regular day-to-day local public health agency (LPHA) operations were drastically decreased, and in some cases completely halted, to maximize local response capacity. In an effort to support the continually evolving needs of the LPHAs as they anticipated and responded to the significant impact of COVID-19 in their local communities, flexibilities in the expenditure of Title V funds through the MCH Services contract were allowed to support implementation of approved science-based approaches to respond to COVID-19 and address related MCH population needs. Expenditures were in accordance with
state fiscal policies and regulations for Title V funds and all other contract funding provisions. Local approaches and responses included: educating public health partners, community agencies, medical providers, health care organizations, and the MCH population about COVID-19; working with local, regional, and/or state public health partners to assure the needs of the MCH population were prioritized and addressed appropriately; provision of accurate information and community status updates; and community-wide educational communication and media campaigns.

Shifting its focus to the "Unwinding of the COVID-19 Public Health Emergency," the MCH Services Program team made efforts to learn more regarding planned State processes and resources available to Medicaid enrollees to maintain continuous Medicaid coverage. As a result, increased sharing of information and resources pertaining to Medicaid coverage for children and women of childbearing age have been shared with the LPHAs to ensure those at the local level are prepared to help eligible community members maintain Medicaid coverage.

Although LPHAs play critical roles in responding to public health threats, and many public health threats impact pregnant women, infants and families, efforts to increase collaboration between MCH and EPR within LPHAs remain limited. Tri-County Health Department, located in rural northwest Missouri, was awarded funding to participate in a national project to increase collaboration between MCH and EPR programs within LPHAs with the goal of improving the lives of pregnant women, new parents, and their infants. Tri-County Health Department developed a strategic plan outlining how to address the needs of MCH populations in their community during future public health emergencies, and they met with internal and external stakeholders to form an advisory committee to inform and operationalize their action plan. To support LPHA efforts surrounding MCH and EPR planning, DHSS will partner with Tri-County Health Department to share the following resources with other LPHAs to assist with incorporating MCH needs into emergency planning:

- *Public Health Emergency Preparedness and Response Checklist for Maternal and Infant Health* from Association of Maternal and Child Health Programs (AMCHP);
- *Infant and Young Child Feeding in Emergencies (IYCF-E) Toolkit* from CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO);
- *New Orleans Breastfeeding Center Infant Ready Emergency Planning Kits*; and

- *Infant and Young Child Feeding in Emergencies* materials from Jefferson County Colorado.

The School Health Program (SHP) participated in coordinated COVID-19 response efforts to communicate practice recommendations and resource options. The SHP leveraged the established frameworks of Show-Me ECHO (Extension for Community Healthcare Outcomes) to partner with the subject matter experts to develop and setup didactic learning opportunities for school nurses on COVID-19 and general infection control practices, as well as other prevalent chronic conditions including autism, asthma, and trauma-informed care. The SHP facilitated conversations with key stakeholders in school nursing across Missouri to identify successes, challenges, needs and barriers from the COVID-19 response in the school setting. From this work, the SHP also collected recommendations for improving response plans for infectious disease management among communities and partners to maintain student wellness and family health.

Over the past couple of years, there has been a significant turnover of public health nurses in all settings, including local and state public health and school nursing. Title V MCH continues to work with state and Department leadership to address gaps in this critical public health profession to ensure capacity to adequately assess and respond to MCH population and program needs in future disasters or public health emergencies.

The COVID-19 pandemic highlighted and exacerbated systematic inequalities affecting vulnerable populations, especially communities of color. Related emerging needs in MCH such as: disruptions to routine maternal, infant, child, and adolescent health care, including routine scheduled immunizations; reductions in breastfeeding prevalence; shortages in child care providers; food insecurity, including decreased access to infant formula and food; increased homelessness; and increased mental health needs, substance use and suicide, just to name a few, further elevated the importance of prioritizing the MCH population in EPR planning and activities. Along with continuation, evaluation and expansion of telehealth models, leveraging new and expanded partnerships, and enhancing MCH data collection, analysis, and observation capacity, these are some of the new MCH challenges being addressed and opportunities being explored.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Collaborative Work with Federal, State & Non-Governmental Partners

Maternal/Infant Health

The Department of Health and Senior Services (DHSS) Title V MCH team members are involved in several efforts to enhance a systems approach to ensuring access to quality health care and needed services for Missouri's MCH population. DHSS partners with several organizations serving Missouri's Bootheel counties to support the Rural Maternity Obstetrics Management Strategies (RMOMS) grant, which was awarded to Saint Francis Healthcare System in Cape Girardeau. The RMOMS grant seeks to support health care providers, hospitals, public health, and social support agencies to work together with communities to build on local resources to meet the health care needs of women and newborns and create a new model of service delivery.

The MCH leadership participates in the Department of Social Services (DSS), MO HealthNet Division Maternal/Infant Health Coordination meetings to maintain mutual understanding of existing activities to address maternal and infant health priorities and collaborate regarding maternal and infant health projects and initiatives. Additional information regarding Partnerships for Maternal/Infant Health can be found in the Women/Maternal Health Population Domain narratives.

Child/Adolescent Health

Nearly all state government early childhood programs are consolidated in a single Office of Childhood at the Department of Elementary and Secondary Education (DESE), including the Title V funded Home Visiting (HV), Early Childhood, Safe Cribs, Child Care Inclusion, and Child Care Health Consultation programs. To meet the authorizing legislation requirements of Section 509 of the Social Security Act, an interagency contract between DHSS and DESE establishes: DHSS Title V MCH authority and oversight for Title V allocations to DESE and the programs receiving Title V funding; accountability measures and reporting requirements related to Title V funding allocations; and interagency MCH data sharing and reporting requirements. A MOU was executed between DHSS and the DESE Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program to collaborate on programs and activities to improve maternal, infant, and child health outcomes.

DHSS has a MOU with DSS, DESE and the Children's Trust Fund (CTF) to facilitate exchange and use of information regarding incidences of child maltreatment and/or neglect among HV program clients to assess the degree to which families enrolled in HV have lower substantiated/called-in reports and whether the number of reports declines over time as clients work with their home visitors to develop parenting and resiliency skills. The MOU only collects data to comply with required MIECHV performance measure reporting for comparison between MIECHV, Title V funded HV programs, and CTF HV outcomes.

The State Dental Director plays an essential role in state oral health programs. The Office of Dental Health (ODH) partners with DSS, the Missouri Coalition for Oral Health (MCOH), the Missouri Primary Care Association (MPCA) and the Missouri Dental Association (MDA) to promote oral health education among their constituents. The MCOH promotes oral health through social media and other types of public-facing educational opportunities. The MPCA works with Federally Qualified Health Centers to provide training to dental personnel and dental care to the Medicaid population. The MDA is integral in increasing Medicaid rates and innovative ways to deliver dental care to the underserved. The MDA also coordinates the biennial Missouri Mission of Mercy, which provides free dental care to Missourians of all ages who cannot otherwise afford or access care.

The School Health Program (SHP) partners with the American Academy of Pediatrics (AAP) to support school

nurse responsiveness to factors contributing to student health. This includes collaborating to update modules in the TEAMS (Training, Education, Assistance, Mentoring, Support) framework to address environmental policies and practices related to infection control in the school setting and engaging with the Missouri Chapter of the AAP to sponsor conferences and training opportunities for school nurses and local physicians to enhance their ability to work with students and families. The State School Nurse Consultant serves as a HUB team member for the Children with Autism and the COVID-19 and Kids ECHOs and is a member of the advisory committees for the Medicaid in Schools Program, the Center of Safe Schools, the Missouri Association of School Nurses, and the MO Eating Disorders Council. SHP training partners include: the Missouri Foundation for Health and the Missouri Legal Aid Society to provide training on assisting families to understand the Medicaid system; the DSS Family Support Division regarding the Medicaid system; the DESE Food Service Director regarding family applications for free and reduced meals; and the Missouri School Board Association regarding new laws and policies related to children in schools. The SHP provides guidance to schools regarding how to promote continuous Medicaid enrollment after termination of the Public Health Emergency.

Title V MCH partners with the Missouri Coordinated School Health Coalition to advance and advocate for school-based health care programs to improve children's health, educational opportunities, academic achievements, and ultimately, life outcomes. The Coalition creates synergy around school-based health by promoting the use of the Centers for Disease Control and Prevention's (CDC) Whole School, Community, Child model.

Title V MCH team members serve as members of the Council for Adolescent and School Health (CASH) to support adolescent and school health and facilitate collaboration and professional development to promote a coordinated family, community, and school approach to achieve healthy adolescent development. The Adolescent Health Coordinator (AHC) partners with a number of statewide and national coalitions/councils and serves as a steering committee member for Supporting Young People, a multi-agency group working towards the goal of creating a statewide Youth Advisory Council. The AHC is a Past-President and n Executive Team Member of the National Network of State Adolescent Health Coordinators, who provide guidance and leadership to those working in adolescent health.

Title V MCH team members participate in the statewide and regional Missouri Department of Transportation (MoDOT) Coalitions for Roadway Safety, partnerships of safety advocates with the common purpose to end traffic fatalities and serious injuries on public roadways. MCH Services Program staff are instrumental in connecting local public health agencies (LPHAs) with the regional coalitions to become involved and gain knowledge and resources to implement their local MCH work plans.

Children and Youth with Special Health Care Needs

The Bureau of Special Health Care Needs (SHCN) partners with several public and private entities in support of children with special health care needs through formal and informal relationships. Contracts are in place with LPHAs to provide service coordination on a regional basis for the Children and Youth with Special Health Care Needs (CYSHCN) Program. The regional Service Coordinators specialize in resource referrals and are knowledgeable and connected with local businesses, agencies, churches, and philanthropic organizations. SHCN Family Partners are experts in connecting with public and private partners to link families to the appropriate resources. SHCN staff members are involved with various councils, including the Missouri Assistive Technology Advisory Council and the Missouri Developmental Disabilities Council. The Bureau administers the Missouri Brain Injury Advisory Council.

Crosscutting Partnerships

The MCH Director serves on the Advisory Board for ParentLink at the University of Missouri-College of Education and Human Development. ParentLink provides parenting resources and support to incarcerated parents, maintains a lending library of parenting materials, and provides the Ages & Stages Questionnaires (ASQ) to help caregivers

keep track of their child's development. DHSS contracts with ParentLink to: 1) manage TEL-LINK, Missouri's toll-free MCH hotline; 2) implement a statewide MCH Navigator pilot to connect parents, caregivers and families with needed resources to optimize health outcomes; and 3) maintain the MCH WarmLine as the access point for caregivers to obtain family strengthening information and support. Through the WarmLine, caregivers can visit with Family Support Specialists, who have backgrounds in human service fields such as social work and assist families to think through solutions to parenting concerns, obtain community service and other resource information, and access print resources and the Loan Library.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

Service Coordinators and Family Partners from the Bureau of Special Health Care Needs (BSHCN) at the Department of Health and Senior Services (DHSS) refer participants and families to MO HealthNet, Missouri's Medicaid program within the Department of Social Services, for determination of eligibility and services and to assist participants and families in navigating the Medicaid system. The SHCN information system links with the Department of Social Services (DSS) data system to obtain the current Medicaid status of participants. The information system for the Missouri Balanced Incentive Program, also referred to as Missouri Community Options and Resources (MOCOR), refers children and youth with special health care needs (CYSHCN) under the age of 21 to the BSHCN for services. The BSHCN administers the CYSHCN Program; Medicaid referral or verification of active enrollment is a requirement of CYSHCN Program participants. The BSHCN also administers the Healthy Children and Youth (HCY) Program through a cooperative agreement with MO HealthNet. This cooperative agreement enables the BSHCN to obtain funding support for service coordination activities in the CYSHCN Program. The HCY Program provides service coordination and authorization for medically necessary services for MO HealthNet state plan fee for service system (not enrolled in the MO HealthNet Managed Care Plans) recipients with special health care needs from birth to age 21. The HCY Program implements a portion of the Early Periodic Screening Diagnosis Treatment (EPSDT) requirements, including assessing the need for in-home nursing services (such as personal care, private duty nursing and skilled nursing visits) for children and youth with serious and complex medical needs. SHCN Nurse Service Coordinators conduct individual assessments with participants and families in the HCY Program during home visits and link participants and families with services and resources that enable participants to remain safely in their homes. An individual plan of care is created for participants to ensure the unique needs of each person are met. In addition, the BSHCN administers the Medically Fragile Adult Waiver (MFAW) Program, which serves medically complex individuals age 21 and over, who have 'aged out' of the HCY Program. MO HealthNet is the Single State Medicaid Agency; the BSHCN administers the MFAW Program through an interagency agreement with MO HealthNet.

Current operations of the BSHCN involve three separate MOUs with the DSS. The DHSS and DSS are exploring the possibility of combining agreements for programs with similar authorities. SHCN staff collaborate with MO HealthNet staff in developing and updating policies and processes related to CYSHCN.

An example of extensive collaboration between the BSHCN and MO HealthNet is related to the implementation of statewide managed care Medicaid. In an effort to minimize negative impact to children receiving in-home services, BSHCN management staff members were included in conversations with MO HealthNet staff, Managed Care Companies, and MO HealthNet providers during the transition to implement managed care statewide. The BSHCN shared processes and forms to promote continuity of statewide operations, regardless of Managed Care/fee for service status. The BSHCN also provided MO HealthNet with a listing of HCY participants prior to the statewide implementation to ensure the participants were appropriately identified and given a choice of receiving services through Managed Care or fee for service. In addition, SHCN staff contacted participants/families receiving services through the HCY Program who were identified as possibly transitioning from fee for service Medicaid to Managed Care to inform them of changes regarding authorization of in- home services and to provide them with information about who to contact with questions regarding their Medicaid status. Ongoing communication between MO HealthNet, Managed Care Companies, provider agencies, and the BSHCN is required post-implementation to ensure effective service provision as individuals change Managed Care Companies and/or fee for service Medicaid, which inadvertently impacts their services. For participants enrolled in the HCY Program, the BSHCN assists with authorization of in-home services to avoid gaps in services when there are changes in coverage. In addition, the BSHCN provides MO HealthNet with enrollment information on a weekly basis to ensure participants of the CYSHCN Program are provided an opportunity to choose between Managed Care Medicaid and fee-for-service Medicaid. The BSHCN also collaborated extensively with MO HealthNet through the COVID-19 pandemic to

coordinate services for the HCY and MFAW programs, including substantial work to allow Missouri flexibility for implementation due to the public health emergency.

A MOU between the DHSS, the DSS, and the Department of Mental Health sets forth the terms and conditions surrounding utilization and support of the Common Client Area (a centralized repository in which an individual's personal information is input and stored when being assigned a unique identifier). The MOU also establishes a governance structure for the Common Client Area that includes all the agencies that utilize Common Client Area data.

Data Sharing

Additional data sharing agreements between the DHSS and DSS include:

- Vital Records shares birth and death data with DSS to determine eligibility for services.
- Agreement for the DHSS and local public health agencies to perform lead screening and home assessments for children who test positive for elevated blood lead levels.
- The DHSS receives Medicaid data to determine eligibility for WIC.

In an effort to ensure the long-term sustainability of the Medicaid program while maintaining the quality of services delivered to the most vulnerable populations, MO HealthNet initiated the Medicaid Transformation initiative. The goals of the Medicaid transformation effort are to:

- Bring Medicaid spending growth in line with the rate of growth for Missouri;
- Ensure access to health care and services to meet the needs of Missouri's most vulnerable populations;
- Improve participant experience and health care outcomes and increase their independence;
- Partner with providers to modernize care delivery system; and
- Become a leader in the implementation of value-based care in Medicaid.

Among the Transformation Office initiatives is a MO HealthNet effort to focus on improving infant mortality rates in Missouri. In doing so, low birth weight infants' data is linked back to their mothers to see what kind of care they received before and after birth. In researching the data surrounding this, it has been discovered that Medicaid claims are typically tied to the head of household's DCN. This means the infant could be tied to the father, teenage mother's father, aunt, uncle, foster parent, etc. The data is unreliable and quite burdensome to make any meaningful decisions with respect to the impact of care on maternal and neonatal outcomes. In an effort to enhance Medicaid linkage to birth certificate data, DSS will provide DHSS with a list of all infant DCNs, and DHSS will in turn provide data from the associated birth certificates in an effort to identify the care received by the birth mother and other social determinants of health data that is provided from the mother when completing birth certificate forms. This will provide MO HealthNet further insight into the social/economical needs of mothers that could be resulting in low birth weight babies and NICU admissions. It will also provide a comparison between healthy births and complicated births.

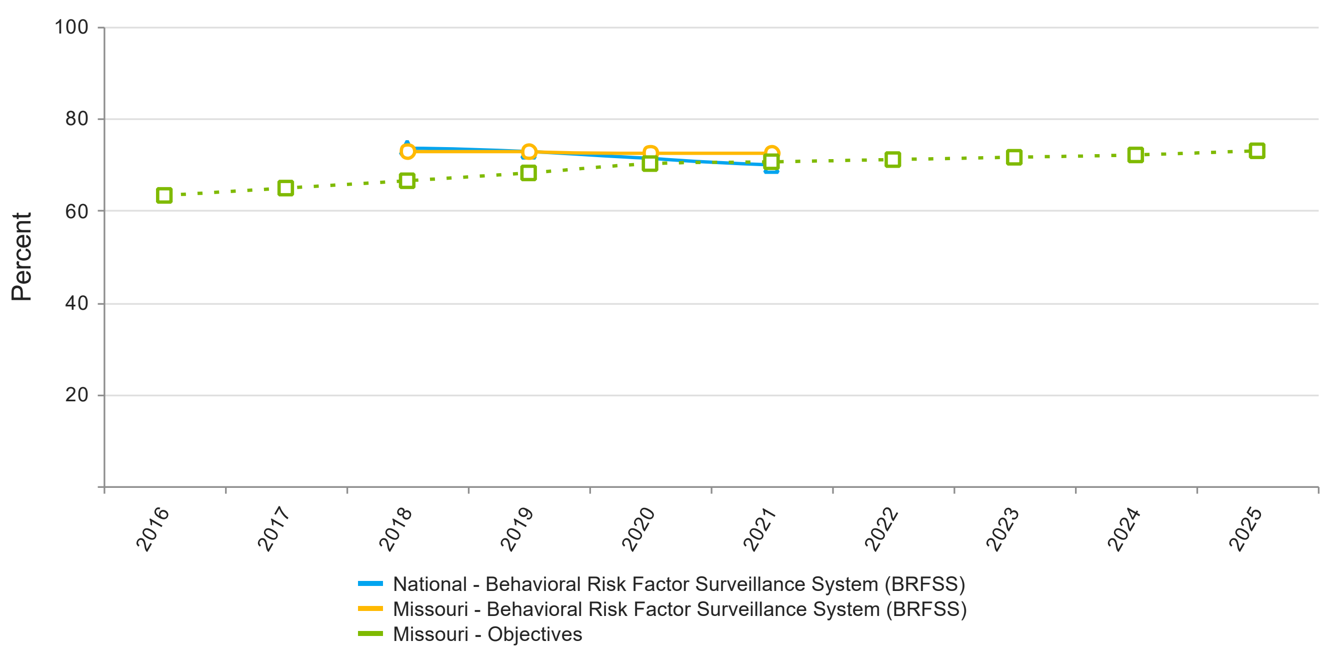
The ultimate goal will be to use this collaboration of data to develop value-based payment models or quality initiatives within the Medicaid program to address these social/economical issues and reduce the number of low birth weight infants. Currently, Missouri is in the lowest quartile in regards to this care, and this linkage is expected to not only drive data-driven decision-making processes but also aid with program planning, monitoring and evaluation.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	2019	2020	2021	2022
Annual Objective			70.1	70.5	71
Annual Indicator		72.9	72.6	72.5	72.4
Numerator		757,602	754,373	755,016	751,551
Denominator		1,038,992	1,039,355	1,041,255	1,038,345
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	66.4	68.1	70.1	70.5	71
Annual Indicator	72.9	72.6	72.5	72.5	
Numerator	769,769	769,579	755,016	755,016	
Denominator	1,055,678	1,060,305	1,041,255	1,041,255	
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	
Data Source Year	2018	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	71.5	72.0	72.9

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			85.8	86.2
Annual Indicator	85.3	83.7	86.7	86.6
Numerator	604	1,001	1,204	1,573
Denominator	708	1,196	1,388	1,816
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	86.8	87.2	87.9

State Action Plan Table

State Action Plan Table (Missouri) - Women/Maternal Health - Entry 1

Priority Need

Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

By 2025, DHSS will develop/promote strategies to increase the percent of women who had an annual preventive medical visit from 72.9% (BRFSS 2018) to 73.6%.

By 2025, DHSS will promote strategies to reduce the incidence rate of severe maternal morbidity from 74.0 per 10,000 delivery hospitalizations (SMM rate based on without blood transfusion, PAS 2018) to 73.3 per 10,000 delivery hospitalizations.

Strategies

Implement community-based health promotion efforts.

Communicate the value of and collaborate with partners in maternal health initiatives.

Raise awareness of the importance of reproductive life planning.

Educate women on the importance of immunizations.

Promote comprehensive health care for pregnant women and women of childbearing age.

Support activities and facilitate partnerships to create environments that support healthy eating and active living.

Partner with tobacco control programs and community-based partners to assure delivery of effective tobacco cessation services.

Participate in maternal and women's health partnerships by convening public health and advocacy partners for strategic thinking and action, engaging clinicians as partners, and engaging collaboratives to improve maternal health and health care equity.

Address underlying social determinants of health.

Build program and policy evaluation capacity.

ESMs	Status
ESM 1.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).	Active

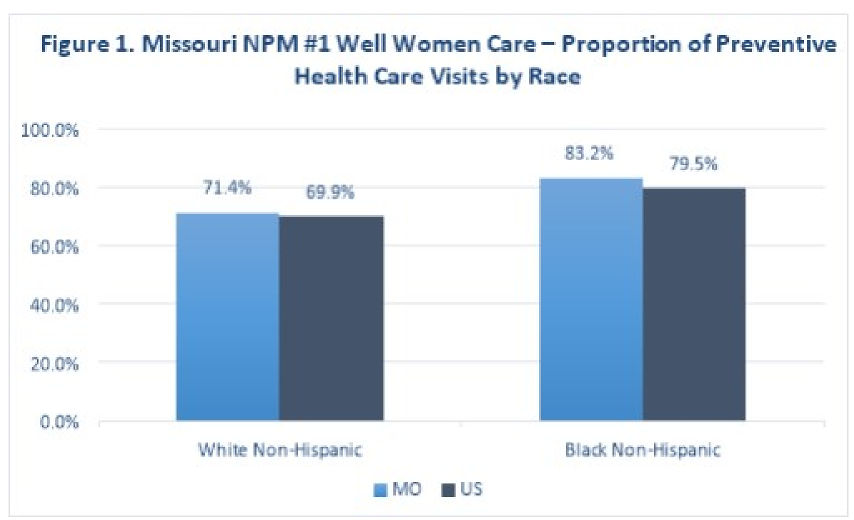
NOMs

- NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
- NOM 3 - Maternal mortality rate per 100,000 live births
- NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
- NOM 5 - Percent of preterm births (<37 weeks)
- NOM 6 - Percent of early term births (37, 38 weeks)
- NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
- NOM 9.1 - Infant mortality rate per 1,000 live births
- NOM 9.2 - Neonatal mortality rate per 1,000 live births
- NOM 9.3 - Post neonatal mortality rate per 1,000 live births
- NOM 9.4 - Preterm-related mortality rate per 100,000 live births
- NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
- NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
- NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
- NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

NPM #1 Well Women Care – Improve pre-conception, prenatal and postpartum health care services for women of childbearing age

The health and wellbeing of the mother before, during, and after pregnancy is important not only for the woman but also for the newborn. Women who maintain a healthy lifestyle during the preconception period are less likely to experience adverse pregnancy and obstetric outcomes and are also more likely to experience better postpartum health that extends across their life span.

According to the 2021 Behavioral Risk Factor Surveillance System (BRFSS), 72.4% of Missouri women between 18-44 years reported having a preventive health care visit within the past year. This is higher than the national proportion of 69.7% for 2021. There were racial differences in the proportion of women who had a preventive health care visit, with Missouri being similar to national levels (Figure 1). A higher percentage of insured women (76.5%) compared to uninsured women (41.3%) received a preventive visit. A lower percentage of those with less than a high school education (50.9%) received a preventive visit in the past year than those with more than a high school education (75.2%). The proportion of Missouri women with more than a high school education that received a preventive medical visit in the past year was also higher than at the national level (71.1%). In Missouri, 66.5% of those with a household income less than $25,000 had a preventive visit in the past year compared to 77.6% among those with a household income greater than $75,000. A slightly larger percentage of married women (72.4%) had a preventive visit in the past year than unmarried women (72.3%).



Missouri Vital Statistics (MVS) data for 2021 indicate 73.1% of women began prenatal care in the first trimester, which is slightly lower than the 73.4% observed in 2020. First trimester initiation was also lower in Missouri compared to the national level (78.3%) in 2021. There is a racial gap in first trimester initiation in Missouri, but that gap has narrowed. MVS data for 2020 showed that 77% of White Missourians began prenatal care in the first trimester compared to 60% of Black Missourians. While first trimester prenatal care initiation decreased for Black Missourians (61.4%) from 2020, it increased for White Missourians (76.5%) during that same year.

According to 2021 MO PRAMS, 89.4% of Missouri women received a postpartum checkup. This proportion is higher than the 85.1% reported for 2020. Women without health insurance (82.3%) had a lower percentage of receiving a postpartum checkup compared to their counterparts who were privately insured (93.8%) and Medicaid-insured (83.9%). Non-Hispanic Black women (84.7%) had lower rates of receiving a postpartum checkup compared

to Non-Hispanic White women (90.9%). Women with less than a high school diploma (79.6%) had lower rates of receiving a postpartum checkup than women with a high school diploma (84.1%), some college (90.6%), and a college degree or higher (95.3%).

The Office on Women's Health (OWH) continued to provide education and resources to promote well woman care, including the distribution of *WOMEN: Take Charge of Your Health* publication and the *My Health Tracking Card* and continuation of the Women's Health Network listserv. The *WOMEN: Take Charge of Your Health* publication includes information on topics such as preventive health, preconception health, obesity prevention, breastfeeding, postpartum depression, and disease prevention. This resource is also available on the Department of Health and Senior Services (DHSS) website at www.health.mo.gov/womenshealth. The *WOMEN: Take Charge of Your Health* publication is available in English and Spanish and can be accessed online and in print. The *My Health Tracking Card* provides a means to track blood pressure, cholesterol, and weight. Resources were provided to the general public, local public health agencies (LPHAs), and others who contact the OWH or visit the website. The Women's Health Network listserv comprises organizations and individuals concerned with women's health. The network's purpose is to provide timely information about current issues in women's health, such as changes in services for women, changing technology in women's health, available resources, training opportunities, events and funding opportunities. In 2022, the OWH surveyed the network and found that 89% of listserv members reported an increase in opportunities to disseminate information through the Women's Health Network Newsletter.

The Missouri Women's Health Council continued to meet quarterly. The Council is an advisory group comprised of thought leaders with expertise in women's health and the broad range of factors that affect health outcomes and wellbeing. Council members are appointed by the Department of Health and Senior Services (DHSS) Director and reflect the geographic diversity of Missouri. The Council is charged with informing and advising DHSS regarding women's health risks, needs, and concerns and recommending potential strategies, programs, and legislative changes to improve the health and well-being of all women in Missouri. The Council consists of women from a variety of professions, including health care providers, researchers, healthcare administrators, social workers, as well as, multiple directors of critical social service foundations serving women throughout Missouri. During FFY2022, the OWH developed a priority document for DHSS. Priorities highlighted in the document include increased access to care, improved data transparency, and support for mental health services.

The Office of Dental Health (ODH) continued to educate mothers and children about the importance of oral health for their overall health and well-being. This included the promotion of dental visits during pregnancy. As quantities allowed, the ODH supplied infant toothbrushes and *Healthy Smiles from the Start* booklets to the St. Louis Safe Kids Coordinator for use during baby safety classes. The baby safety classes cover safe sleep habits, car seat safety, breast and bottle-feeding and oral care. The training reaches pregnant moms, new parents and grandparents and is presented in English and Spanish.

The ODH also continued to provide education to women about the importance of oral health for the mother's overall health, during pregnancy and throughout her lifespan. This education takes place through literature developed by the ODH and the Missouri Dental Association. These materials are distributed to women via an ongoing successful collaboration with the Women, Infants, and Children (WIC) Program and the Title V MCH funded Home Visiting Program. Materials are also distributed via LPHAs, dental offices, and at community outreach events. The importance of dental visits among pregnant women is reinforced in literature distributed by the ODH via its collaboration with WIC, the Home Visiting Program, and Federally Qualified Health Centers (FQHCs).

As part of a pilot program, the ODH contracted with three local public health agencies (LPHAs) to provide oral health education, a dental screening and fluoride varnish to pregnant moms who seek services at their agency. The LPHAs also educated the local obstetricians on the importance of dental health during pregnancy The LPHA also set up a

dental visit at a local Medicaid-providing dental clinic so the pregnant mom may have an easier time receiving dental services and this improves her dental health. Between January and September 2022, 77 pregnant women received education about oral health. Of the 77 pregnant women, 51 received a visual dental screening. Twenty-three pregnant women scheduled dental appointments but only eight of them completed their dental appointments. Thirty-five women received a fluoride varnish application at the time of the WIC visit/appointment. The LPHAs educated five local obstetricians on the importance of good oral hygiene during pregnancy. The ODH promoted this program during the 2023 Spring Regional LPHA Meetings.

Community Health

The MCH Services Program continued to contract with LPHAs to support a leadership role for LPHAs at the community level to promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for low income, at-risk pregnant women. Twenty LPHAs are working to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age as their Priority Health Issue (PHI).

- The New Madrid County Health Department worked to increase physical activity in order to prevent and reduce obesity among women of childbearing age. Health department staff collected data regarding health behaviors of women of childbearing age as well as barriers and challenges to implementing lifestyle changes. The health department plans to use that data to implement a "Women Walk Program". The program, which will be offered to WIC program participants, will encourage women of childbearing age to walk as a group at the health department or a local park starting with a goal of 30 minutes each week for 8 weeks.
- The Adair County, Chariton County and Perry County Health Departments are working to prevent and reduce smoking among women of childbearing age and pregnant women. These LPHAs are increasing efforts to assess smoking status among women of childbearing age and offer smoking cessation resources and programs. Outreach efforts focus on engaging community partners and providers to strengthen referral networks and increase collaborative educational efforts and resource sharing.
    - The Adair County Health Department has created a policy to screen all women of childbearing age that present to the health department for any service for smoking status. A screening and referral tool has been developed and staff have been trained on how to use it. The MCH Coordinator attended the SCRIPT (Smoking Cessation and Reduction in Pregnancy Treatment Program) training in November 2022 and plans to implement the smoking cessation program at the health department in January, 2023 to increase the number of childbearing women who are screened for smoking status and referred for cessation education and services—increasing the number of women of childbearing age who quit smoking.
    - The Perry County Health Department facilitates the Baby & Me Tobacco Free program to reduce the number of pregnant and postpartum women who smoke. The program inspires and empowers pregnant women and their families to overcome nicotine addiction and works to support communities in order to disrupt the generational impacts of tobacco. The health department created three billboard messages that are displayed on a digital billboard in Perry County and this has increased community awareness and participation in the program.
- One LPHA is working to decrease the number of women with a recent live birth who experience frequent postpartum depressive symptoms as their PHI and one LPHA is working to improve mental health care services for women of childbearing age. These LPHAs are working collaboratively to increase community awareness of postpartum depression, increase educational opportunities to providers and community members, and increase the awareness, adoption, and implementation of evidence-based postpartum depression screening tools.
    - The Callaway County Health Department developed a policy to screen all consenting postpartum women that present for WIC services using the Edinburgh Postnatal Depression Scale (EPDS) screening tool.

The policy was approved by the County Commission in February of 2022 and has increased the number of postpartum women who are receiving mental health resources and services to manage postpartum depression. 85 postpartum women have been screened, with 22 scoring over 10 out of 30, indicating a need for referral. Women are referred to a local provider and contacted weekly by health department staff to ensure the referral was successful. Regardless of their score on the EDPS questionnaire, all postpartum women are given mental wellness resources.

- The Atchison County Health Department hosted a “Stress Less Fest” for women of childbearing age and their children. The event included a yoga, a sensory bin, a coloring, and a stress ball making station to allow participants to explore fun and soothing ways to reduce stress and promote positive mental health. Moms received a self-care basket that included items that promote physical and mental wellness. There were 13 attendees and participants reported an increase in knowledge on strategies to reduce stress and achieve mental wellness.

- Eight LPHAs are working to ensure women of childbearing age receive an annual preventative well woman visit. Some are working to change organizational practices to include well-women care as part of the services offered at their health departments while others are collaborating with local FQHCs to screen and refer women for services.
  - Miller County Health Center designed two family rooms for use during Perinatal Program, breastfeeding support, and WIC services appointments. These rooms use a Trauma-Informed Interior Design to create a comfortable and safe space. The color scheme, furniture, and overall design facilitate an atmosphere of openness and security, allowing for more thorough and impactful appointments. The rooms also act as a central waiting location while staff members come to the room to provide services. This has increased the number of services the mother is able to receive in one visit versus having to make multiple visits (*see picture below of one of the rooms*). The Perinatal Program is provided by the health educator and/or certified lactation consultant at the health center. The goal of this program is to provide pregnant women with increased knowledge and resources. Once a woman obtains a positive pregnancy test, she is referred to WIC. At the time of WIC enrollment, the woman is scheduled for her first WIC appointment as well as an appointment directly after with the Perinatal Program Coordinator. During the first perinatal program appointment, the pregnant woman is screened for safe sleep environment, infant car seat, breastfeeding knowledge, accessibility to prenatal vitamins, and other resources. The health educator then connects them to these resources.

- The McDonald County Health Department worked to increase the number of women who have an annual preventative visit and created self-care as an incentive for women of childbearing age who complete their annual preventative visit at the health department. These kits include items to promote physical and

mental health, such as a water bottle to increase water intake, a pedometer to increase physical activity, and a cookbook to increase knowledge on preparing a healthy meal. (*picture of self-care kit below*)

- The Springfield-Greene County Health Department requires all staff to be trained in the Advancing Health Equity training series and have incorporated this training into NEST Partnership. NEST stands for NUTURE, EMPOWER, SUPPORT, and TEACH. NEST Partnership provides nurse case management for at-risk prenatal and postpartum women or families with young children. Services are delivered in the home during scheduled visits for nurse assessment, intervention, education and collaboration with health care providers. Staff have reported increased knowledge as a result of completing the training series. In addition, the health department has started a health equity committee and NEST has a staff member serving on the committee. The committee developed a health equity toolkit which will be used to evaluate internal MCH policies for equity and inclusion. This has increased staff knowledge and awareness of health equity in working with the MCH population.
- Two LPHAs are working to reduce racial disparities and ensure black women of childbearing age receive preconception, prenatal, and postpartum health care services. These LPHAs are working closely with their internal and external partners, including local hospital labor and delivery units and local universities within their medical training programs.

The MCH Services Program supported LPHA efforts to: provide education on the importance of adequate dental care and overall oral health, collaborate with partners to provide screening, referral and direct provision of preventive dental services for oral health needs, and increase the number of women receiving a preventive dental visit during pregnancy. LPHA and/or community partner efforts to implement education programs for pregnant women, families, and providers on the benefits of delivery after 39 weeks gestation, the risks of preterm delivery, and the risks associated with a cesarean birth are also being supported.

- Wright County Health implemented a dental varnish program where staff provide oral assessment, education, referrals and applications of fluoride varnish to pregnant women. This service increased the number of pregnant women that receive an oral health screening and fluoride varnish application. 59 pregnant women received an oral health screening and education and 36 pregnant women received dental varnish.

The TEL-LINK Program helped improve maternal and child health by providing 2,721 health care service referrals to increase access to care for any Missourian who needs assistance. The program promotes this service through search engine campaigns to provide outreach to the underserved population. TEL-LINK provided referrals to a wide range of services such as: smoking cessation, dental care providers, WIC clinics, mental health treatment centers, health insurance providers, and many more.

The Newborn Health Program continued to partner with a variety of community health providers to raise awareness/educate the MCH population on resources for women of childbearing age and their families which includes preconception, prenatal, and postpartum care, as well as smoking cessation, postpartum mood disorders, and the importance of taking folic acid. The program accomplishes this through the free distribution of the *Pregnancy and Beyond* books and a wide variety of educational materials. All of these resources contain information to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age. The program tracked the distribution of these materials and obtained feedback from partners on how they use the materials and ways to improve them. The Healthy Births and Babies (HBB) Unit continued to utilize and promote an informal maternal and child health internal work group and maximize outreach opportunities at conference exhibits, health fairs, and through the Home Visiting Programs by distributing various educational materials.

The Missouri WIC Program promoted the importance of depression screening utilizing the Patient Health Questionnaire-2 (PHQ-2) for prenatal, breastfeeding, and non-breastfeeding women. The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression as a “first step” approach. Currently, 27 local agencies use the PHQ-2 screening. WIC continued the referral system to the Home Visiting Program, TEL-LINK program, the Missouri Primary Care Association, and other support programs. WIC staff also continued outreach efforts to enroll pregnant women into the WIC Program during their first trimester. For some, WIC is the first stop once they discover they are pregnant. WIC helps pregnant women by supporting a healthy pregnancy from the start; the nutritious foods, education, and resources WIC provides help to ensure the best possible outcome for mom and baby.

Home Visiting

The Title V MCH funded Home Visiting Program continued to share information with all contracted local implementing agencies to educate home visitors about the Affordable Care Act (ACA) marketplace enrollment process including any changes in access for enrolled participants. Home visitors accessed resources through weekly updates. As the Home Visiting Program received updates on enrollment procedures, the information was forwarded to contracted home visitors, who utilized it to assist women in applying for and accessing MO HealthNet (Missouri’s Medicaid) coverage for unborn children, newborns, and pregnant women, to assure they attained appropriate prenatal care. The Home Visiting Program also collected annual performance measure data on the percent of mothers enrolled in home visiting prenatally or within 30 days after delivery who receive a postpartum visit with a health care provider within 8 weeks of delivery. In FY22, 57.4% (112/195) of women received a postpartum follow-up visit. With the transition of the Home Visiting Program to the Department of Elementary and Secondary Education (DESE)-Office of Childhood (OOC) in FY2021, opportunities to collaborate with partners, both internal and external, are continuing to address access to care.

Additional Title V MCH funded Home Visiting Program services included:

- Promotion of smoking cessation to all primary caregivers who answer yes to smoking at enrollment or at any subsequent 6 month time points. Annual performance measure data was collected on the percentage of primary caregivers who reported smoking, using tobacco, or other forms of nicotine delivery, including e-cigarettes, at enrollment and were referred to tobacco cessation counseling or services within three months of enrollment. FY22 data indicated that 42% (39/92) of primary caregivers enrolled in OOC funded home visiting programs who reported using tobacco or cigarettes at enrollment were referred to tobacco cessation services within three months of enrollment. (In addition, home visitors were provided with information and resources on tobacco cessation through the weekly update. Home Visitors shared resources such as the DHSS Missouri Tobacco Quitline and TEL-LINK with participants.
- Providing information and resources that promote the benefits of pregnancy to the full 40 weeks to all contracted home visitors to share with clients. Resources included DHSS and March of Dimes materials.

Title V MCH funded Home Visiting Program Specialists assessed the receipt and use of these resources during the monthly subrecipient monitoring calls with contracted local implementing agencies and during annual trainings.

- Screening all prenatally enrolled clients for depression within three months of delivery. Primary caregivers not enrolled prenatally were screened within the first three months of enrollment. Home visitors utilized the Public Health Questionnaire 9 (PHQ-9) depression screening tool at these prescribed time points and additionally anytime home visitors recognized potential symptoms of depression. Individuals who screened positive were referred to the appropriate services. In FY22, 80% of primary caregivers (268/335) enrolled in home visiting were screened for depression within three months of enrollment (for those not enrolled prenatally) or within three months of delivery (for those enrolled prenatally). Additionally, FY22 data indicated that 13% of primary caregivers (9/69) who tested positive for depression completed referrals to services for a positive depression screening.
- Providing contracted home visitors with information on oral health resources from the ODH and the Missouri Primary Care Association to share with enrolled primary caregivers to promote the importance of receiving preventive dental care during pregnancy.

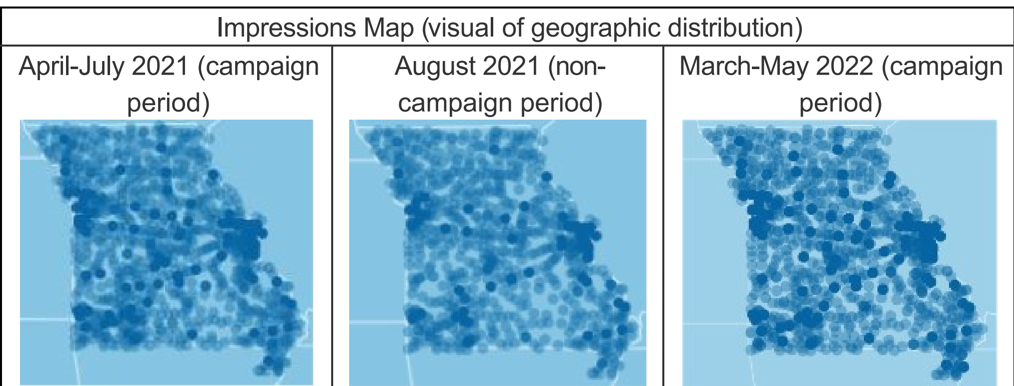
Environmental Health

Many persons are not aware that lead exposure can be a problem for women of childbearing age, a developing fetus and a nursing infant. The most serious effect of high levels of lead exposure during pregnancy are miscarriage and stillbirth. Other pregnancy problems such as gestational hypertension, low birth weight and premature delivery can also occur. Prenatal lead exposure impairs children's neurodevelopment, placing them at increased risk for developmental delay, reduced IQ, hearing impairments, and learning and behavioral problems.

DHSS lead poisoning prevention staff continued to perform the following activities to prevent or decrease blood lead poisoning in pregnant women and their babies:

- Provided community lead education via various outreach events such as health fairs;
- Participated in updating outreach materials such as the "*Pregnancy and Beyond*" booklet and other pamphlets and brochures which are distributed to expectant and new parents;
- Made contact with pregnant women and their health care providers when they were known to have elevated blood lead levels (EBL) of 5 mcg/dL or higher (tracked by the ABLES staff); and
- Provided lead education and resource materials to health care providers, LPHA and health plan lead case managers, as well as WIC Program staff regarding the need to discuss lead poisoning prevention and lead testing with clients. This included providing LeadCare Analyzers and lead test kits to LPHAs that do not have the capacity to provide accurate lead screenings—allowing them to offer this service on a regular basis.

The Prenatal Substance Use Prevention Program promoted the importance of prenatal substance use prevention to promote healthy pregnancy and birth outcomes. The program utilized statewide community placement sites, which house substance exposed infant manikins to demonstrate the effects of drugs and alcohol during pregnancy. Despite the challenges of COVID-19 in calendar year 2021, the community placement sites demonstrated the substance exposed manikins 114 times, educating 1,683 individuals. In calendar year 2022, sites were able to utilize the manikins 125 times and educated 2,442 individuals. In addition, awareness campaigns promoted healthy pregnancy and abstaining from all substances before, during, and after pregnancy. The campaigns utilized geographic, demographic and life stage targeting. The ads ran for four months in 2021 (over 1,820,000 impressions) and three months in 2022 (over 1,480,000 impressions). *(visual of geographic distribution of impressions below)*



Impressions Map (visual of geographic distribution)		
April-July 2021 (campaign period)	August 2021 (non-campaign period)	March-May 2022 (campaign period)

The Safe Cribs for Missouri Program continued to educate each crib recipient on smoking cessation and the consequences of smoking during pregnancy. Missouri Tobacco Quitline tip cards and MO HealthNet resources were utilized.

Maternal Mortality

The OWH abstracts and reviews all pregnancy-associated mortalities in Missouri. This is done to ensure that information from all maternal deaths occurring within one year of pregnancy termination is captured. Maternal mortality cases that occurred in 2020 have been abstracted and are being reviewed by the Pregnancy-Associated Mortality Review (PAMR) board. Abstraction of 2021 cases is ongoing. The reviews aid in the identification of strategies to prevent maternal mortality. DHSS published an annual report on maternal mortality with findings from the PAMR and collaborated with partners and other key stakeholders to implement the recommendations.

Through a competitive grant process, DHSS was selected for a 5-year grant awarded through the Centers for Disease Control and Prevention's (CDC) Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program. This funding directly supports agencies and organizations that coordinate and manage Maternal Mortality Review Committees (MMRC) to identify, review and characterize maternal deaths and identify prevention opportunities. The OWH is wrapping up year three of the grant and planning for year four activities. The OWH improved internal processes to expedite maternal mortality case identification, abstraction and review by working with the Bureau of Vital Records to use provisional death files. Furthermore, maternal mortality cases were grouped by date of death for abstraction and review. For example, if at all possible, deaths that occur at the beginning of the year are abstracted first and brought to the PAMR Board for review. In addition, a Patient Abstract System (PAS) linkage was developed during year two of the grant to identify additional hospitalizations and/or emergency room visits to aid in case abstraction. The PAS linkage was further refined by developing a linkage to identify cases of early pregnancy in hospital discharge data where there would be nothing else to indicate a pregnancy from the death certificate (i.e. early miscarriage). This looks at all women of birthing age (10-60) who died in a given year and uses the diagnostic and procedure coding to identify women who had an ICD-10 O code (or A34). This code is used in maternal records for pregnancy and childbirth. It uses a combination of name/date of birth and social security number/date of birth to identify such cases. As this is a newly developed linkage, further information on outcomes will be forthcoming. Through the ERASE MM grant, the OWH contracts with the Missouri Hospital Association (MHA) to implement patient safety bundles in Missouri birthing facilities, clinics and critical access hospitals. Implementation of the "Care for Pregnant and Postpartum People with Substance Use Disorder" (CPPPSUD) bundle began in 21 facilities. The bundle was implemented in response to the June 2021 PAMR report that identified maternal overdoses as a leading cause of maternal death.

Soon after launching the Missouri Maternal-Child Learning and Action Network (MC-LAN) in 2018, DHSS and the MHA partnered to join the American College of Obstetricians and Gynecologists (ACOG), as funded by the Health

Resources and Services Administration, Alliance for Innovation on Maternal Health - AIM. Through this effort, MHA takes the lead on implementation of maternal safety bundles in Missouri birthing facilities. As the first initiative, Missouri implemented the AIM "Severe Hypertension in Pregnancy" patient safety bundle. In response to the Centers for Medicare and Medicaid Services "Birthing Friendly" hospital designations rule, MHA opened up Missouri's AIM collaborative to allow facilities to implement the Severe Hypertension in Pregnancy (SHP) bundle or Obstetric Hemorrhage (OH) bundle in addition to the CPPPSUD Bundle. Facilities implementing the SHP or OH bundles have online access to bundle resources, including recordings from previous webinars. While facilities are expected to report data on some bundle elements, they do not receive intensive support as the active CPPPSUD collaborative. The OWH and the MCH Director collaborated with MHA and other key stakeholders through the MC LAN to provide guidance, knowledge sharing and peer support as the initiatives continue. The MC LAN provides strategic guidance and focus of high-value opportunities to improve clinical, operational and outcome performance, and to develop collaborative partnerships to achieve these aims. In addition, the committee partners with the communities it serves to achieve better communication, and educate the public on quality and safety initiatives of the health care community. This committee meets three times a year with additional virtual meetings as needed.

Other Title V MCH Activities Related to the Women/Maternal Health Domain

The OWH supported several initiatives to assist women of child bearing age. While these initiatives were not funded by Title V MCH, staff funded by Title V MCH leveraged Title V MCH support to ensure adequate response to emerging issues. First, the OWH supported the Uninsured Women's Health Services Program. With the Missouri Department of Social Services (DSS), the OWH reimbursed medical providers for women's health services. These included: approved methods of contraception; testing and treatment of sexually transmitted diseases, including pap tests and pelvic exams; family planning, counseling, education on various methods of birth control; and drugs, supplies, or devices related to the women's health services described above, when they are prescribed by a physician or advanced practice nurse. During the 2022 state fiscal year 26,728 individuals were enrolled in the program. The estimated cost savings to the state due to unintended pregnancy was $25,701,576. Second, the OWH maintained a public listing of pregnancy assistance information and ultrasound providers. The OWH sends a survey annually in order to develop a listing of private and public agencies available in the state to help pregnant women. This listing of assistance and ultrasound providers is indexed geographically and is available online. Third, the OWH represented the Department in several statewide task forces and commissions, including the Missouri Rights of Victims of Sexual Assault Task Force and the Combatting Human Trafficking and Domestic Violence Commission. Additionally, the OWH supported the statewide Sexual Assault Nurse Examiner Telehealth Network. This network is in the beginning stages and will expand access to forensic exams across the state. Finally, the OWH led the start of several new initiatives to improve the health of women in the state. These included a tobacco cessation program for pregnant women, a doula training initiative, a free prenatal care program in Kansas City, Missouri, and a perinatal quality collaborative for the prevention and treatment of opioid abuse disorders among pregnant and postpartum women.

Through participation in the Association of State and Territorial Health Officials (ASTHO) and the Association of Maternal and Child Health Programs (AMCHP) Promoting Innovation in State & Territorial MCH Policymaking (PRISM) Learning Community, DHSS partnered with the University of Missouri Kansas City Institute for Human Development (UMKC-IHD) to organize, convene and facilitate a statewide Maternal Health Multisector Action Network (the Network). Focused on a life course framework, the Network promotes a coordinated, multidisciplinary system of care for women of childbearing age and pregnant and parenting mothers to assure health equity, racial/social justice, and a comprehensive continuum of care, including prevention and treatment efforts, for women/mothers with mental health and substance use disorders (SUD). The Network used a landscape scan of State Policy Options for Perinatal Women with Substance Use Disorders provided by AMCHP to inform its priorities, goals, strategies, and future policy initiatives and aims to address risk and protective factors that influence

health disparities within families and communities through the Life Course Perspective.

The Network was established in 2022 and has over 200 individual stakeholders; 40 of whom are active participants. A diverse, multi-sectored group of MCH, public health, mental and behavioral health, SUD treatment, social services, and other community stakeholders, including LPHAs, were invited to participate in the Network efforts. Two groups oversee the work of the Action Network: 1) the Moms' Self-Advocacy Network, comprised of mothers with lived experience, and 2) the Planning Committee, comprised of content experts and key stakeholders with expertise in MCH and SUD. The Mom's Self-Advocacy Network is being developed.

To incorporate the lived experiences of mothers of young children affected by substance use and mental health challenges, the Network promoted partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities. The UMKC-IHD conducted six focus groups or "mapping sessions" to better understand the facilitators and barriers to accessing high quality and equitable services for mothers affected by substance use and mental health disorders. The UMKC-IHD recruited two groups of individuals for focus groups: Mothers of young children affected by substance use throughout the state and service providers or individuals who work at organizations/agencies that provide services to mothers affected by SUD and mental health disorders before, during and/or after pregnancy. Understanding the lived experience is crucial to guiding the development of future services and support systems available to address maternal substance use and mental health, resulting in improved health outcomes for mothers and their children. Focus group discussions identified the following themes:

- Facilitators to care included:
    - Practitioners who listen wholeheartedly to their patients and learn about their patient/their lives;
    - Childcare available with treatment or other recovery services;
    - Access to transportation, phone, and internet; and
    - Advocates, such as doulas, community health workers, and home visitors.
- Barriers to care included:
    - Long wait times between the decision to access SUD treatment/detox and admission;
    - Lack of a recovery community with shared experiences of motherhood;
    - Access to care-organizations and agencies only provide services and treatment during business hours, which is when many mothers work or provide care for their children;
    - Fear of being vulnerable and the possible repercussions of disclosing substance use; and
    - Stigma and biased care from providers, clinicians, child welfare, legal system, and community.

UMKC-IHD facilitated three Action Network meetings in March, July, and September of 2022. By incorporating the voices of mothers with lived experience, the Network identified the following five priority areas associated with maternal substance use and mental health:

1. Social Determinants of Health/Stigma/Justice/Equity;
2. Wraparound Services/Team Birth Approach;
3. Medicaid Expansion;
4. Child and Family Support Services; and
5. Criminal Justice Issues.

Work groups were formed around the five priority areas, and the landscape scan helped identify areas of strength, opportunities, gaps in services, and policy options. The workgroups serve to develop strategic action plans for Missouri-specific priorities, as decided by the Moms' Self-Advocacy Network, Planning Committee and the Action Network.

As the state's chief maternal child health strategist, the MCH Director worked to broaden the scope of MCH partnership beyond DHSS and other state agencies. As a convener of multidisciplinary, cross-sector collaborations and facilitator of meaningful and diverse partnerships, Title V MCH brings MCH partners and programs together across programmatic siloes and organizational boundaries to promote the health of the MCH population and address social determinants of health and health inequities. For example, the MCH Director facilitates collaboration with the two Healthy Start grantees (Nurture KC, and Missouri Bootheel Regional Consortium) and their partners to facilitate sharing of information and resources, shared learning and identification of opportunities for alignment and collective impact. The MCH Director is actively engaged in statewide collaborative efforts to promote the health of women of childbearing age, including but not limited to participation in PAMR, MC-LAN, Women's Health Council, the DSS Maternal/Infant Health Efforts coordination meetings, the Uplift Connection, the ParentLink Advisory Council, and the Missouri Association for Infant and Early Childhood Mental Health.

Women/Maternal Health - Application Year

NPM #1 Well Women Care – Improve pre-conception, prenatal and postpartum health care services for women of childbearing age

The Office on Women's Health (OWH) will continue to provide education and resources to promote well woman care, including the distribution of *WOMEN: Take Charge of Your Health* publication and the *My Health Tracking Card* and continuation of the Women's Health Network listserv. The *WOMEN: Take Charge of Your Health* publication includes information on topics such as preventive health, preconception health, obesity prevention, breastfeeding, postpartum depression, and disease prevention. It will be updated as needed to include evidence-based information, resources, and recommendations from experts and leaders in women's health, including hotlines like 988, tobacco quitline, and the domestic violence hotline. This resource is also available on the Department of Health and Senior Services (DHSS) website at www.health.mo.gov/womenshealth. The *WOMEN: Take Charge of Your Health* publication is now available in English and Spanish and can be accessed online and in print. The next printing of the book will include a QR code to a survey. This survey will collect data on what participants learned and how they used the resource. The *My Health Tracking Card* provides a means to track blood pressure, cholesterol, and weight. Resources are provided to the general public, local public health agencies (LPHAs), and others who contact the OWH or visit the website. The Women's Health Network listserv comprises organizations and individuals concerned with women's health. The Network's purpose is to provide timely information about current issues in women's health, such as changes to services for women, changing technology in women's health, available resources, training opportunities, events and funding opportunities. The Women's Health Network newsletter will be distributed at least two times a month.

The Missouri Women's Health Council will continue to meet quarterly. The Council is an advisory group comprised of thought leaders with expertise in women's health and the broad range of factors that affect health outcomes and wellbeing. Council members are appointed by the DHSS Director and reflect the geographic diversity of Missouri. The council is charged with informing and advising DHSS regarding women's health risks, needs, and concerns and recommending potential strategies, programs, and legislative changes to improve the health and well-being of all women in Missouri. The council consists of women from a variety of professions, including health care providers, researchers, healthcare administrators, social workers, and directors of critical social services foundations serving women throughout Missouri. The council will conduct strategic planning to align with the DHSS strategic plan. This will help focus the efforts of the council to better support the OWH.

The Office of Dental Health (ODH) will continue to educate mothers and children about the importance of oral health for their overall health and well-being during pregnancy and throughout the lifespan, including the promotion of dental visits during pregnancy. This education takes place through literature developed by the ODH and the Missouri Dental Association. These materials are distributed to women via an ongoing successful collaboration with the Women, Infants, and Children (WIC) Program and the Title V MCH funded Home Visiting programs. Materials are also distributed via LPHAs, Federally Qualified Health Centers (FQHC), dental offices, and at community outreach events.

The ODH is piloting a program to provide funding through the LPHA WIC office to provide oral health education and supplies, fluoride varnish and a warm hand off to a dental provider. The LPHA staff encourages the mother to keep the appointment by emphasizing the importance of oral care during pregnancy. The LPHA will track the referral outcomes to determine the impact of the initiative. The ODH currently has contracts with three LPHAs. As funding allows and if more LPHAs are interested, the ODH will expand the contract to grow this important initiative.

The ODH is contracting with Uzazi village in Kansas City to provide dental care to pregnant and postpartum women.

Uzazi village is a non-profit organization that provides perinatal health care to racially diverse, underserved, pregnant women who are served by Medicaid. A dental provider in the area has agreed to provide dental care two days a month and will serve an average of eight women a day. ODH is coordinating the donation of the larger dental equipment needed for the clinic and the purchase of smaller equipment and supplies. Medicaid will be billed for the dental services provided..

Community Health

The MCH Services Program will continue to contract with LPHAs to support a leadership role for LPHAs at the community level to promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for low income, at-risk women:

- Twenty LPHAs have selected to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age as their Priority Health Issue (PHI).
- One LPHA has selected to prevent and reduce obesity among women of childbearing age as their PHI.
- Four LPHAs have selected to prevent and reduce smoking among women of childbearing age and pregnant women as their PHI. These LPHAs will continue to increase efforts to assess smoking and offer smoking cessation resources and programs. Outreach efforts will continue to engage community partners and providers to increase collaborative education efforts and resource sharing, and strengthen referral networks.
    - The Ozark County Health Department developed Quit Kits that include tobacco cessation education and resources and are provided to local medical providers and WIC staff to distribute to women of childbearing age that have been identified as using tobacco. The health department plans to develop a method of follow-up to measure impact.
    - The Chariton County Health Department is collaborating with the WIC office to screen and identify women of childbearing age that are smoking. All pregnant women participating in WIC are screened for smoking status. Those identified as smoking are referred to a nurse who administers the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) Program. SCRIPT is an award-winning, evidence-based program shown to be effective in helping pregnant women quit smoking. SCRIPT is designed to integrate into a setting that provides routine prenatal care or home visiting services and is designed to meet her where she is. A woman receives "*A Pregnant Woman's Guide to Quit Smoking*" booklet, a video screening of "*Commit to Quit*", and a brief 10-15 minute counseling conversation intended to spark her confidence and desire to quit smoking. The health department is coordinating with the WIC visit to minimize the number of visits the woman has to make to the office. Currently, the health department has four women actively participating in SCRIPT.
    - The Perry County Health Department is working to expand the Baby and Me Tobacco Free (BMTF) Program into their WIC Program, which screens women of childbearing age for smoking status. This will allow the health department to provide on-site smoking cessation resources for women of childbearing age. The BMTF Program is an evidence-based smoking cessation program proven to reduce the burden of tobacco on the pregnant and postpartum population. Essential elements of the program are individualized counseling using 1:1 facilitation, biomarker feedback to test for tobacco use, and contingency management with the use of vouchers toward diapers and baby wipes. Since October, 2022, 44 women have been screened for smoking status at their WIC appointment. Currently the program has two active participants. The health department will continue working to increase community awareness of this program by strategically placing billboard messaging close to a busy intersection in town as well as next to one of the largest manufacturing plants that employs over 1600 individuals. Three messages have been used so far, with analytics provided by the billboard company showing an average of 1,409 daily impressions and 157,900 impressions over the course of three months.

    - The Adair County Health Department has collaborated with the WIC Program to implement the BMTF tele-health option for pregnant and postpartum women. The WIC program screens and refers pregnant women to the BMTF Program via an online referral form. Once the referral is made, a BMTF telehealth counselor reaches out within three business days. The health department receives status updates once the referral is complete. Each telehealth participant receives a personal carbon monoxide (CO) monitor known as the iCOquit Smokerlyzer. The device connects to a user's smartphone via Bluetooth. After the breath test is completed, the results are instantly accessed by the participant and sent to a dashboard account that allows counselors to view CO level readings in real time. Since implementation in March, 2023, 40 WIC participants have been screened for smoking status, with five being referred to BMTF telehealth support; two of those referrals are actively enrolled.
- Two LPHAs selected to decrease the number of women with a recent live birth who experience frequent postpartum depressive symptoms as their PHI and one LPHA has selected to improve mental health care services for women of childbearing age. These three LPHAs will continue to work collaboratively to increase community awareness of postpartum depression, increase educational opportunities to providers and community members, and increase the awareness, adoption, and implementation of evidence-based postpartum depression screening tools.
    - The Callaway County Health Department collaborates with the WIC Program to screen postpartum participants using the Edinburgh Postnatal Depression Scale (EPDS) screening tool and provide referral and resources to mental health services as needed. The screening tool is available in English and Spanish. If the woman scores above a 10, she is referred to a mental health provider and contacted weekly to ensure the referral was successful. The health department is planning to expand to offer screenings to all postpartum women who visit the health department for other services. So far in FFY2023, the health department has screened 59 mothers and referred 12 of them to mental health providers and services.
    - The Springfield-Greene County Health Department, NEST Partnership, began utilizing a Community Health Worker in September 2022 as part of the Community Health Advocate Program to increase the number of pregnant and postpartum women that have awareness and access to in-home case management services. NEST stands for NUTURE, EMPOWER, SUPPORT, and TEACH. NEST Partnership provides nurse case management for at-risk prenatal and postpartum women or families with young children. Services are delivered in the home during scheduled visits for nurse assessment, intervention, education and collaboration with health care providers. In addition, an online, HIPAA compliant referral form that outside agencies can utilize to refer to the NEST was implemented in November 2022 and 11 referrals have been received so far.
- Ten LPHAs have selected to ensure women of childbearing age receive an annual preventative well visit. Some will be changing organizational practices to include well-woman care as part of the services offered at their health departments while others will be collaborating with local FQHCs to screen and refer for services.
    - The Howell County Health Department is working to increase the number of women who receive an annual preventative visit. An electronic medical record was implemented in September 2022 that sends appointment text reminders immediately after the appointment is made and one day prior to the appointment. Transportation is provided at no cost using Health Tran, a service that allows the health department to schedule rides with local taxi services. In addition, to increase awareness of the importance of a woman's annual exam and services offered at the health department, an educational flyer was created and put in a local mailer that is distributed by mail to approximately 14,200 homes, businesses, and dorm rooms, covering five zip codes in Howell County.
    - The Madison County Health Department is working to increase the number of women of childbearing age that have insurance coverage for women's health services. Staff have been trained to screen

women of childbearing age for insurance coverage and provide education on available services as well as help them to complete the insurance application process. A Community Health Worker was hired in 2023 and has been trained to assist. In FFY2023, 246 women of childbearing age have been screened for insurance coverage and 200 of these women were insured; 19 had private insurance and 181 had Medicaid. Of the 46 women uninsured women, 36 women received assistance with the Medicaid application process from nursing staff and/or the Community Health Worker.

- Two LPHAs have selected to reduce racial disparities and ensure Black women of childbearing age receive preconception, prenatal, and postpartum health care services. These LPHAs plan to work closely with their internal and external partners, including but not limited to local hospital labor and delivery units and universities within their medical training programs at the .
    - The St. Louis County Department of Public Health has developed a birth justice policy to include screening pregnant women to determine the need for doula and home visiting nursing care with the intent of building trust in the healthcare system. This may result in improved birth outcomes. This policy is currently in the editing phase and will be presented to Administration after an MCH Lived Experience Advisory Board is developed and can review and provide feedback on the proposed policy.
    - The City of St. Louis Department of Health is working to develop inclusive, culturally congruent care models and policies specific to implicit bias that OBGYN clinical staff, including physicians and nurses, will implement into practice as a required annual training.

The MCH Services Program will also support LPHA efforts to provide education on the importance of adequate dental care and overall oral health. LPHAs will collaborate with partners to provide screening, referral and direct provision of preventive dental services, and increase the number of women receiving a preventive dental visit during pregnancy. LPHA and/or community partner efforts to implement education programs for pregnant women, families, and providers on the benefits of delivery after 39 weeks gestation, the risks of preterm delivery, and the risks associated with a cesarean birth will also be supported.

The TEL-LINK Program will help improve MCH by providing health care service referrals to increase access to care for any Missourian who needs assistance. The program promotes this service through search engine campaigns to provide outreach to the underserved population. TEL-LINK will partner with tobacco control programs, WIC clinics, dental care providers, and more to provide referrals on a wide range of services, such as smoking cessation, dental care providers, WIC clinics, mental health treatment centers, health insurance providers, and many more.

The Newborn Health Program will continue to partner with a variety of community health providers to raise awareness/educate the MCH population on MCH resources for women of childbearing age and their families, including preconception, prenatal, and postpartum care, smoking cessation, postpartum mood disorders, and the importance of taking folic acid. The program will accomplish this through the free distribution of the *Pregnancy and Beyond* books and a wide variety of educational materials. All of these resources contain information to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age. The program will track the distribution of these materials and obtain feedback from partners on how they use the materials and ways to improve them. The Healthy Births and Babies (HBB) Unit will continue to utilize and promote an informal MCH internal work group and maximize outreach opportunities at conference exhibits, webinars, virtual baby showers, health fairs, and through the Home Visiting programs by distributing various educational materials.

The Missouri Women, Infants, and Children (WIC) Program will promote the importance of depression screening utilizing the Patient Health Questionnaire-2 (PHQ-2) for prenatal, breastfeeding, and non-breastfeeding woman. The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for

depression in a “first step” approach. WIC will continue the referral system to the Home Visiting programs, TEL-LINK Program, the Missouri Primary Care Association, or other support programs. WIC will also continue outreach efforts to enroll women in the WIC Program in their first trimester.

Home Visiting

The Title V MCH funded Home Visiting programs will continue to share information with all contracted local implementing agencies (LIA) to help home visitors better understand the Affordable Care Act (ACA) marketplace changes and uncertainties. Home visiting staff will assist enrolled clients to access insurance for prenatal, postnatal, and well woman care through emails and postings within the Missouri Home Visiting Gateway resources and the Weekly Updates. Through a standard agenda topic on the monthly subrecipient monitoring and support calls with each LIA supervisor, Home Visiting Program Specialists will continue to address needs for updated resources for accessing a regular and ongoing source of healthcare, including current guidelines for accessing and maintaining insurance coverage. The Home Visiting programs will also collect annual performance measure data on the percentage of mothers enrolled in home visiting prenatally or within 30 days after delivery who receive a postpartum visit with a health care provider within 8 weeks of delivery.

Additional Title V MCH funded Home Visiting program services include:

- Promoting smoking cessation for to all primary caregivers who report smoking at enrollment and/or the subsequent 6-month visit. Annual performance measure data will be collected on the percentage of primary caregivers who report smoking, tobacco use or other forms of nicotine delivery, including e-cigarettes, at enrollment and are referred to tobacco cessation counseling or services within three months. In addition, home visitors will be provided with tobacco cessation information and resources, such as the BMTF Program, Tobacco Quitline and TEL-LINK, to share with enrolled participants;
- Providing information and resources to all enrolled pregnant women promoting the benefits of continuing healthy pregnancies to the full 40 weeks. These resources will include DHSS and March of Dimes educational materials. Title V MCH funded Home Visiting Program Specialists will assess the distribution and use of these resources during monthly subrecipient monitoring calls with the LIAs;
- Screening all clients enrolled prenatally for symptoms of depression within three months of delivery. Primary caregivers not enrolled prenatally will be screened within the first three months of enrollment. Home visitors will utilize the Public Health Questionnaire 9 (PHQ-9) depression screening tool during these prescribed timeframes and anytime home visitors recognize potential symptoms of depression, and individuals who screen positive will be referred to appropriate services. Annual performance measure data will be collected for depression screening as described above, including data on the percentage of completed referrals. Current resources on mental health are shared with contracting LIAs through Weekly Updates.
- Providing contracted home visitors with ordering information for oral health resources from the DHSS Office of Dental Health to share with enrolled primary caregivers promoting the importance of receiving preventive dental care during pregnancy and at all stages of life for both primary caregivers and their children.

Environmental Health

Many persons are not aware that lead exposure can be a problem for women of childbearing age as well as the developing fetus and/or nursing infant. The most serious effects of high levels of lead during pregnancy are miscarriage and stillbirth. Other pregnancy problems such as gestational hypertension, low birth weight and premature delivery can also occur. Prenatal lead exposure impairs children’s neurodevelopment, placing them at increased risk for developmental delay, reduced IQ, hearing impairments, and learning and behavioral problems.

DHSS lead poisoning prevention staff will continue to perform the following activities to prevent or decrease blood

lead poisoning in pregnant women and their babies:

- Provide community lead education via various outreach events such as health fairs;
- Participate in updating outreach materials such as the "*Pregnancy and Beyond*" booklet and other pamphlets and brochures which are distributed to expectant and new parents;
- Make contact with women and their health care providers when pregnant women have elevated blood lead levels (EBL) of 5 mcg/dL or higher (tracked by the Adult Blood Lead Epidemiology and Surveillance staff); and
- Provide lead education and resource materials to health care providers, LPHA and health plan lead case managers, as well as WIC Program staff regarding the need to discuss lead poisoning prevention and lead testing with clients. This will include providing LeadCare Analyzers and lead test kits to LPHAs that do not have the capacity to provide accurate lead screenings, allowing them to offer this service on a regular basis.

The Prenatal Substance Use Prevention Program will promote the importance of prenatal substance use prevention to promote healthy pregnancy and childbirth. The program will partner with statewide community-based partners to house substance exposed infant manikins to demonstrate the effects of drugs and alcohol during pregnancy. In addition, awareness campaigns will promote healthy pregnancy and abstaining from all substances before, during, and after pregnancy.

The Safe Cribs for Missouri Program will continue to educate each crib recipient on smoking cessation and the consequences of smoking during pregnancy. Information shared includes the BMTF Program, Missouri Tobacco Quitline tip cards and MO HealthNet resources.

Maternal Mortality

The OWH will continue to abstract and review all pregnancy-associated mortalities in Missouri. This will be done to ensure that information from all maternal deaths occurring within one year of pregnancy is captured. These reviews will aid in the identification of strategies to prevent maternal mortalities. DHSS will report findings from the Pregnancy-Associated Mortality Review (PAMR) and collaborate with partners and other key stakeholders to implement PAMR recommendations. The OWH will continue to identify new ways to share recommendations, such as data dashboards, one-pagers, and briefs.

DHSS was selected through a competitive grant process for a 5-year grant awarded through the Centers for Disease Control and Prevention's (CDC) Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program. This funding directly supports agencies and organizations that coordinate and manage Maternal Mortality Review Committees (MMRC) to identify, review and characterize maternal deaths and identify prevention opportunities. The OWH continues to improve internal processes to expedite maternal mortality case identification, abstraction and review by working with the Bureau of Vital Records to use provisional death files. Furthermore, maternal mortality cases are grouped by date of death for abstraction and review. For example, deaths that occur at the beginning of the year are abstracted first if possible and brought to the PAMR Board. These process improvements will continue to be refined during year three of the grant. In addition, a Patient Abstract System (PAS) linkage was developed during year two of the grant to identify additional hospitalizations/emergency room visits to aid in case abstraction. Through the ERASE MM grant, the OWH contracts with the Missouri Hospital Association (MHA) to implement patient safety bundles in Missouri birthing facilities, clinics and critical access hospitals. MHA will continue implementing the "Care for Pregnant and Postpartum People with Substance Use Disorder" (CPPSUD) bundle. According to the PAMR reports published in June 2021 and June 2022, mental health conditions were the leading underlying cause of pregnancy-related deaths, followed by cardiovascular disease—highlighting the need for this work. The Maternal/Infant Mortality Coordinator will work closely with the PAMR Board and MCH leadership to implement the initiatives in this grant.

Soon after launching the Missouri Maternal-Child Learning and Action Network (MC-LAN) in 2018, DHSS and MHA partnered to join the American College of Obstetricians and Gynecologists (ACOG), as funded by the Health Resources and Services Administration, Alliance for Innovation on Maternal Health - AIM. Through this effort, MHA is taking the lead on implementation of maternal safety bundles in Missouri birthing facilities. As the first initiative, Missouri began implementing the AIM “Severe Hypertension in Pregnancy” patient safety bundle. Since the start of implementing these initiatives, the MC-LAN has become the Perinatal Quality Collaborative (PQC). The PQC has since started implementing the AIM CPPSUD patient safety bundle. The OWH will continue collaborating with MHA and other key stakeholders through the PQC to provide guidance, knowledge-sharing and peer support in developing strategic quality initiatives based on the Triple Aim principles of improving and evaluating perinatal quality and population-based programs. The PQC provides strategic guidance and focuses on high-value opportunities to improve clinical, operational and outcome performance, and to develop collaborative partnerships to achieve these aims. In addition, the committee partners with the communities it serves to achieve better communication, and educate the public on quality and safety initiatives of the health care community. This committee meets three times a year with additional virtual meetings as needed. Missouri birthing facilities enrolled in the AIM will be required to report data metrics into the AIM data portal. DHSS and MHA will work together to assist birthing facilities with data submission to minimize burden on the facilities and leverage key stakeholders to assist with the implementation AIM bundles.

Other Title V MCH Activities Related to the Women/Maternal Health Domain

The OWH supports several initiatives to assist women of childbearing age. The Office supports the Uninsured Women’s Health Services Program. With the Missouri Department of Social Services (DSS), the OWH reimburses medical providers for women’s health services. These include: approved methods of contraception; sexually transmitted disease testing and treatment, including pap tests and pelvic exams; family planning, counseling, education on various methods of birth control; and drugs, supplies or devices related to the women’s health services described above, when they are prescribed by a physician or advanced practice nurse. The OWH continues to work with DSS and the Women’s Health Council to identify areas for improvement in the program, such as application processes and eligibility. The OWH maintains a public listing of pregnancy assistance information and ultrasound providers and the list is indexed geographically and available online. The OWH sends a survey annually in order to develop a listing of private and public agencies in the state to help pregnant women. Common services provided include food, clothing, supplies related to pregnancy, parenting skills and educational programs, and adoption assistance. The OWH supports a prenatal care program in Kansas City to provide free group prenatal care. The OWH supports tobacco cessation for pregnant and postpartum women and their households through telehealth with the BMTF Program. The OWH works with BMTF to publicize the program and offer it at no cost to participants across the state. The OWH leads a doula training program to increase the number of doulas and doula training organizations across the state. The OWH also represents the Department on several statewide task forces and commissions, including the Missouri Sexual Assault Response Team and the Combatting Human Trafficking and Domestic Violence Commission. Finally, the OWH supports the statewide Sexual Assault Nurse Examiner Telehealth Network. This network is in the beginning stages and will expand access to forensic exams across the state.

The Missouri Maternal Health Multisector Action Network (the Network) will continue its effort and dedication in connecting stakeholders with existing resources and toolkits and fostering partnerships amongst stakeholders. The Network will work closely with the key partners in the state to: evaluate the gaps in the support system for mothers and their young children affected by maternal substance use and mental health, and make sure that the Network is positioned to fill the gaps in the support system. This involves a strategic plan for sustaining the Network in the long term. With that in mind, the Network will continue to connect stakeholders in order to increase collaborations and decrease siloes. The Network workgroups will continue focusing on actions to address the evolving needs of the

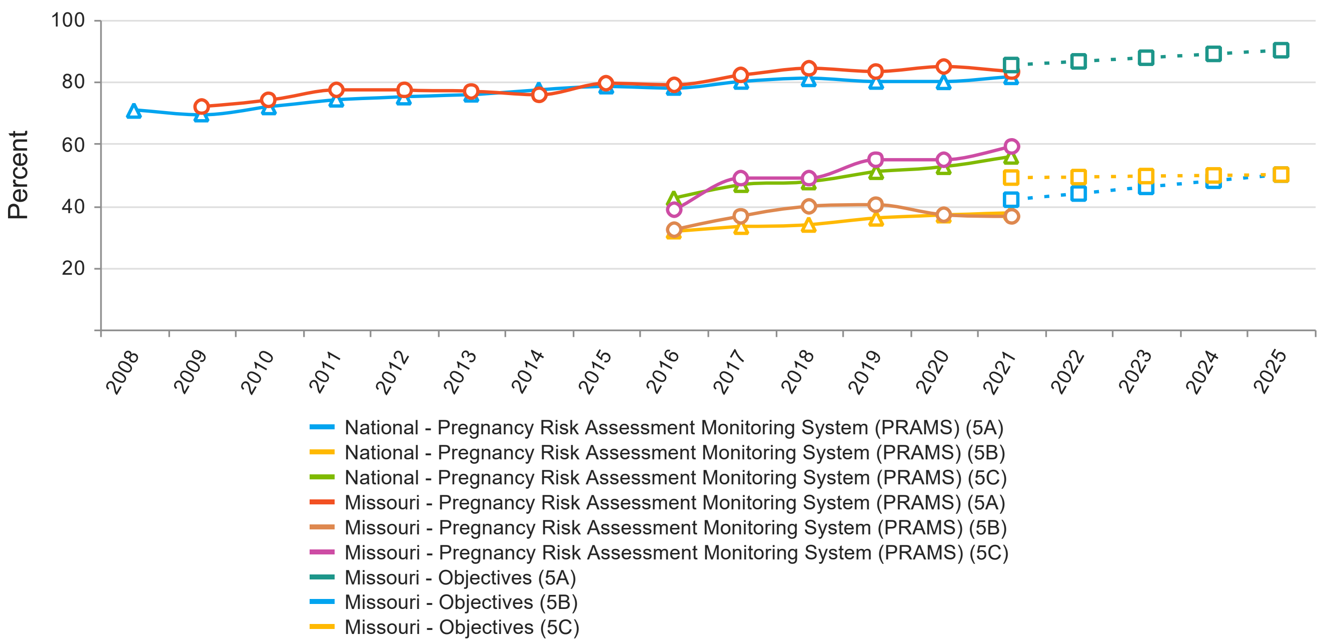
mothers and their children. In addition, the Network will recruit mothers to participate in the Mothers' Self-Advocacy Network, which will be launched in FFY 2024. A major goal of the Advocacy Network will be to prepare mothers to testify in the Missouri legislature during the 2024 legislative session.

As the state's chief maternal child health strategist, the MCH Director works to broaden the scope of MCH partnership beyond DHSS and other state agencies. As a convener of multidisciplinary, cross-sector collaborations and facilitator of meaningful and diverse partnerships, DHSS brings MCH partners and programs together across programmatic silos and organizational boundaries to promote the health of the MCH population and address social determinants of health and health inequities. The MCH Director will continue to actively engage in statewide collaborative efforts to promote the health of women of childbearing age, including but not limited to engagement in PAMR, MC-LAN, Women's Health Council, the DSS Maternal/Infant Health Efforts coordination meetings, the Uplift Connection, the ParentLink Advisory Council, and the Missouri Association for Infant and Early Childhood Mental Health. The MCH Director will continue to collaborate with the two Healthy Start grantees (Nurture KC, and Missouri Bootheel Regional Consortium) and their partners to facilitate sharing of information and resources, shared learning and identification of opportunities for alignment and collective impact.

Perinatal/Infant Health

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			85.2	86.4
Annual Indicator	84.0	83.1	84.8	82.9
Numerator	55,547	54,118	53,369	51,856
Denominator	66,118	65,137	62,925	62,533
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

State Provided Data				
	2019	2020	2021	2022
Annual Objective			85.2	86.4
Annual Indicator	83.1	84.8	84.8	
Numerator	54,118	53,369	53,369	
Denominator	65,137	62,925	62,925	
Data Source	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	87.6	88.8	90.0

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	2020	2021	2022
Annual Objective			41.9	43.9
Annual Indicator	39.9	40.3	37.1	36.6
Numerator	25,485	25,609	23,096	22,467
Denominator	63,920	63,599	62,314	61,451
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

State Provided Data				
	2019	2020	2021	2022
Annual Objective			41.9	43.9
Annual Indicator	40.3	37.1	37.1	
Numerator	25,609	23,096	23,096	
Denominator	63,599	62,314	62,314	
Data Source	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	46.0	48.0	50.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			49	49.2
Annual Indicator	48.7	55.0	54.6	58.9
Numerator	31,408	35,105	33,976	36,271
Denominator	64,465	63,808	62,273	61,579
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			49	49.2
Annual Indicator	55	54.6	54.6	
Numerator	35,105	33,976	33,976	
Denominator	63,808	62,273	62,273	
Data Source	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	49.5	49.7	50.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			83.6	83.8
Annual Indicator	83.3	91.8	76.6	99.4
Numerator	234	202	108	166
Denominator	281	220	141	167
Data Source	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	84.0	84.6	85.0

State Action Plan Table

State Action Plan Table (Missouri) - Perinatal/Infant Health - Entry 1

Priority Need

Promote safe sleep practices among newborns to reduce sleep-related infant deaths.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

By 2025, Increase the percent of infants placed to sleep on their backs from 84.0% (2018 PRAMS) to 85.2%.

By 2025, Increase the percent of infants placed to sleep on a separate approved sleep surface from 39.9% (2018 PRAMS) to 41.1%.

By 2025, Increase the percent of infants placed to sleep without soft objects or loose bedding from 48.7% (2018 PRAMS) to 55.5%.

Strategies

Distribute information and education about sleep-related infant deaths.

Support programs that provide cribs for low-income families.

Collaborate with partners to distribute safe sleep resources to low-income families.

Assess baseline and post-intervention safe sleep practices among program participants and families.

Partner with community service providers and other agencies to conduct trainings on infant safe sleep that target parents, child care providers, grandparents, home health care professionals, staff of obstetric and pediatric clinics, retailers, and faith-based organizations.

Facilitate partnerships with other state agencies, hospitals, nonprofits, media, and other stakeholders to develop innovative programs and policies that promote safe infant sleep, reduce infant mortality, encourage smoking cessation, and promote breastfeeding, immunizations, and prenatal care.

Build program and policy evaluation capacity.

ESMs	Status
ESM 5.1 - At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment.	Active

NOMs

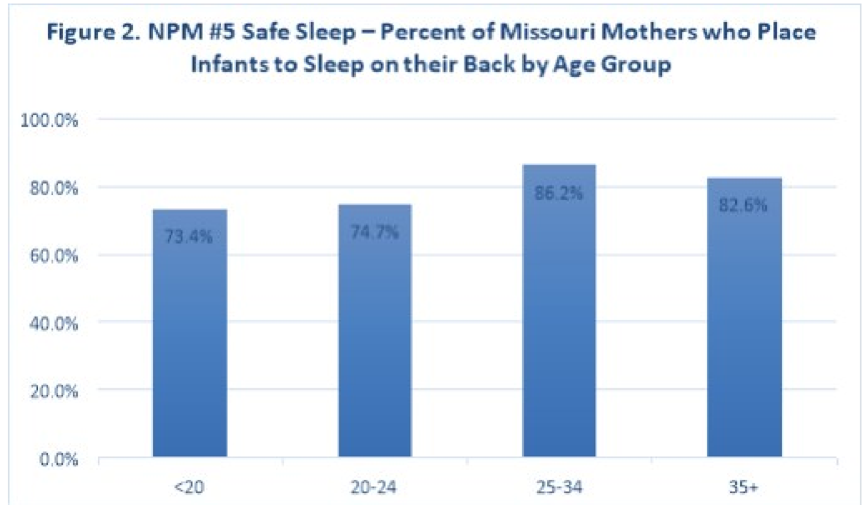
NOM 9.1 - Infant mortality rate per 1,000 live births

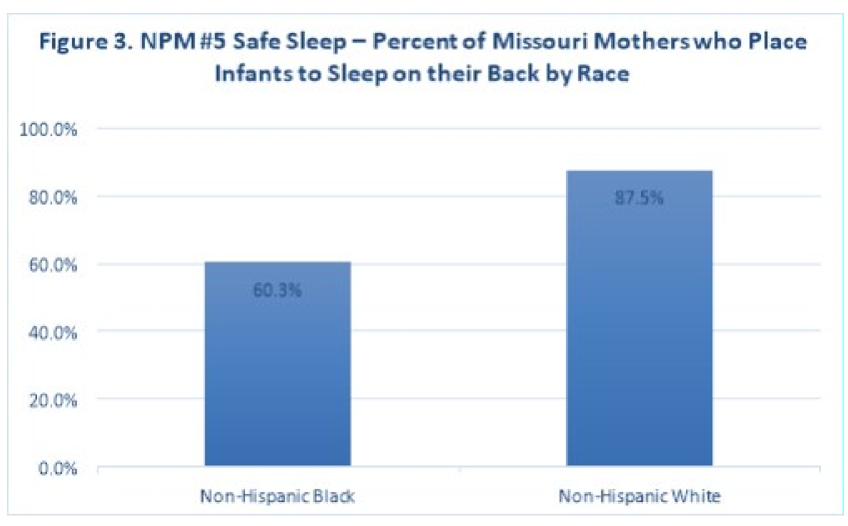
NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NPM #5 Safe Sleep – Promote safe sleep practices among newborns to reduce sleep-related infant deaths

According to the American Academy of Pediatrics (AAP), throughout the first year of life, sleeping babies die accidentally from: suffocation, smothering, wedging, being trapped under someone else while sharing a bed, being placed to sleep on a surface not intended for an infant, and Sudden Infant Death Syndrome (SIDS). Infant deaths due to unsafe sleep practices continue to be a significant contributor to infant deaths in the US and Missouri. The AAP has issued evidence-based recommendations for a safe infant sleep environment. The recommendations are based on case-control studies of infants up to one year of age. Even though safe sleep was not selected as a top priority during the 2016-2020 needs assessment, Missouri selected the percent of infants placed to sleep on their backs as a State Performance Measure. According to the 2021 Pregnancy Risk Assessment Monitoring System (PRAMS), there was a 4% increase in Missouri mothers (82.9%) who placed infants to sleep on their backs from 2016. This exceeded the HP2020 goal of 75.9% but was lower than the percent of mothers who placed infants to sleep on their backs in 2020 (84.8%). PRAMS data indicate younger mothers are less likely to place babies to sleep on their backs (Figure 2). There was a racial difference in 2021 between Non-Hispanic White and Non-Hispanic Black mothers who placed infants to sleep on their backs (Figure 3). This difference between the two increased from 2020, where it was 17%, to 27.2% in 2021. Within the increasing disparity, there was also a decrease into 2021 from the 2020 percentage for Non-Hispanic Black women of 10.7%. In this same time frame, Non-Hispanic White women only saw a decrease of 0.5% in 2021. College graduates were the highest proportion of mothers who laid infants to sleep on their back (91.9%). Those with private insurance had a higher percentage of infants placed to sleep on their backs (88.3%) than those on Medicaid (77.3%). Continued education and outreach is needed to decrease these disparities and increase awareness among mothers and caregivers who are not practicing safe sleep.





Safe Sleep Initiatives

Resources
The Bureau of Community Health and Wellness (BCHW) serves as the state lead for Safe Kids Worldwide to implement and facilitate the accomplishment of common goals and objectives concerning childhood injury prevention. BCHW provided funding for 10 Safe Kids (SK) coalitions that serve 60 counties. All 10 coalitions provide unintentional injury prevention services to children aged 0-19 years. The SK coalitions, which are led by local public health agencies (LPHAs), non-profit entities, and local hospital systems, address priorities including crib safety and safe sleep based on community needs. The coalitions work closely with law enforcement officers, firefighters, paramedics, medical professionals, educators, businesses, public policy-makers, and most importantly parents, children, and adolescents. Through this network, more than 650 cribs were provided along with AAP safe sleep education and training. In addition, more than 80 safe sleep events and trainings were held to increase participant knowledge on ways to reduce the risk of infant injury or death due to unsafe sleep environments. These events involved more than 1,200 participants such as expectant and new parents, caregivers, relatives (such as grandparents), foster parents, first responders, and public safety officers. The SK coalitions continued to conduct media campaigns with safe sleep promotion messages and work with policy-makers to address gaps in policies that could prevent safe sleep injuries.

SSM Health Cardinal Glennon Children’s Hospital, the site of the SK Coalition in St. Louis, continued to provide the one-hour Safe Sleep Training developed by the co-chairs of the SSM Health Safe Sleep Champion committee. First responders including law enforcement, health care providers, first responders, emergency medical services personnel, firefighters, and other public safety professionals received training on evidence-based infant safe sleep recommendations. The training was available in person and virtually through Cardinal Glennon’s Arlo training website. As first responders respond to many non-emergent situations, they can assess for potential unsafe sleep environments if a child is in the home. The goal of the training was for first responders to understand the importance of infant safe sleep, have the knowledge needed to identify an unsafe sleep environment, and be able to provide evidence-based safe sleep education to caregivers in the communities they serve. The ultimate goal was to prevent tragic infant loss related to unsafe sleep practices. Pediatric residents, advanced practice nurses, and all new employees at SSM Health Cardinal Glennon Children’s Hospital were also trained as safe sleep champions.

The Cardinal Glennon Safety Program continued to offer monthly Baby Safety 101 and virtual infant CPR classes where safe sleep education was provided. Cardinal Glennon also partnered with community agencies to provide the Baby Safety 101 classes within the community to reduce barriers for the most vulnerable populations. Upon completion of the class, the caregiver was provided a free safe sleep environment if they lacked the means to

purchase one. The safe sleep environment included a portable play yard, fitted crib sheet, sleep sack, bulb suction syringe, pacifier, and the "*Sleep Baby Safe and Sound"* book by Charlie's Kids Foundation. Caregivers also received a bag of home safety resources and an informational folder on safe sleep.

All Title V MCH funded Home Visiting Program contracted home visitors actively promoted and provided resources on the ABCs (**A**lone, on their **B**ack, in a **C**rib) of Safe Sleep. Home visitors worked with the Safe Cribs for Missouri Program and other local partners to obtain portable cribs for families who could not afford one. Annual performance measure data on safe sleep was collected on the percentage of infants enrolled in home visiting who are always placed to sleep on their backs, and without bed-sharing, or soft bedding. Safe sleep practices are tracked on the safe sleep infant form from age zero to 12 months. Data from FY22 indicated that 73.5% of infants (291/396) less than 12 months were always placed to sleep on their backs, without bed-sharing or soft bedding. The Home Visiting Program continued to update and provide all contracted home visitors with information on how to obtain portable cribs and create safe sleep environments as recommended by the AAP. This information was shared with contracted home visiting agency staff for distribution to enrolled families through a variety of ongoing communication including: posts on the Home Visiting Program's web-based data collection system, and in the *Weekly Update* emailed to each contracted home visitor and supervisor; monthly subrecipient monitoring calls with contracted agencies; and during annual home visiting professional development events.

The Safe Cribs for Missouri Program provided 236 portable cribs and safe sleep educational resources to 63 participating agencies covering a total of 74 counties. The program expanded access to other resources for safe sleep educators. All education programs and resources comply with the evidence-based AAP safe sleep recommendations. The Safe Cribs for Missouri Program previously collaborated with the Children's Division (CD) and the Child Fatality Review Program at the Department of Social Services (DSS) and the Children's Trust Fund (CTF) to develop Part two of the new online safe sleep training for CD staff who work directly with families. As a member of the State Safe Sleep Coalition, the program collaborated with CTF, CD, Infant Loss Resources, Inc., children's hospitals, and other coalition members to implement the new strategic plan to reduce sleep related infant deaths. The strategic plan was developed with the guidance of the National Institute for Children's Health Quality.

The Safe Sleep Coalition partners work to provide safe sleep education and technical assistance to hospitals. The Safe Cribs Program participates in the Safe Sleep Coalition. Safe sleep providers were encouraged to utilize resources for safe sleep, including the safe sleep video, "This Side Up" t-shirt, and other educational materials that were available from the Department of Health and Senior Services (DHSS) at no charge.

The TEL-LINK Program helped improve maternal and child health by providing health care service referrals to increase access to care for any Missourian who needs assistance. The program promoted this service through search engine campaigns to provide outreach to underserved populations. TEL-LINK provided referrals to a wide range of services such as, safe crib providers, WIC clinics, audiologists, car seat providers, child care facilities, and many more.

The MCH Services Program continued to contract with the seven LPHAs that selected promotion of safe sleep practices among newborns to reduce sleep-related infant deaths as a priority health issue.

- Crawford County Health Department increased the number of infants placed to sleep on their back on a separate approved sleep surface without soft objects or loose bedding. The health department partnered with the Safe Cribs for Missouri Program, administered by the Department of Elementary and Secondary Education (DESE) to provide portable cribs and safe sleep education to low-income families who have no other resources for obtaining a crib. In addition, the health department created safe sleep kits that include safe sleep education, a safe sleep approved sleep sack, a pacifier, and a set of fitted crib sheets. These

were provided to those who have an infant when they presented to the health department for services such as Women, Infants, and Children (WIC), obtaining a birth certificate, and immunizations. When kit was presented, health department staff also provided education on safe sleep as well as guidance on how to use the safe sleep kit. Staff then followed up with participants after 4-6 weeks to survey them on the benefits of the kit. (*Picture of kit below*).

- Cole County Health Department staff increased provider and community awareness regarding safe sleep by disseminating a handout with a QR code to the Cole County Breastfeeding Coalition and OBGYN providers. They educated them about the safe sleep program, and encouraged them to make referrals to Safe Cribs Program. In addition, the health department collaborated with the Cole County Breastfeeding Coalition to host a World Breastfeeding Week event at the Cole County Fair. A portable building equipped with an air-conditioned breastfeeding area and changing table was set up for mothers and infants. “Swag bags” were given to the first five people who visited the booth each night, 25 bags were given out over the week. The bags included safe sleep information, flyers for community resources, and information on the health department’s Safe Cribs Program. These flyers were also available at the booth for everyone. Three “Safe Sleep Survival Kits” were also given as grand prizes. Each kit included a pack and play, a fitted crib sheet, HALO wearable sleep sack, and a package of pacifiers (*Picture of kit below*).

- Vernon County Health Department increased community awareness and education related to safe sleep by creating and placing a Safe Sleep billboard strategically on one of the main roads in Vernon County to provide safe sleep messaging and make community members aware of the health department’s resources related to safe sleep (*Picture of billboard below*).

DHSS continued to participate in the Maternal and Child Learning and Action Network (MC LAN) to assist with implementation of infant morbidity/mortality reduction initiatives throughout the state. State legislators allocated state funds during SFY23 for a Perinatal Quality Collaborative (PQC). With this allocation, the naming of the MC LAN transitioned to the Missouri PQC. The MC LAN/Missouri PQC launched a Missouri Neonatal Abstinence Syndrome (NAS) collaborative in 2021, coinciding with implementation of the Care for Pregnancy and Postpartum People with Substance Use Disorder bundle. The NAS collaborative works to implement the Eat, Sleep, Console model of care in 14 facilities, including activities such as: supporting the mother-infant dyad and the mother as "medicine;" establishing Safe Plans of Care for the mother and infant; and accessing training on stigma and bias reduction.

Collaboratives

The MCH Director, MCH Services Program team, and Office on Women's Health (OWH) continued to participate in, as well as be a resource for, the local and regional infant mortality initiatives, including: Generate Health and FLOURISH in St. Louis; Nurture KC in Kansas City; and Missouri Bootheel Regional Consortium Bootheel Babies & Families initiative in the southeast region of the state. Nurture KC and Missouri Bootheel Regional Consortium are the two Healthy Start Grantees in Missouri.

- St. Louis: Generate Health's initiatives focus on five strategic priorities: health equity, maternal and infant health, perinatal behavioral health, immunizations, and making change happen. FLOURISH St. Louis works in coordination with Generate Health. FLOURISH is a collective impact initiative aimed at making St. Louis a place where healthy babies and families flourish. FLOURISH focuses on six priority issues: coordinated quality care, safe sleep, housing, transportation, home visitation and behavioral health.
- Kansas City: Nurture KC's focus is on traditionally low-income families who reside in hard to reach neighborhoods in Missouri and Kansas. They have a special emphasis on cultural competency and strive to help people of all racial, ethnic, and socio-economic backgrounds. Nurture KC has a special focus on safe sleep and coordinates the Safe Sleep Task Force, a group of committed volunteers working to reduce infant deaths through education on safe sleep practices. Nurture KC also provides eligible families with cribs.
- Southeast Missouri: Bootheel Babies & Families (BBF) has three key focus areas: healthcare, safe sleep habits, and substance misuse. Unsafe sleep is the primary cause of infant mortality in that region of the state. BBF also organizes and hosts the annual low birth weight conference, which brings together community members, partners, organizations, national speakers.

Child Care Providers

The Child Care Compliance Section is responsible for licensing and regulating child care programs. Through ongoing regulatory inspections, the Child Care Compliance Section verified compliance with licensing rules regarding infant safe sleep. The Child Care Compliance Section educated child care providers about infant safe sleep practices through technical assistance and training. Section 210.223.4, RSMo requires all employees and volunteers of licensed child care facilities who care for infants under one year of age to successfully complete department-approved training on the most recent safe sleep recommendations from the AAP prior to initial licensure or within their first 30 days of employment, and every three years thereafter. The DESE Quality Programs Section

reviewed and approved safe sleep training, and ensured training was available via a variety of platforms in order to increase licensed child care providers' knowledge of infant safe sleep practices. During child care inspections, Child Care Compliance staff reviewed training records to ensure all required staff had successfully completed department-approved training on safe sleep within the required timeframes. Child care providers are required to share their approved safe sleep plan that meets the AAP guidelines with families upon enrollment. By providing new families with a policy that meets the current AAP guidelines, child care providers advanced the educational outreach to families.

The Child Care Health Consultation (CCHC) Program continued to assist licensed child care providers in meeting the safe sleep training requirement set forth in Section 210.223.4, RSMo. CCHC staff also continued to provide department-approved safe sleep training and consultations related to safe sleep as needed/requested by regulated and unregulated child care facilities. Consultations focused on assessment of the facility's safe sleep policies, implementation of safe sleep policies and procedures, and opportunities for continued evaluation and improvement of safe sleep practices. Consultants provided 57.5 hours of department approved safe sleep training and 11 hours of consultation related to safe sleep practices, policies, and procedures. The CCHC Program increased the number of safe sleep trainings and consultants available to child care providers in their respective communities, and increased child care provider knowledge of AAP safe sleep guidelines—including the importance of placing infants to sleep on their backs, on separate safe sleep approved surfaces, and without soft objects or loose bedding. These trainings also increased the provider's knowledge of which home environments place infants at the highest risk for unsafe sleep environments and sleep related deaths. As family participation during program services is encouraged, the CCHC Program increased knowledge of safe sleep practices among parents. Child care providers reported increased confidence in communicating with parents regarding concerns with safe sleep procedures implemented in the child care setting. The CCHC Program increased access to evidence-based information and resources regarding safe sleep practices for child care providers and families, and increased knowledge of organizations to contact for free safe-sleep resources including access to cribs for low income families. The capacity for LPHAs to deliver CCHC Program services was severely impacted by the COVID-19 pandemic.

Breastfeeding

Hospitals

The State Breastfeeding Coordinator continued to collaborate with the Missouri Breastfeeding Coalition on statewide initiatives, including the Missouri "Show-Me 5" Hospital Initiative and the Missouri Breastfeeding Friendly Worksite and Child Care programs. In collaboration with DHSS, the Missouri Breastfeeding Coalition hosted a series of webinars with national speakers and speakers from Missouri Baby Friendly hospitals to encourage other hospitals to implement Missouri "Show-Me 5" and Baby Friendly Hospital practices. The collaborative met seven times in FFY22 and enjoyed speakers on topics including neonatal hypoglycemia protocols, Baby Friendly USA (BFUSA) training requirements for staff, BFUSA patient surveys, and breastfeeding equity. The collaborative also had networking calls to share ideas and resources for improving maternity care practices. Funds from the State Physical Activity and Nutrition (SPAN) grant from the Centers for Disease Control and Prevention (CDC) were leveraged to support the webinars. The Missouri Breastfeeding Coalition Board identified lactation training for nursing staff as a major need in Missouri, and an important barrier to Baby Friendly Hospital designation. Statewide training for all health care providers in Missouri continued with the ultimate goal of increasing the number of International Board Certified Lactation Consultants (IBCLCs) in the state. Basic and advanced lactation training was offered at no cost to WIC local agency staff, hospital nurses working with new mothers and infants, and community partners working with breastfeeding mothers. In FFY22, five basic breastfeeding courses were offered to 150 participants, and one 45 hour advanced lactation course was offered to 32 participants. Of those attending the 45-hour course, ten stated that they planned to sit for the exam to become an IBCLC within the next two years; two of them have successfully passed the exam. Another five stated they were taking the training to receive continuing education credits to recertify as IBCLCs; all five

are certified. The remainder took the training to further their professional knowledge and provide better care to the breastfeeding dyads ~~with whom they currently work~~. Over the four years this course has been offered, 24 attendees certified as new IBCLCs and 38 retained certification. Providing training free of charge has been an effective method of growing the IBCLC work force in Missouri.

Local Public Health Agencies (LPHAs)
The BCHW assisted LPHAs in building their capacity to achieve policy and environmental changes that increase access to healthy foods (including breastfeeding support) through the electronic platform Nutrition and Physical Activity Self-Assessment for Child Care (GoNAPSACC). The primary objective of services provided by contractors is to increase the capacity of child care providers to make measurable environmental and policy improvements related to nutrition and physical activity practices within the child care setting. Additionally, statewide breastfeeding efforts and recognition programs are supported through the SPAN grant.

The Missouri WIC program provided additional funding through the Breastfeeding Friendly WIC Clinic Program to WIC local agencies that provided breastfeeding support beyond what is federally required through the WIC program, which includes providing after hours support, classes, support groups, breast pumps and working with other community partners to increase breastfeeding awareness. The state provided education to local agencies and health department professionals on breastfeeding and worked to increase the number of IBCLCs in these facilities, as well as increasing the number of trained peer counselors that can provide mother-to-mother support and encourage partnerships with health care providers and other community organizations. Many of the local agency staff who work in WIC also partner with or work directly on MCH initiatives, and serve many of the same participants. In FFY22, 83 of 116 local agencies provided breastfeeding peer counseling services, and 52 local agencies qualified as Breastfeeding Friendly. Local agency staff participated in the trainings described above and continued to grow in their capacity as lactation providers.

The MCH Services Program supported LPHA efforts to promote breastfeeding initiation at birth and continuation of exclusive breastfeeding through the first six months of life, and continuation of breastfeeding as long thereafter as mother and child desire, including:

- Provision of breastfeeding peer counseling;
- Breastfeeding support groups;
- Individual, community, and provider education;
- Breast pump loan programs; and
- Promotion of breastfeeding friendly worksites and child cares.

The CCHC Program continued to support LPHAs in the facilitation of consultations and trainings to promote breastfeeding practices in the child care setting. CCHC staff provided 31.5 hours of consultation and training on the importance of supporting breastfeeding in the child care setting, its benefits to the children and mothers who are breastfeeding, how to safely and effectively support breastfeeding in the child care setting, and referring child care providers and children in child care and their families to WIC. Consultations and trainings provided by the CCHC Program also assisted in the development and implementation of policies and procedures that encourage and support breastfeeding, and are welcoming and inclusive of all mothers of infants in child care as well as employees who breastfeed, and provide referrals to outside resources- such as WIC. In addition, trainings also focused on safe handling and storage of breastmilk. The CCHC program increased access to evidence-based information and resources regarding breastfeeding for child care providers and families.

Breastfeeding Friendly Sites
The BCHW partnered with the Missouri Chamber of Commerce, the Missouri Chapter of Society of Human

Resource Managers, and the Missouri Council for Activity and Nutrition's (MOCAN) Worksites workgroup to educate employers on the Affordable Care Act (ACA) provision for employers to provide workplace accommodations that enable breastfeeding employees to express breast milk. There was a large turnover in staff at LPHAs and WIC local agencies in FFY22, as evidenced by the high number of staff taking the basic breastfeeding training required for all WIC staff. While approximately 90 new WIC staff take this training in a normal year, nearly 150 new staff members took the training in FFY22. Due to this turnover and staff shortages in the breastfeeding peer counseling program, there was limited outreach for the Breastfeeding Friendly Worksite program. In FFY22, six new businesses were designated as Breastfeeding Friendly Worksites.

Collaboration continued with the Missouri Breastfeeding Coalition and local breastfeeding coalitions to promote the Breastfeeding Friendly Child Care Program. Similar to the "Breastfeeding Friendly Worksite Award," the "Breastfeeding Friendly Child Care" award recognizes child care facilities who meet advanced criteria on breastfeeding support. To date, 74 child care facilities that serve 4,800 children have achieved Breastfeeding Friendly recognition.

The CCHC Program provided consultation and continuing education training to child care providers that promote breastfeeding friendly child care facilities for parents of children enrolled and employees who are breastfeeding. LPHAs utilized the CCHC program as a partner in promoting the Breastfeeding Friendly Child Care and Breastfeeding Friendly Work Place awards, and as an important source of training. An online training is available for this program due to high provider demand. Both of these award programs are low cost, efficient, and provide realistic means to sustain support for breastfeeding families. Partnering with Child Care Aware, the "Breastfeeding Friendly Child Care" award, and corresponding online training was promoted, as well as recognizing those who meet the criteria and earn the award distinction. Plans to further promote the award to parents and providers are being implemented. DHSS, DESE, and MOCAN ensure that these two awards are highlighted during all worksite wellness outreach efforts. The MOCAN worksites workgroup encouraged businesses to implement a wellness program for their staff. The WorkWell Missouri Toolkit was developed to assist employers with reducing risk factors for chronic diseases, poor nutrition (including breastfeeding support), inactivity, stress, and tobacco use. The toolkit is designed to help organizations assess and improve workplace wellness policies and practices. MOCAN members promoted this toolkit by partnering with organizations and assisting businesses to improve health and well-being.

Resources for Parents

The Bureau of Genetics and Healthy Childhood Newborn Health Program participates in statewide educational activities that increase awareness and promote recommended MCH practices, including breastfeeding. The Newborn Health Program also provides free informational resources including Missouri's prenatal and newborn health book, *Pregnancy and Beyond*. The resources raise awareness and educate Missourians on the importance of breastfeeding, and direct the public to resources to assist with breastfeeding. In addition to print materials, the Newborn Health Program maintains a webpage that provides electronic access to similar breastfeeding information/resources. The program will track the distribution of these materials and obtain feedback from its partners on how the materials are used and ways to improve the materials.

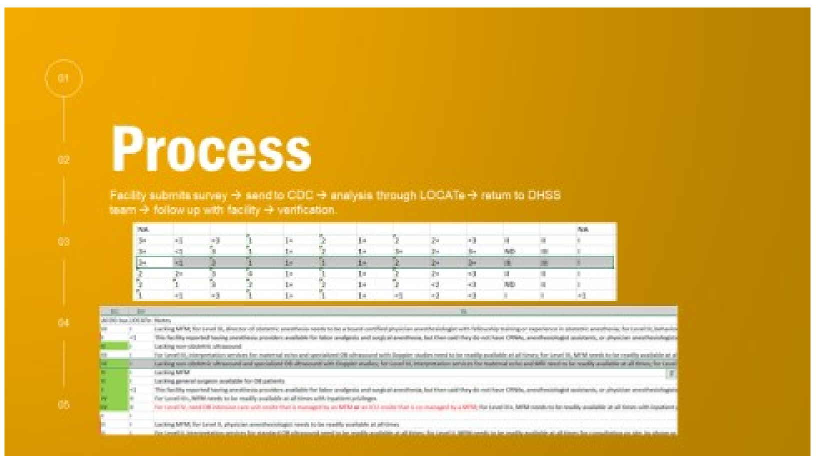
The Title V MCH funded Home Visiting programs' contracted home visitors provided education, resources, and support to enrolled prenatal participants to promote breastfeeding initiation and continuation to at least 6months. In FY22, 11.3% (17/150) of infants were breastfed any amount in the first six months among mothers who enrolled in home visiting prenatally. The Home Visiting programs assessed home visitors' breastfeeding technical assistance needs during monthly subrecipient monitoring calls and provided resources and training opportunities through ongoing communication. Collaboration with the State Breastfeeding Coordinator and the Home Visiting Program continued to assure up to date information, training opportunities, and support for all contracted home visitors.

Other Title V MCH Activities Related to the Perinatal-Infant Health Domain

Risk-appropriate Care

The Office on Women's Health (OWH) continues to implement provisions of Senate Bill 50 (SB50). SB50 requires Missouri birthing facilities to report their levels of maternal and neonatal care to DHSS every three years. The OWH implemented provisions of the legislation by surveying all birthing facilities through the CDCs Levels of Care Assessment Tool (LOCATe). The Office of Epidemiology added enhancements to the CDC-provided version of the LOCATe database to make the entire process electronic and more efficient. LOCATe helped identify which facilities have no formal written transfer plan for high-risk and/or complex cases.

The OWH collaborated with the Missouri Hospital Association (MHA) to send communication to 64 facilities regarding the LOCATe survey. Every hospital that provides birthing services in Missouri is a member of MHA making them a key partner in this effort. Following the first round of surveys, there was a 37% discrepancy in the facilities self-assessed level of neonatal care vs. the LOCATe level of neonatal care. Furthermore, a 76% discrepancy was identified in the facilities self-assessed level of maternal care vs. the LOCATe level of maternal care. The OWH provided intense technical assistance to each facility needing to correct discrepancies and facilitated comprehensive communication within facilities. This communication included a WebEx training with key staff members such as the directors of obstetrics, nursing and quality improvement. The training covered key elements such as the process of implementation, reporting dates and requirements, and goals of the program (*image shows a sample virtual presentation slide*).



It is imperative that all staff within a facility are fully aware of their capabilities according to the standards set forth by the AAP, the American College of Obstetricians and Gynecologists (ACOG), and the Society for Maternal-Fetal Medicine (SMFM). The OWH learned early in the survey process that just because someone is the director of obstetrics, it does not necessarily mean they are fully aware of their facilities capabilities and that communication is key. LOCATe also helped identify 15 facilities that have no formal written transfer plan for high-risk and/or complex cases. The OWH worked with the MC LAN and gathered three different policies/procedures that will be shared as a template with those facilities. Having a written formal transfer plan for complex maternal patients in all facilities will ensure a more standardized approach to caring for these high risk patients. This activity will also increase the likelihood of high-risk, very low birth weight babies being born at a level III+ facility, therefore, reducing infant morbidity and mortality. SB 50 also requires all birthing facilities to have their levels of care verified every three years by either the AAP, ACOG, or DHSS. All but one facility has been verified and the OWH continues to have quarterly calls with ACOG and The Joint Commission's verification team to stay up to date on progress and any changes that need to be communicated. The OWH and the MCH Epidemiology team are working on a neonatal and maternal

level of care map of all the facilities and it will be shared on the Risk Appropriate Care website. This will ensure birthing people can accurately assess what facility(s) meet their needs.

Count the Kicks

In FFY18, the Newborn Health Program partnered with Healthy Birth Day, Inc. to implement and operate a Count the Kicks Public Awareness Campaign program to support pregnant women and reduce Missouri stillbirth rates. According to the CDC, Missouri has the 18th highest stillbirth rate in the country. Missouri vital statistics show that there are approximately 353 stillborn births each year in the state. The continued use of Count the Kicks in Missouri has the potential to save 91 babies every year if Missouri's stillbirth rate decreases by 26 percent, as has happened in neighboring Iowa where the campaign began. Count the Kicks teaches the method and importance of counting baby's kicks in the third trimester of pregnancy. Free Educational materials can be ordered from Count the Kicks at https://www.countthekicks.org/order-materials/. The Newborn Health Program hosted four webinars targeting parents as teachers (PAT) and this resulted in an increase in the number of orders for Count the Kicks resources. The program will continue to partner with a wide range of community health partners to promote the Count the Kicks program.

Newborn Screening

The Newborn Screening Program continued to work towards increasing awareness of newborn screening with the goal of ensuring all newborns have access to newborn screening shortly after birth thereby reducing the risk of mortality/morbidity related to undiagnosed and untreated metabolic, genetic, and endocrine disorders. The program continued to work with the Missouri Midwives Association and the Amish and Mennonite communities to provide education and technical assistance when needed. Missouri law requires all babies born in the state to be screened for over 70 different disorders including hearing loss and critical congenital heart disease. On December 1, 2021, the Newborn Screening Program launched the implementation phase to screen all Missouri newborns for adrenoleukodystropy (XALD). On December 1, 2022, the Missouri State Public Health Laboratory went live with the routine reporting of XALD on the standard newborn screening laboratory reports.

The Newborn Screening Program staff also worked on the following initiatives:

1. Implemented memorandums of agreement with immunology specialists to ensure the timely follow-up of newborn blood spot results that indicate a baby is at high risk for severe combined immunodeficiency (SCID).
2. Updated the newborn screening booklet with new graphics as well as adding recently implemented disorders. This booklet is available free of charge from the department warehouse to all providers involved in newborn screening as well as parents and the general public.
3. Updated the parent survey process. Surveys are distributed via postal mail but now have an option to participate by scanning a QR code for convenience in responding. Messages in regard to newborn screening were posted via social media outlets for Rare Disease Day.
4. Presented about newborn screening during training webinars for PAT and breakout sessions for the Conference of the Young Years. Feedback from the PAT webinars indicated participants gained new knowledge that would aid in educating families.

The Newborn Screening Program contracts with tertiary genetics centers for follow-up of abnormal blood spot screens and other genetics services. Challenges were encountered when the University of Missouri lost its genetics program. However, the program redistributed funds to other genetic centers to cover the gap in services in the central region of the state.

Maternal Health Multisector Action Network

DHSS continued to partner with the University of Missouri Kansas City Institute for Human Development (UMKC-IHD) to facilitate a statewide Maternal Health Multisector Action Network (the Network). The Network was established in

2022 and has over 200 individual stakeholders, 40 of whom are active participants. A diverse, multi-sectored group of maternal and child health, public health, mental and behavioral health, SUD treatment, social services, and other community stakeholders, including LPHAs, were invited to participate in the Network efforts. Focused on a life course framework, the Network promotes a coordinated, multidisciplinary system of care for women of childbearing age and pregnant and parenting mothers to assure health equity, racial/social justice, and a comprehensive continuum of care, including prevention and treatment efforts, for women/mothers with mental health and substance use disorders (SUD). (*More information on the Network is in the women/maternal health narrative.*)

Oral Health

The Office of Dental Health (ODH) continued to educate mothers about the importance of oral health for their overall health and well-being. This is accomplished via continued collaboration with the Missouri Primary Care Association (MPCA) to provide education to women about the importance of dental visits during pregnancy. The ODH supplied infant toothbrushes and *Healthy Smiles from the Start* booklets to the St. Louis Safe Kids Coordinator for use during their baby safety classes. The classes covered safe sleep habits, car seat safety, breast and bottle-feeding and oral care. The training reached pregnant moms, new parents and grandparents and was presented in English and Spanish.

Injury Prevention

In FFY22 SSM Health Cardinal Glennon Children's Hospital (site of Safe Kids St. Louis) provided approximately 933 injury prevention consultations to patients and families for all risk areas. Healthcare providers entered an injury prevention consult order into the electronic medical record (EMR) based on the results of safety assessments. During the safety assessment, the physician was required to ask parents about sleeping concerns for any child under the age of one. If there were sleeping concerns, one-on-one safe sleep education was provided by a member of the safety program. Charlie's Kids Foundation provided a safe sleep environment at no cost, including a portable play yard, fitted crib sheet, sleep sack, bulb suction syringe, pacifier, and the "Sleep Baby Safe and Sound" book. The injury prevention team member who provided the education and resources completed documentation in the patient's EMR. The injury prevention consult was not exclusive to infant safe sleep. The consult also included safety education and resources for all unintentional injury risk areas, including car seat and bike safety, gun locks, medication lock pouches, and home & water safety resources.

Perinatal/Infant Health - Application Year

NPM #5 Safe Sleep – Promote safe sleep practices among newborns to reduce sleep-related infant deaths

Safe Sleep Initiatives

Resources
The Bureau of Community Health and Wellness (BCHW) serves as the state lead for Safe Kids Worldwide to implement and facilitate accomplishment of common goals and objectives concerning childhood injury prevention. BCHW also provides funding to 10 Safe Kids coalitions that serve 60 counties. All 10 coalitions provide unintentional injury prevention services to children aged 0-19 years. The coalitions are led by local public health agencies (LPHAs), non-profit entities, and local hospital systems. The coalitions address injury prevention priorities such as crib safety and safe sleep based on community needs. The coalitions will continue to provide cribs, safe sleep education and resources to parents/caretakers, conduct media campaigns with safe sleep promotion messages, and work with policy makers to address gaps in policies that could prevent safe sleep injuries. The SK coalitions will continue to work closely with law enforcement officers, fire fighters, paramedics, medical professionals, educators, community agencies, businesses, public policy makers, and most importantly parents, children, and adolescents.

All Title V MCH funded Home Visiting Program contracted home visitors will actively promote and provide resources on the ABCs (**A**lone, on their **B**ack, in a **C**rib) of Safe Sleep. Home visitors will coordinate with the Safe Cribs for Missouri program and/or other local partners to obtain portable cribs for families who cannot afford one. Annual performance measure data on safe sleep will be collected on the percentage of infants enrolled in home visiting who are always placed to sleep on their backs, without bedsharing and without soft bedding. This data will be collected at birth and will continue to be updated through twelve months of age. The Home Visiting Program will continue to update and provide all contracted home visitors with information on how to obtain portable cribs and create safe sleep environments as recommended by the American Academy of Pediatrics (AAP). This information will continue to be shared with contracted home visiting agency staff for distribution to enrolled families through a variety of ongoing communication including: posts on the Missouri Home Visiting Gateway Website, the *Weekly Update* emailed to each contracted home visitor and supervisor, monthly subrecipient monitoring calls with contracted agencies, and during annual home visiting professional development events.

The Safe Cribs for Missouri Program in the Department of Elementary and Secondary Education (DESE) Office of Childhood (OOC) provides portable cribs and safe sleep education resources to participating agencies. The program will continue to partner with the Department of Health and Senior Services (DHSS) and Safe Sleep Coalition partners to provide current educational resources to promote SIDS risk reduction and safe sleep environments and practices. Updated DHSS warehouse ordering information will be provided annually to agencies contracting with the Safe Cribs for Missouri Program. All education programs and resources will continue to comply with the evidence-based AAP safe sleep recommendations. As a facilitator of the statewide Safe Sleep Coalition, the Safe Cribs Program will collaborate with the Department of Social Services (DSS) Children's Division (CD), Infant Loss Resources, Inc., pediatric hospitals, and other coalition members to promote implementation of the coalition's strategic plan. The strategic plan was developed with the guidance of the National Institute for Children's Health Quality to achieve the overall goal of reducing sleep-related infant deaths. Updated resources, including a brochure and training videos, will be available on the Home Visiting webpage.

The Safe Cribs for Missouri Program will continue to partner with the Safe Sleep Coalition members to provide safe sleep education and technical assistance to hospitals. Resources will include the safe sleep video, the "This Side Up" t-shirt, and other educational materials available from DHSS at no charge.

The TEL-LINK Program will continue to provide health care service referrals to increase access to care for any Missourian who needs assistance. The program promotes this service through search engine campaigns to provide outreach to underserved populations. TEL-LINK will support and collaborate with community-based programs that provide cribs for low-income families.

The MCH Services Program will continue to contract with the seven LPHAs that selected promoting safe sleep practices among newborns to reduce sleep-related infant deaths as a priority health issue.

- The Vernon, Crawford, and Cole County Health departments collaborate with the WIC office to screen participants who are 32+ weeks gestation and/or have an infant up to one year of age for safe sleep status and risk. Those identified in need are provided a pack-n-play, safe sleep education and a Safe Sleep Survival kit. The Safe Sleep Survival kit is designed using the National Cribs for Kids Program as a model and includes a Philips Soothie Pacifier, HALO Sleep Sack, and a fitted crib sheet. Vernon County is working with their local OBGYN offices to increase awareness of safe sleep programming. On average, the office sees 97 pregnant women per month and each new patient receives a prenatal packet that includes information regarding safe sleep and the services the health department provides. In addition, the health department has billboard messaging regarding the Safe Sleep Program strategically placed at a busy intersection in Nevada. Per the billboard company analytics, on average there are 2.2 people per vehicle (approximately 3,000 impressions daily). In FFY2023, nine pack-n-plays and Safe Sleep Survival kits paired with safe sleep education and set-up demonstration have been provided to new moms. In FFY2023, the Cole County Health Department has provided 25 pack-n-plays and Safe Sleep Survival kits to new moms. Crawford County has provided eight pack-n-plays and 23 Safe Sleep Survival Kits to moms and newborns.

DHSS will continue to participate in the Maternal and Child Learning and Action Network (MC LAN) to assist with implementation of infant morbidity/mortality reduction initiatives throughout the state. The MC LAN launched a Missouri Neonatal Abstinence Syndrome (NAS) collaborative in 2021 and this coincided with implementation of the Obstetric Care for Women with Opioid Use Disorder. Throughout the next two years, participating organizations will focus on changing the model of care for substance-exposed newborns, including supporting the mother-infant dyad and the mother as “medicine;” incorporating the functional assessment model Eat, Sleep, Console into practice; establishing Safe Plans of Care for the mother and infant; and accessing training on stigma and bias reduction. Similar to the maternal projects through the MC LAN, participating hospitals will be required to submit data through MHA for progress and outcomes monitoring.

The Mothers, Infants and NAS ECHO (Extension for Community Healthcare Outcomes), created by the University of Missouri’s Telehealth Network and the Missouri Hospital Association (MHA) to support rural health care providers in caring for the mother-infant dyad with substance exposure, The MCH Director and Maternal/Infant Mortality Coordinator will continue to participate in the bi-monthly ECHO to:

- Improve identification of mother-infant dyads affected by substance use disorder (SUD) by implementing validated screening techniques, guidelines and referrals;
- Support implementation of the Eat, Sleep, Console (ESC) non-pharmacologic care model for optimal health and psychosocial outcomes;
- Provide guidance for use of pharmacologic interventions for infants with in-utero exposure from maternal substance use;
- Identify a framework to connect hospitals with internal and external support/resources for the mother-infant dyad; and
- Ensure mothers with SUD receive appropriate pain and withdrawal assessment and treatment after delivery to stabilize symptoms, promote recovery, and support optimal family function.

Collaboratives

The MCH Director, MCH Services Program team, and Office on Women's Health will continue to participate in, as well as be a resource for, the local and regional infant mortality initiatives, including Generate Health and FLOURISH in St. Louis, Nurture KC in Kansas City, and the Missouri Bootheel Regional Consortium Bootheel Babies & Families initiative in the southeast region of the state. Nurture KC and Missouri Bootheel Regional Consortium are also the two Healthy Start Grantees in Missouri.

- St. Louis: Generate Health's initiatives will focus on five strategic priorities: health equity, maternal and infant health, perinatal behavioral health, immunizations, and making change happen. FLOURISH St. Louis works in coordination with Generate Health. FLOURISH is a collective impact initiative aimed at making St. Louis a place where healthy babies and families flourish. FLOURISH focuses on six priority issues: coordinated quality care, safe sleep, housing, transportation, home visitation and behavioral health.
- Kansas City: Nurture KC's focus is on traditionally low-income families who reside in hard to reach neighborhoods in Missouri and Kansas. They have a special emphasis on cultural competency and strive to help people of all racial, ethnic, and socio-economic backgrounds. Nurture KC has a special focus on safe sleep and coordinates the Safe Sleep Task Force, a group of committed volunteers working to reduce infant deaths through education on safe sleep practices. Nurture KC also provides cribs to eligible families.
- Southeast Missouri: Unsafe sleep is the primary cause of infant mortality in the southeast region of the state. Bootheel Babies & Families has three key focus areas including healthcare, safe sleep habits, and substance misuse and will continue to organize and host the annual low birth weight conference to bring together community members, partners, organizations, and national speakers.

Child Care Providers

The DESE OOC Compliance Section is responsible for licensing and regulating child care programs. Through ongoing regulatory inspections, OOC will verify compliance with licensing rules regarding infant safe sleep. OOC will educate child care providers about infant safe sleep practices through technical assistance and training. Section 210.223.4, RSMo requires all employees of licensed child care facilities who care for infants under one year of age, and any volunteer who may be assisting at the facility to complete department-approved training on the most recent AAP safe sleep recommendations prior to initial licensure or within their first 30 days of employment, and every three years thereafter. OOC will review and approve safe sleep training, and ensure training is available in a variety of formats in order to increase licensed child care providers' knowledge of infant safe sleep practices. During child care inspections, OOC staff will review training records to ensure all required staff and volunteers have successfully completed department-approved trainings on safe sleep for infants within the required timeframes. Child care providers are required to share their approved safe sleep plan that meets the AAP guidelines with families upon enrollment and this helps advance outreach to families.

The Child Care Health Consultation (CCHC) Program will continue to assist licensed child care providers in meeting the safe sleep training requirement set forth in the Missouri Revised Statute 210.223.4. LPHA staff that provide CCHC Program services will continue to provide consultation and training regarding safe sleep practices to child care providers at both regulated and unregulated child care facilities. Consultations will be provided regarding the assessment of the child care program's policies regarding safe sleep, assessment of the implementation of safe sleep policies and procedures, and opportunities for continued evaluation and improvement of safe sleep practices. CCHC Program safe sleep trainings for child care providers will address the elements of safe sleep, such as the importance of placing infants to sleep on their backs, on separate safety-approved sleep surfaces, and without soft objects or loose bedding. These trainings will also increase provider knowledge regarding which infants are at highest risk for sleep-related deaths and/or which home environments place infants at the highest risk for unsafe sleep environments and/or sleep-related deaths. Trainings will also continue to assist child care providers in addressing parent/guardian concerns with safe sleep procedures implemented in the child care setting. CCHC

Program safe sleep trainings and consultations will be updated with the most recent safe sleep guidelines from the AAP by the start of FFY2024. Family attendance during CCHC Program services will be encouraged, and evidence-based information and resources regarding safe sleep practices will be provided to families. Educational materials about sleep-related deaths and safe sleep practices, including organizations to contact for access to free safe-sleep resources, will also be provided to child care providers and parents/guardians.

Breastfeeding

The CCHC Program will continue to support child care and early care and education programs through consultations and trainings to promote breastfeeding practices in the child care setting provided by LPHA staff. LPHA staff will provide consultations and trainings for child care providers to assist in the development and implementation of policies and procedures that: 1) encourage and support breastfeeding, 2) are welcoming and inclusive to all mothers, including employees who breastfeed 3) provide referrals to outside resources such as WIC, and 4) provide education about the important role breastfeeding plays in the health of both the mother and the child. In addition, trainings will focus on safe handling and storage of breastmilk and the benefits of breastfeeding for both infants and mothers. Parent/guardian attendance during all program services is encouraged, and evidence-based information and resources on breastfeeding will be provided to child care providers and families.

Hospitals

The State Breastfeeding Coordinator will continue to collaborate with the Missouri Breastfeeding Coalition on statewide initiatives, including the Missouri "Show-Me 5" Hospital Initiative and the Missouri Breastfeeding Friendly Worksite and Child Care programs. In collaboration with the Missouri Breastfeeding Coalition, DHSS will host a series of webinars led by speakers from Missouri Baby Friendly hospitals, as well as national speakers, to encourage other hospitals to implement the Missouri "Show-Me 5" Hospital Initiative and Baby Friendly Hospital practices. These webinars will alternate between a speaking topic and networking session every other month, allowing hospitals working on improving maternity care practices to benefit from mentorship from staff at designated Baby Friendly hospitals. Funds from the State Physical Activity and Nutrition (SPAN) grant from the Centers for Disease Control and Prevention (CDC) will be leveraged to support the webinars, if this grant is awarded to Missouri for FFY23-28. If the grant is not awarded, the collaborative will continue to meet for networking and volunteer speakers will be utilized. The Missouri Breastfeeding Coalition Board identified lactation training for nursing staff as a major need in Missouri. Lack of lactation training is also a barrier to Baby Friendly Hospital designation. Statewide training for all health care providers in Missouri will continue to increase the number of International Board Certified Lactation Consultants (IBCLCs) in the state. Basic and advanced lactation training will be offered at no cost to WIC local agency staff, hospital nurses working with new mothers and infants, and community partners working with breastfeeding mothers. Funds from the SPAN grant from the CDC will also be leveraged to support the IBCLC training, if this grant is awarded to Missouri for FFY23-28. If the grant is not awarded, the Breastfeeding coordinator will solicit funding from other sources such as WIC and Title V MCH.

Local Public Health Agencies (LPHAs)

The Missouri WIC program will provide additional funding through the Breastfeeding Friendly WIC Clinic program to local WIC agencies that provide breastfeeding support beyond what is federally required through the WIC program. The additional support will include providing after hours support, classes, support groups, breast pumps and working with other community partners to increase breastfeeding awareness. The state will also provide education on breastfeeding to local WIC agencies and health department professionals and work to increase the number of IBCLCs in these facilities. Additionally, the state will work to increase the number of trained peer counselors that provide mother-to-mother support and encourage partnerships with health care providers and other community organizations. Many of the local agency staff who work in WIC also partner with or work directly on MCH initiatives, and serve many of the same participants.

The MCH Services Program will support LPHA efforts to promote breastfeeding initiation at birth and continuation of

exclusive breastfeeding through the first six months of life, and continuation of breastfeeding as long thereafter as mother and child desire. Planned efforts include:

- Provision of breastfeeding peer counseling;
- Breastfeeding support groups;
- Individual, community, and provider education;
- Breast pump loan programs; and
- Promotion of breastfeeding friendly worksites and child care centers.

The MCH Services Program, Southwest Region District Nurse Consultant attends the Missouri Breastfeeding Coalition meetings. The Missouri Breastfeeding Coalition is the state coalition engaged in protecting, promoting and supporting breastfeeding for all Missouri residents. Discussion often includes coalition business, hearing from members of local coalitions about their activities around supporting breastfeeding, sharing updates about interesting news, including state and national happenings, and sharing updates about state initiatives.

The MCH Services Program East/Southeast Region District Nurse Consultant serves on the Board of Directors for Bootheel Babies & Families (BBF). BBF supports, educates, and empowers families and community partners to improve maternal and child outcomes, enabling families to thrive. BBF is a community-led model comprised of six counties in the Bootheel region of the state, working together to lower the Infant Mortality Rate through these key focus areas: healthcare, safe sleep habits, and substance misuse. Each of the six counties (Scott, New Madrid, Mississippi, Pemiscot, Dunklin, and Stoddard) host monthly meetings within their communities.

The CCHC Program will continue to support LPHAs through consultations and trainings to promote breastfeeding practices in the child care setting. LPHA staff will provide consultations and trainings to child care providers to assist in the development and implementation of policies and procedures that: 1) encourage and support breastfeeding, 2) are welcoming and inclusive to all mothers including employees who breastfeed and 3) provide referrals to outside resources- such as WIC- when indicated. In addition, trainings will focus on safe handling and storage of breastmilk and the benefits of breastfeeding for both infants and mothers. As parent/guardian attendance during all program services is encouraged, evidence based information and educational resources and materials regarding breastfeeding will be provided to child care providers and families.

Breastfeeding Friendly Sites

The BCHW will partner with the State Breastfeeding Coordinator, the Missouri Council for Activity and Nutrition's (MOCAN) Worksites workgroup, and other stakeholders to educate employers on the Affordable Care Act (ACA) provision for employers to provide workplace accommodations that enable breastfeeding employees to express breast milk and the Providing Urgent Maternal Protections (PUMP) for Nursing Mothers Act ("the PUMP Act"), which requires employers to provide "a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk" and "reasonable break time", for employees to pump for up to one year after birth. The BCHW and the state breastfeeding coordinator will continue to recognize employers achieving criteria for the Missouri Breastfeeding Friendly Worksite program. To receive the award, employers must address policy for breastfeeding support, educate expecting mothers on their breastfeeding policies, provide a private room appropriate for expressing milk, offer flexible scheduling and make breastfeeding resources available. Many local breastfeeding coalitions and LPHA WIC peer counselors will continue doing outreach to businesses about the importance of worksite lactation support.

The MOCAN worksites workgroup encourages businesses to start and implement a wellness program for their staff. The WorkWell Missouri Toolkit was developed to assist employers with reducing risk factors for chronic

diseases, poor nutrition (including breastfeeding support), inactivity, stress, and tobacco use. The Toolkit is designed to help organizations assess and improve workplace wellness policies and practices. MOCAN members and partners will continue to promote the toolkit and partner with other organizations assisting businesses in the state to improve employee health.

Similar to the "Breastfeeding Friendly Worksite Award," the "Breastfeeding Friendly Child Care" award recognizes child care facilities who meet advanced criteria on providing breastfeeding support. Criteria include having a written policy that reflects support of breastfeeding; providing a welcoming environment for breastfeeding families; offering breastfeeding resources to parents; feeding infants on demand; communicating with families about feeding preferences; and training staff to support breastfeeding parents. Collaboration will continue with the Missouri Breastfeeding Coalition and local breastfeeding coalitions to promote the Breastfeeding Friendly Child Care Program.

Partnering with Child Care Aware, the "Breastfeeding Friendly Child Care" award and corresponding online training will be promoted, and those who meet the criteria to earn the award distinction will be publicly recognized. Plans to further promote the award to parents as well as providers will continue to be implemented. DHSS, DESE and MOCAN will ensure the "Breastfeeding Friendly Worksite" and the "Breastfeeding Friendly Child Care" awards are highlighted during all worksite wellness outreach efforts. The Breastfeeding Program will also promote the new "Breastfeeding Welcome Here" initiative to recognize businesses that agree to train staff to be welcoming to breastfeeding families and to display a "Breastfeeding Welcome Here" sticker on a door or window. This initiative will require little effort on the part of businesses and will help expand community support for breastfeeding by encouraging businesses that may not have a large number of breastfeeding employees to participate and receive breastfeeding support.

The CCHC Program will continue to provide training for child care providers to promote child care facilities as "Breastfeeding Friendly Child Care Facilities" for parents of enrolled children who are breastfeeding and as "Breastfeeding Friendly Worksites" for employees who are breastfeeding. LPHAs will utilize the CCHC Program as a partner in promoting the awards, as well as an important resource for training. In person and online trainings will be available to meet high provider demand. Both of these award programs are low cost, efficient, and provide realistic means to sustain support for breastfeeding families.

Resources for Parents

The Bureau of Genetics and Healthy Childhood-Newborn Health Program participates in statewide educational activities that increase awareness and promote recommended and evidence-based MCH practices, including breastfeeding. The Newborn Health Program also provides free informational resources including Missouri's prenatal and newborn health book, *Pregnancy and Beyon*d. These resources raise awareness and educate Missourians on the importance of breastfeeding and direct the public to resources to assist with breastfeeding. In addition to print materials, the Newborn Health Program maintains a webpage that provides electronic access to similar breastfeeding information/resources. The program will track the distribution of these materials and obtain feedback from its partners on how the materials are used and ways to improve them.

The Title V MCH funded Home Visiting Programs contracted home visitors will provide education, resources, and support to enrolled prenatal participants to promote breastfeeding initiation and continuation through at least 6 months. Annual performance measure data will be collected on the percent of infants who were breastfed any amount during the first 6 months among mothers who enrolled in home visiting prenatally. The Home Visiting Program will assess home visitors' breastfeeding technical assistance needs through monthly subrecipient monitoring calls and provide resources and training opportunities through ongoing communication. Collaboration with the State Breastfeeding Coordinator will continue to assure up-to-date information, training opportunities, and

support for all contracted home visitors.

Other Title V MCH Activities Related to the Perinatal-Infant Health Domain

Risk-appropriate Care

The OWH will continue to implement provisions of Senate Bill 50 (SB50). SB50 requires Missouri birthing facilities to report their levels of maternal and neonatal care to DHSS every three years. The OWH will implement provisions of the legislation by surveying birthing facilities through the CDC's Levels of Care Assessment Tool (LOCATe). LOCATe will help identify which facilities have no formal written transfer plan for high-risk deliveries. The OWH will collaborate with the MHA to assist identified facilities with incorporating a formal written transfer plan for high-risk patients. Having a written formal transfer plan in all facilities will ensure a more standardized approach for caring for these high-risk patients. This activity will also increase the likelihood of high-risk, very low birthweight babies being born at a level III+ facility, therefore reducing infant morbidity and mortality. SB 50 also requires all birthing facilities to have their levels of care verified every three years by either the AAP, The Joint Commission, or DHSS.

Count the Kicks

In FY18, the Newborn Health program partnered with Healthy Birth Day, Inc. to implement and operate a Count the Kicks Public Awareness Campaign program to support pregnant women and reduce Missouri's stillbirth rates. According to the CDC, Missouri has the 18th highest stillbirth rate in the country. Missouri vital statistics show that there are approximately 353 stillborn births each year. The continued use of Count the Kicks in Missouri has the potential to save 91 babies every year if Missouri's stillbirth rate decreases by 26 percent, as has happened in neighboring Iowa where the campaign began. Count the Kicks teaches the method and importance of counting a baby's kicks in the third trimester of pregnancy. Free educational materials can be ordered from Count the Kicks at https://www.countthekicks.org/order-materials/. The Newborn Health program will continue to partner with a wide range of community health partners to promote the program.

Newborn Screening

The Newborn Screening Program will continue to work towards increasing awareness of newborn screening with the goal of ensuring all newborns have access to newborn screening shortly after birth, thereby reducing the risk of mortality/morbidity related to undiagnosed and untreated metabolic, genetic, and endocrine disorders. Missouri law requires all babies born in the state to be screened for over 70 different disorders, including hearing loss and critical congenital heart disease. The program will continue to work with birth providers in both the medical center setting and the homebirth community to provide education and technical assistance. In addition, the program will network with Community Health Workers and Doulas to disseminate accurate, up to date information about newborn screening during pre and postnatal visits.

The Newborn Hearing Screening Program (NHSP) will continue to work towards ensuring newborns are screened by 1 month of age, diagnosed by 3 months of age, and enrolled in early intervention (EI) by 6 months of age. The NHSP will continue to pursue a reduction in loss to follow-up/loss to documentation to ensure newborns do not miss the opportunity to develop adequate language skills. Activities will include family support, referrals to EI, and education of health professionals and service providers.

Oral Health

Through continued collaboration with the Missouri Primary Care Association (MPCA) to provide education to women about the importance of dental visits during pregnancy, the Office of Dental Health (ODH) will continue to educate mothers about the importance of oral health for their overall health and well-being. The ODH will also continue a pilot program with LPHAs to provide oral health education, fluoride varnish and a warm hand off to a dental clinic for pregnant

women. The LPHAs will emphasize the importance of a dental visit during pregnancy and track the number of pregnant women who keep the appointment. The ODH is also in negotiations with Uzazi Village, which currently provides non-dental, medical care to an underserved population and is located in an urban setting. The ODH is exploring the feasibility of contracting with a dental clinic to provide dental services to the clients at this clinic.

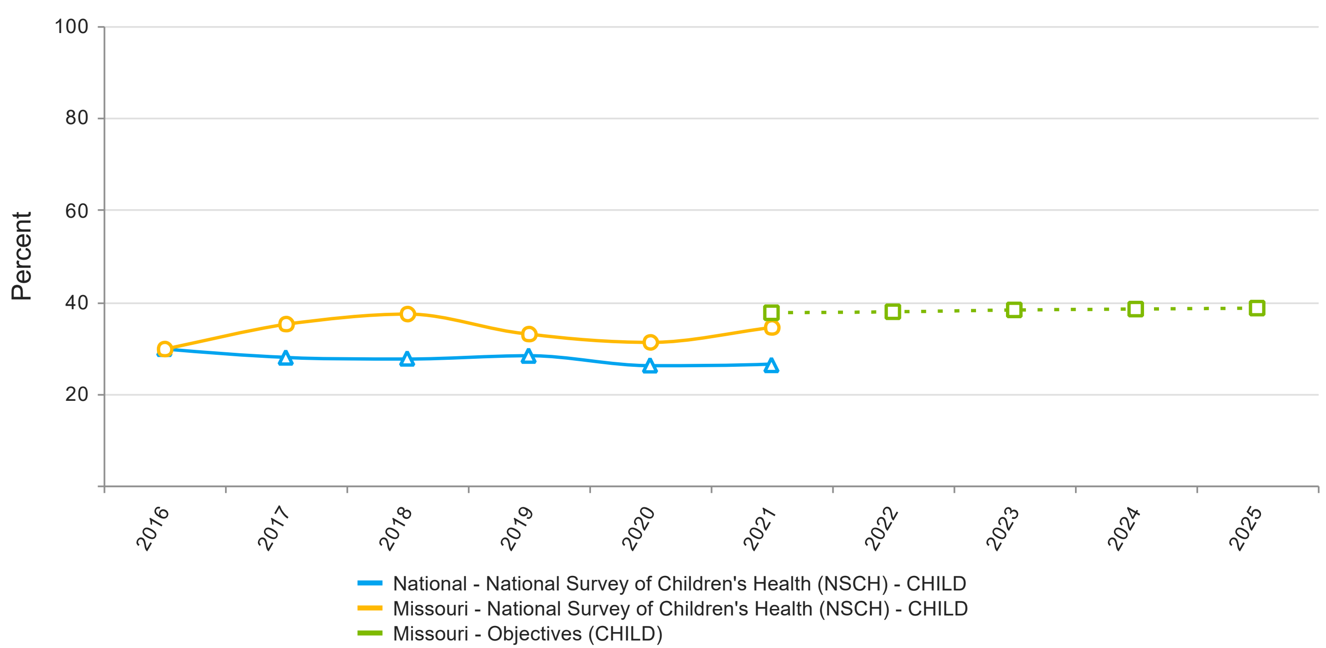
Maternal Health Multisector Action Network

Through participation in the Association of State and Territorial Health Officials (ASTHO) and the Association of Maternal and Child Health Programs (AMCHP) Promoting Innovation in State & Territorial MCH Policymaking (PRISM) Learning Community, DHSS is partnering with the University of Missouri Kansas City Institute for Human Development (UMKC-IHD) to facilitate a statewide Maternal Health Multisector Action Network (the Network). The Network will continue its effort and dedication in connecting stakeholders with existing resources and toolkits and fostering partnerships amongst stakeholders. The Network will work closely with the key partners in the state to reassess and reevaluate the gaps in the support system for mothers and their young children affected by maternal substance use and mental health, and address gaps in the statewide support system. This involves strategic planning for long-term funding and sustainability. The Network will continue to connect stakeholders to increase collaborations and decrease siloes. The Network workgroups will continue focusing on actions to address the evolving needs of the mothers and their children and families. In addition, the Network will recruit mothers to participate in the Mothers' Advocacy Network, which will be launched in FFY 2024. A goal of the Mothers' Advocacy Network will be to prepare mothers to advocate with decision makers on behalf of mothers with SUD and mental health challenges.

Child Health

National Performance Measures

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2019	**2020**	**2021**	**2022**
Annual Objective			37.6	37.8
Annual Indicator	37.4	32.8	31.2	34.3
Numerator	174,971	156,884	145,507	154,430
Denominator	467,457	477,809	465,671	450,203
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data				
	2019	2020	2021	2022
Annual Objective			37.6	37.8
Annual Indicator	32.8	31.2	31.2	
Numerator	156,884	145,507	145,507	
Denominator	477,809	465,671	465,671	
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	
Data Source Year	2018_2019	2019_2020	2019_2020	
Provisional or Final ?	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	38.2	38.4	38.6

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			50	100
Annual Indicator	33	33	352	486
Numerator				
Denominator				
Data Source	MO DHSS Go NAPSACC data	MO DHSS Go NAPSACC data	MOPHIRS Report - CLPHS Service Log	MO DESE CCHC program
Data Source Year	2019	2019	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	200.0	300.0	400.0

State Performance Measures

SPM 1 - Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

Measure Status:	Active

State Provided Data

	2018	2019	2020	2021	2022
Annual Objective	71.5	71.7	71.9	72.1	72.3
Annual Indicator	70.9	74.2	72.5	72.5	69.8
Numerator	923,366	955,152	928,942	928,942	905,262
Denominator	1,302,509	1,288,116	1,280,625	1,280,625	1,296,180
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2019_2020	2020_2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	72.5	72.7	72.9

State Action Plan Table

State Action Plan Table (Missouri) - Child Health - Entry 1	
Priority Need	
Reduce obesity among children and adolescents.	
NPM	
NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	
Objectives	
By 2025, Increase the percent of children, ages 6 through 11, who are physically active at least 60 minutes per day in the past week from 37.4% (NSCH 2017-2018) to 37.77%.	
Strategies	
Implement community-based initiatives to promote and support healthy eating and active living.	
Support activities and facilitate partnerships to create environments that support healthy eating and active living.	
Encourage local health department staff to participate in school wellness committees at school districts within their jurisdiction.	
Increase school-community collaborations to promote health.	
Collaborate with DESE and other stakeholders to support schools to align with the Whole School, While Child, Whole Community model.	
Support school districts in implementation of comprehensive school physical activity programs.	
Build program and policy evaluation capacity.	
ESMs	**Status**
ESM 8.1.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.	Active
NOMs	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	

State Action Plan Table (Missouri) - Child Health - Entry 2

Priority Need

Enhance access to oral health care services for children.

SPM

SPM 1 - Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

Objectives

By 2025, Increase the percent of children, ages 1 through 17, who had a preventive dental visit in the past year from 70.9% (NSCH 2017-2018) to 71.61%.

Strategies

Establish collaborative relationships between non-oral health professionals and oral health professionals to strengthen the focus on oral health in the medical home and to ensure coordinated care.

Develop and distribute oral health educational information and materials geared toward the public and health professionals.

Provide oral health education at community-based settings.

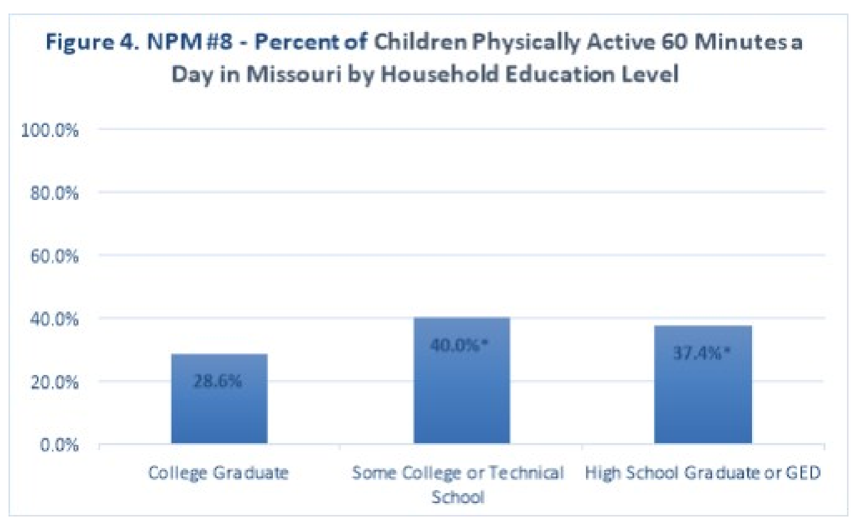
Promote the delivery of preventive oral health care for children and adolescents by oral health professionals in school-based programs.

Build program and policy evaluation capacity.

NPM #8 Physical Activity – Reduce obesity among children and adolescents

Please note that some of the strategies and activities listed below impact both the Child and Adolescent Health domains. To avoid duplication, the information will only be listed in this domain, for which it is anticipated to have a larger impact, but it should be noted that some strategies and activities may address a wider age range.

According to the 2020-2021 National Survey of Children's Health (NSCH) data, 34.3% of Missouri children ages 6-11 years were physically active for at least 60 minutes every day, compared to their national counterparts (26.3%). Girls (29.2%) less likely met the physical activity benchmark than boys (38.9%). Survey findings suggest lower physical activity levels for children from college graduate or higher households (Figure 4). Children with public insurance only (39.6%*) were more frequently physically active for an hour daily than their national counterparts (28.1%).



Obesity is complex, and environmental and behavioral factors play a critical role. Healthy eating and regular physical activity are critical to achieving and maintaining good health. Missouri works to implement best practices to ensure all Missourians live in communities that support these healthy habits. The 2021 Behavioral Risk Factor Surveillance System (BRFSS) reports more than two of every three adults are overweight (32.0%) or obese (37.2%). Some degree of adult obesity is likely reflective of poor dietary habits and sedentary behaviors formed in childhood that persist into adulthood. With that in mind, it is critical to support healthy habits early. About 80% of Missouri school districts provided data through the Department of Elementary and Secondary Education (DESE)/ Department of Health and Senior Services (DHSS) data system collaborative. Of those students represented, 63,100 (8.3%) had asthma and had medication at home or school for the 2021-2022 school year. Additionally, there was a 0.34% increase in the proportion of students with diabetes. Obesity and chronic condition prevalence rates are significantly higher among African American and Hispanic communities, which compounds the gap in health equity and educational attainment for children from these minority groups.

Addressing obesity requires collaboration from multiple organizations. One way Missouri brings these partners together is through the Missouri Council for Activity and Nutrition (MOCAN), the statewide obesity prevention council facilitated by University of Missouri Extension (UME). MOCAN's member organizations are structured into workgroups specific to settings or topics: schools & child care, physical activity, worksites, food systems, and healthcare. DHSS staff supported through MCH funding participated in MOCAN workgroups to support statewide

improvements in physical activity.

Policy and Environmental Changes

Developing a healthier community involves creating a culture that promotes the benefits of physical activity and allows access to safe places to be active. Public policy is essential in supporting opportunities for children, youth, and families to develop healthy physical activity practices. Strategies to promote policy and environmental changes that can foster healthier communities and safe places to be physically active include collaboration with internal partners, local public health agencies (LPHAs), youth, and statewide and community organizations with similar goals. In FFY22, program staff in the Bureau of Community Health and Wellness (BCHW) continued to contract with LPHAs to implement policy and environmental changes that increased opportunities for children to engage in physical activity across multiple settings.

Child Care Wellness contracts supported two LPHAs in providing training and technical assistance to child care providers in improving child care physical activity and nutrition policies and practices. LPHAs used the University of North Carolina's

Nutrition and Physical Activity Self-Assessment for Child Care (Go NAPSACC) online system to assist child care providers to improve children's health through 47 practices, policies, and environments that instill habits supporting lifelong health and well-being. The Child Care Health Consultation (CCHC) Program Manager supported LPHA staff that provide Go NAPSACC technical assistance and consultation to child care providers.

DHSS, through BCHW and the Community Food and Nutrition Assistance program, continued to support child care providers in implementing policies and practices that support physical activity. DHSS provided training, resources and technical assistance related to physical activity policies and practices to assist childcare providers in their efforts to become Missouri MOve Smart child care facilities. The DESE CCHC Program continued to provide training and consultation for child care providers and health promotion for children. Training focused on: reinforcing the importance of physical activity, incorporating physical activity into daily routines, and implementing evidence-based policies and procedures that support physical activity for staff and children. Consultations centered on: the recommended guidelines for physical activity and nutrition, addressing facilitators and barriers to indoor and outdoor physical activity, implementing screen time policies, and the Nemours Children's Health Physical Activity Learning Sessions (PALS) training content. Additionally, the CCHC Program offered training on becoming a Missouri MOve Smart Child Care.

With the support of the State Physical Activity and Nutrition Grant, the BCHW contracted with Missourians for Responsible Transportation to lead the Missouri Complete Streets Advisory Committee. This committee consists of active transportation experts and advocates that collaborate to assist communities with improving the accessibility of non-motorized transportation throughout the state. To date, 190 linear miles connecting everyday destinations are planned through the Complete Streets polices and active transportation plans. The plans are expected to reach over 58,649 Missouri citizens.

Professional Development, Training, and Resources

BCHW staff were also available to provide training and technical assistance on obesity prevention strategies for local communities. To ensure staff are well-informed and can provide quality assistance, they participated in professional development opportunities, such as the Academy of Nutrition and Dietetics Food and Nutrition Conference and Expo, the Southern Obesity Summit, and other evidence-based training (i.e. Physical Activity and Public Health Practitioner's Course on Community Interventions).

BCHW continued to support Missouri communities in their obesity prevention efforts by providing professional development and training opportunities for key stakeholders. Additionally, technical assistance and resources were

available to assist efforts in increasing regular physical activity and healthful eating. BCHW also assisted communities in assuring interventions are inclusive of individuals of all abilities.

The School Health Program (SHP) supported school nurses to engage with students and families in addressing overweight/obesity in children. School nurses and school mental health staff (social workers and counselors) requested help in having difficult conversations related to eating disorders, being overweight and behavioral health issues with parents. SHP sponsored education and professional development in best-practices through collaboration with stakeholders and organizational partners to make tools and resources available to school nurses. These activities have facilitated connections between students and families, schools, and communities as evidenced by the number of sessions offered for school staff and the response from participants related to increased comfort level in having difficult conversations with parents.

The CCHC Program provided 155.5 hours of training and consultation for child care providers on best practices for physical activity and nutrition, implications of healthy weight on overall health, and the role of breastfeeding in child nutrition and obesity prevention. Sessions also focused on physical activity and its positive effects on weight, physical and mental health, and the development of motor, social/emotional, and cognitive skills. Trainings also addressed how to incorporate structured and free active play into daily routines, AAP guidelines for limiting screen time, and age appropriate activities to promote physical activity. In June 2022, 25 CCHC Program trainers completed Nemours PALS 'train the trainer' sessions, and are now equipped to provide physical activity trainings to child care providers.

The CCHC Program provided 278.75 hours of health promotion for children on the topics of physical activity and nutrition. Topics were delivered in fun, developmentally appropriate, and engaging ways. Health promotion increased children's knowledge on the importance of physical activity and enabled children's participation in fun activities through songs, books, and games that promote structured and unstructured play. Health promotion also provided visual and hands on demonstrations of healthy snacks and drinks, and resources to share with families about physical activity and nutrition. CCHC Program services continued to use the '12345 Fit-Tastic! Healthy Lifestyles Initiative messaging and guidelines, which incorporate nutrition and physical activity guidelines into resources for child care providers and children. The initiative is developed by the Kansas City Healthy Lifestyles Collaborative and funded by Children's Mercy Hospital. CCHC Program services increased access to information about physical activity and nutrition guidelines for children and families, continued to be inclusive of adults and children of all abilities, and encouraged family participation in program services. CCHC Program services continued to provide evidence-based resources and educational materials for child care providers and the parents/guardians of children in child care. The capacity for LPHAs to deliver CCHC Program services was severely impacted by the COVID-19 pandemic.

Partnerships
BCHW staff participated in a number of coalitions and partnerships that help to advance progress towards the state's goals of improving access to nutritious foods and physical activity throughout Missouri. Examples of groups in which staff were involved with include: MOCAN, Missouri Convergence Partnership, Missouri Coordinated School Health Coalition, DESE Wellness Workgroup, and the Missouri Complete Streets Advisory Committee. Staff have the opportunity to network and identify collaborative opportunities with other organizations working on similar goals, share resources and leverage funding to expand the reach of their work.

The MCH Services Program continued to contract with the 22 LPHAs that selected promoting physical activity and reducing and preventing overweight/obesity as the Priority Health Issue to be addressed in their FFY 2022-2026 MCH Services contract work plan. LPHA efforts to prevent and reduce overweight/obesity and increase physical

activity among children and adolescents included:

- Pulaski County Health Department has increased the number of children and adolescents engaged in physical activity for at least 60 minutes/day. The Adolescents Committed to Improvement via Exercise (A.C.T.I.V.E.) Program, which has been implemented by four after school programs, has collectively impacted over 100 children and adolescents who were trained to complete a 5K. In addition, the health department facilitates an AquaCize class in the summer months for women of childbearing age and children. The class is held at a local pool and encourages children and families to be active (*Pictures below.*)

- Randolph County Health Department staff increased community knowledge regarding physical activity and nutrition by appearing at several community events with a smoothie bike. The bike grabs attention and is a fun tool to teach attendees about making healthy food and physical activity choices. Children and adolescents at the events made fruit smoothies and discussed what makes a smoothie “healthy”. They added ingredients to the blender and pedaled for 30 seconds. (*Picture of Smoothie Bike below.*)

- Clay County Public Health Center increased community knowledge by hosting a Family Fun Day in North Kansas City where over 500 women, children, and their families attended. They had several fun activities focused on reducing obesity among children and adolescents. Tony Temple, founder of Temple Made Fitness (TMF), authored the book *Animal Movement*, which inspires children to play, move and use mindful journaling to spark imagination and physical activity. Tony led a session for children from his book. There were also several partners who brought interactive games for children. To further engage young children, there were face painters who painted sports themes, like soccer balls and basketballs, as well as images of fruits and vegetables.

SPM #1 Oral Health – Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last

year

According to NSCH 2020-2021 data, nationally 75.1% of children ages 1-17 years old had a preventive dental visit in the past year. This was a greater percentage than in Missouri (69.8%). A lower percentage of Missouri children ages 1-5 years old (48.2%) had a preventive dental visit than their national counterparts (54.7%). This age group also had a lower percentage than Missouri children ages 6-11 years old (76.5%) and 12-17 years old (80.7%). Children who most frequently had a preventive dental visit in the past year lived in college educated households (76.9%) followed by some college or technical school (69.4%), and high school graduate or GED (36.0%) households. Children with private insurance only (76.8%) more frequently had a preventive dental visit than publicly insured only (64.3%) and uninsured (40.1%) children. Children in two-parent, married households (72.4%) reported having more frequent preventive dental visit in the past year than single parent households (67.8%).

Ordering information for oral health resources from the Office of Dental Health (ODH) and the Missouri Primary Care Association (MPCA) was provided to all MCH funded home visitors to promote National Children's Dental Health Month, which is observed in February. National Children's Dental Health Month was also highlighted in the Home Visiting Program's newsletter, *Quality Outlook*, and in the *Weekly Update* emailed to all MCH funded home visitors and supervisors. The weekly update provided links to materials, webinars, and other resources that highlight the importance of preventive annual dental care in children. The Missouri WIC Program collaborated with the ODH to procure infant and toddler toothbrushes to have them available in local WIC agencies.

Additionally, literature is available to LPHAs, dental offices, and community outreach events such as health fairs. The importance of regular dental care is also stated within the context of the ODH's promotion of the use of dental sealants. Referrals and care coordination components of the Preventive Services Program (PSP), described in more detail below, also encourage regular dental visits for children, particularly those identified as having a dental need.

The ODH experienced continued success with the PSP, an evidence-based fluoride varnish and oral health education program. Each child receives an oral health screening by a dental professional, two applications of fluoride varnish, oral health literature and supplies, and oral health education. The oral health education is either provided by school staff or the dental professionals that volunteer to operate PSP. Educational materials are provided by the ODH (for grades K-12), but some schools choose to use their own materials. Prior to COVID-19, PSP served about 90,000 children each year; in FY22 PSP served 42,500 children. Due to the Coronavirus pandemic, many schools did not allow visitors for the 2020-2021 and 2021-2022 schools years. For those schools, PSP adapted to provide grade-specific, narrated educational videos for teachers to show their classes. Additionally, for schools that did not have their own educational materials or training, a Zoom call could be scheduled with the school's Oral Health Consultant. Oral health supplies and literature were still distributed, and fluoride varnish was either applied by a trained school staff member or a parent/caregiver. The ODH's Oral Health Consultants were available to school nurses to advise them on possible dental health needs. School nurses could take pictures of a child's teeth if there was a questionable issue and an Oral Health Consultant helped to determine if there was a need for dental care. Only a few school nurses had questions about oral care during these school years. Starting in the 2021-2022 school year, PSP went back into the schools and participation has steadily increased. Since 2014, there has been a 5.3% decrease in the decay rate among PSP participants. Unfortunately, there has been an increase in PSP children who have an unmet dental need. A survey conducted by Lincoln County Health Department found nearly 61% of PSP participants needed early dental care in 2023 as opposed to 2020, when about 39.5% of children needed early dental care. This could be due to the oral health workforce shortage. The Elsberry school district, located in Lincoln County, recently told us how grateful they were for the PSP program. The statistics at their school district indicate a great need for PSP.

Through a HRSA grant, the ODH supported 22 LPHAs providing fluoride varnish services to WIC participants, most of whom are also Medicaid eligible. LPHA staff provided fluoride varnish services twice a year and received Medicaid

reimbursement. The first few years of this program, the Medicaid reimbursement rate was about $13.50, however, with the Medicaid remuneration rate nearly doubling for some procedures, the fluoride varnish reimbursement rate (by a medical practitioner) is nearly $22. Additionally, the fluoride varnish costs less than a dollar per application and this makes the program very sustainable. Fifteen of these LPHAs are continuing this fluoride varnish program because it is sustainable, but most importantly, it provides the children with fluoride varnish, something that may not otherwise be available in their area.

Much of Missouri is a dental health provider shortage area, meaning many Missourians are not located close to a dentist nor do they have a dental home. COMTREA (a Federally Qualified Health Center (FQHC)) assists parents in understanding the importance of oral health and linking children with dental care to address barriers to dental services such as transportation, ability of parents to miss work or pay for services, and knowledge of available services. The ODH worked with COMTREA to provide assistance and support as needed in the form of educational materials and handouts.

The SHP coordinated with the ODH and other programs to provide evidence-based information, resources, and professional development to school nurses. This enabled them to utilize best practices when educating children and parents about oral health, including promoting the need for annual dental visits and regular preventive practices.

The ODH continued to promote the use of dental sealants as an effective means of preventing decay on newly erupted molars and is actively seeking new partnerships to provide dental sealants in school-based clinics. Through grants not funded by the Title V MCH Block Grant, the ODH continues to work with two LPHAs and two dental health clinics to apply sealants in their clinics and at local schools. ODH is hoping to contract with two other dental hygiene schools to bring this program to more schools. During the 2021-2022 school year, were 503 children received dental sealants. Over the past five years, 6,737 sealants were placed on 1,997 children.

The TEL-LINK Program referred 204 callers to dental clinics to increase awareness of community resources to access dental health services. The program continued to provide targeted outreach campaigns through online search engines to the underserved population through effective marketing strategies. The campaign reached over 175,000 Missourians resulting in 7,491 individuals taking action to find out more.

The CCHC Program provided 32.75 hours of trainings and consultations for child care providers on the implications of oral health on overall health, and evidence-based guidelines, policies and procedures that promote optimal oral health among children. As a result of CCHC consultations and trainings, child care providers had increased knowledge of the link between a child’s oral health and their overall health and well-being. Providers also reported increased awareness of oral health promotion strategies they can implement at their facility. CCHC trainings also increased child care provider knowledge regarding identifying abnormal oral conditions in infants and young children. Trainings also focused on oral care implications for children with special healthcare needs (CSHCN), and overcoming challenges and barriers to providing oral care among the CSHCN population. The CCHC Program also provided 105.5 hours of health promotion on oral health topics to children in child care. Sessions were delivered in fun, developmentally appropriate, and engaging presentations. As a result, children could verbalize why their teeth are important, what could happen if they don’t care for their teeth, and how to identify unhealthy snacks and beverages that can harm their teeth. These children also participated in fun hands on demonstrations of proper brushing and flossing techniques and were provided with educational materials, toothbrushes, and toothpaste to enhance their excitement around oral care and their ability to participate in oral care at home. The educational materials also increased parental awareness of the importance and recommended frequency of preventive dental checkups. CCHC services continued to: 1) be inclusive of adults and children of all abilities, 2) encourage family involvement in program services, 3) provide children’s oral health service referrals to outside community resources,

and 4) optimize the overall health of children in child care. The capacity for LPHAs to deliver CCHC Program services was severely impacted by the COVID-19 pandemic.

The MCH Services Program supported LPHA efforts to:

- provide education on the importance of adequate dental care and overall oral health;
- collaborate with partners to provide screening, referral and direct provision of preventive dental services for oral health needs; and
- increase the number of children, ages 1 to 17 years, receiving a preventive dental visit in the last year.

Additionally, the MCH Services Program continued to contract with the eight LPHAs that selected enhancing access to oral health care services for children as the Priority Health Issue for their FFY 2022-2026 MCH Services contract work plan.

- Wright County Health Department increased oral health knowledge among internal staff by training three nurses, one nutritionist and three clerks using the Varnish Volunteer Training for Preventative Services. A dental varnish program has been implemented at the health department and staff can provide oral assessment, education, referrals and applications of fluoride varnish to pregnant women, and children up to age 18 years. This service increased the number of children and pregnant women that receive an oral health screening and fluoride varnish application. 135 children received an oral health screening and education; and 56 children received fluoride varnish application. In addition, the health department developed oral health kits, which included a toothbrush, toothpaste, floss, and educational materials. The kits were distributed to all children ages 1-17 who visited the health department for any service. About 135 children received the kit. This increased the number of children that have access to oral health supplies and could participate in oral hygiene (see picture of kits below).
- Audrain County Health Department increased knowledge regarding oral health. The health department also increased access to oral hygiene products (toothbrushes, toothpaste and floss) by providing oral health programs and education to schools, daycare centers and at community events.In total, 833 students and 139 children in daycare benefited from this initiative. *(Picture below.)*

Other strategies included providing education to the public, city officials, dental and medical professionals, and public health authorities about the safety and effectiveness of community water fluoridation in preventing dental caries. The ODH also continued efforts to improve the Missouri Oral Health Surveillance System through updating oral health fact sheets and compiling regional reports that provide oral health statistics and related information.

Through a grant not funded by Title V MCH, the ODH is contracting with two dental clinics and two dental hygiene schools to provide teledentistry services to schools, targeting the counties with very few or no dentists. This will provide dental services to children who may not have access to those services.

The ODH's Five-Year State Oral Health Plan was finalized and disseminated and is still a subject of ongoing communication with its partners.

ODH continued its efforts to:

- Increase access dental care by providing education about the importance of maintaining the adult dental benefit among MO HealthNet recipients. Information is distributed to policymakers, dental providers, leaders, and oral health stakeholders via the DHSS website and partners like the Missouri Coalition for Oral Health and Missouri Dental Association;
- Contract with the MPCA to provide education and technical assistance to State Dental Directors from all FQHCs in Missouri. The MPCA also assisted the ODH with distributing educational materials regarding the importance of a dental health home for everyone, particularly for pregnant women, and children;
- Support the development of the oral health workforce in Missouri through collaborations with the DHSS Office of Rural Health and Primary Care on incentive programs for dental professionals; and
- Implement the referral portion of PSP, which links children with an identified dental need to local dental providers. This is coordinated through school nurses and other local champions.

Other Title V MCH Activities Related to the Child Health Domain

Developmental Screening

The CCHC Program continued to provide consultations and trainings for child care providers around health and safety topics, including social-emotional learning, language/communication, cognitive, and movement/physical development in children. The CCHC Program provided 139.75 hours of training and consultation for child care providers regarding developmental screenings and child growth and development.
The CCHC Program also targeted children by providing 189.25 hours of education on multiple areas of child development, including physical growth and development. Information and resources provided were developed in accordance with the Centers for Disease Control and Prevention (CDC) “Learn the Signs. Act Early.” (LTSAE) Program. Through CCHC Program services, child care providers and parents/guardians of children in child care have increased knowledge about the importance of developmental milestones. Child care providers also reported increased confidence in communication strategies to approach challenging discussions such as when they suspect a child is not meeting developmental milestones.

Inclusion Specialists provided parents with a listing of child care providers based on their location. Parents could choose child care that meets the needs of their child and this increases the likelihood of maintaining placement, which will support the educational needs of the child. Inclusion Specialists provided 316 onsite consultations to assist child care providers in developing adaptations and strategies to include CSHCN in everyday classroom activities. They also assisted in setting achievable goals for the child’s ongoing development. Inclusion Specialists delivered group training to increase the knowledge base of 1,904 child care providers in Missouri on how to include CSHCN. Through the social-emotional learning (SEL) project, specialists also delivered evidence-based training to child care professionals to help them understand how children develop socially and emotionally The training also included intervention strategies to foster social-emotional development in practical ways. 44 children were screened as part of the inclusion SEL project, 7 of the 44 scored “at-risk” or above the cut-off for the Ages and Stages Questionnaire®- Social Emotional (2nd Edition). This score indicates a potential for delays or disabilities in social-emotional development and further evaluation or assessment is recommended. Depending on a child’s age, families were either referred to First Steps or the local school district.

The Home Visiting Program’s contracted home visitors used the Ages and Stages Questionnaire®- 3 (ASQ-3), a validated screening tool through Maternal, Infant and Early Childhood Home Visiting (MIECHV), Building Blocks (BB), and Healthy Families Missouri Home Visiting (HFMoHV) programs. The ASQ-3 consists of 21 questionnaires that can be used to identify a child’s developmental needs. Home visitors provided referrals for children who scored below the cut-off points indicating a need for additional developmental information and activities, community support,

or early intervention services through Missouri First Steps or Early Childhood Special Education to contribute to improved school readiness. Annual performance measure data was collected on the percentage of ASQ-3 developmental screenings conducted at the specified time points of 9, 18, and 30 months of age. In FY22, 89.2% (379/425) of enrolled children ages 9, 18, and 30 months received a developmental screening using the ASQ-3. 59.4% (19/32) of children who scored below the cut-off points were referred for further support. A nurse from a LPHA in St. Louis shared that during the 18 month visit she used the ASQ-3 and identified a child who lacked verbal communication. At 21 months, the child was referred to First Steps and is now receiving speech therapy to further his language skills.

Additionally, home visitors continued best practices to screen all children, birth to age three, using the ASQ:SE-2. Home Visitors also provided developmental activities for parents/children who scored in the “monitoring” range and assisted families in accessing services as appropriate. The Home Visiting Program provided all contracted home visitors with education on childhood mental health conditions and warning signs.

The Newborn Health Program partnered with a variety of community health providers to distribute the *Pregnancy and Beyond* booklet, as well as other educational materials that provide information on developmental screening. The program tracked the distribution of these materials and obtained feedback on ways to improve the materials. Based on the feedback, we are planning to have the booklet translated into Bosnian, Russian and Ukrainian. We are also adding information related to Marijuana use during the prenatal and postnatal period.

The Missouri WIC Program implemented the public awareness campaign “Talking is Teaching: Talk, Read, Sing” to help parents recognize their ability to improve their children’s early brain and vocabulary development. Training was provided statewide to WIC agencies, home visitors, Head Start, Parents as Teachers, health care providers, libraries, and other community partners. Handouts were created to give caregivers tips on fun and easy ways to improve their child’s learning. The WIC program also distributed books developed as part of the CDCs LTSAE public health campaign.

The Missouri WIC program continued to offer training and support to local agencies and community partners interested in implementing the WIC Developmental Milestones Program (DMP). A total of 60 local WIC agencies implemented the DMP with two new agencies joining in FFY2~~2~~23. Participating agencies use a set of age-appropriate developmental checklists, based on the LTSAE public health campaign, to increase parents’ awareness of developmental milestones and to promote the early identification of potential developmental delays. Local agencies refer participants for screening and early intervention services to primary care physicians or Individuals with Disabilities Education Act diagnostics programs, such as First Steps (0-3 years of age) and Early Childhood Special Education (3-5 years). Local agencies may also refer their participants to ParentLink, an affiliate of the Help Me Grow National Center, for validated screening and connection to intervention programs. The local agency added ParentLink to their referral form. This includes the name of the facility, address, and phone number. The parent has a choice to reach out to ParentLink. ParentLink staff then utilize the ASQ-3 and ASQ: SE to assess the child’s overall development (such as communication, gross motor, fine motor, problem solving, and social skills) and social-emotional challenges (such as ability to calm down, take direction and follow rules, communicate, perform daily activities, act independently, demonstrate feelings, and interact with others). The WIC Program further collaborated through ParentLink, Help Me Grow Missouri’s ambassador, to integrate supportive services that help children thrive Help Me Grow helps to ensure families can access needed services. Data reports from the Missouri WIC Management and Information System (MIS) on referrals and follow-ups will be available for the first time in FFFY24. These reports will be used to assess the program’s effectiveness in providing referrals and access to early intervention programs.

To improve the program’s effectiveness, DHSS provided technical assistance to all participating WIC agencies.

DHSS provided education and promotional items, including printed materials such as the developmental checklists and the Amazing Me books developed by the CDC. Information on various child development topics was shared through monthly updates on the Missouri WIC webpage. For FY23, the Missouri WIC program considered promotional materials to assist parents in assessing their child's development, such as feeding utensils. These resources were also available to other internal and external stakeholders to promote early identification of developmental delays.

This is the fourth year the Missouri WIC program has collaborated with the Association of State Public Health Nutritionist (ASPHN). The program worked with the ASPHN to update the "Milestones Matter" Nutrition Education modules. There were 43,810 "Milestones Matter" nutrition education modules completed by WIC participants in all states from June 2021-July 2022. Missouri uses WIChealth.org platform, the Introduction to Child Development for WIC Staff training module, and other child development content on the WICShopper app to include CDC's revised milestones. The ASHPN committee worked with National WIC Association (NWA) to add the Introduction to Child Development module to the WIChealth platform. This allows other states to access this resource. WIC Agencies were required to complete the training module. The Missouri WIC Facebook page posted monthly to promote the program to local agencies and the public. Results from a FY21 survey were used to determine current program participation rates, clinic activities, and training needs of participating agencies. The survey also gathered data on program interest from agencies not currently enrolled. The feedback is being used to design future promotional activities.

NPM #8 Physical Activity – Reduce obesity among children and adolescents

Please note that some of the strategies and activities listed below impact both the Child and Adolescent Health domains. To avoid duplication, the information will only be listed in this domain, for which it is anticipated to have a larger impact, but it should be noted that some strategies and activities may address a wider age range.

Policy and Environmental Changes
Developing a healthier community involves creating a culture that promotes the benefits of physical activity and allows access to safe places to be active. Public policy is essential in supporting opportunities for children, youth, and families to develop healthy physical activity practices. Strategies to promote policy and environmental changes that can foster healthier communities in which opportunities and safe places to be physically active abound include collaboration with internal partners, local public health agencies (LPHAs), youth, and statewide and community organizations with similar goals. Program staff in the Bureau of Community Health and Wellness (BCHW) will continue to contract with LPHAs to implement policy and environmental changes that increase opportunities for children to engage in physical activity in early care and education settings.

The LPHAs will use the University of North Carolina's Nutrition and Physical Activity Self-Assessment for Child Care (Go NAPSACC) online system to assist child care providers to improve the health of young children through practices, policies, and environments that instill habits supporting lifelong health and well-being. The system also tracks child care providers' progress. The Child Care Health Consultation (CCHC) Program Specialist will continue to assist LPHA staff that provide Go NAPSACC technical assistance and consultation to child care providers as part of the program's nutrition and physical activity consultations.

Through BCHW, the Department of Health and Senior Services (DHSS) will continue supporting child care providers to implement policies and practices supportive of physical activity. DHSS will provide training, resources and technical assistance related to physical activity policies and practices to providers aiming to become a Missouri MOve Smart Child Care Provider.

The CCHC Program at the Department of Elementary and Secondary Education (DESE) will provide consultation hours for child care providers to support the implementation of policies and procedures that support physical activity and nutrition. These consultation hours may include recommended guidelines for physical activity and nutrition, policies and procedures that promote indoor and outdoor physical activity, addressing barriers to indoor and outdoor activity, implementing screen time policies, and consultation and training on becoming a Missouri MOve Smart Child Care designated facility. With DESE's change of clock hour provider, it is planned that CCHC clock hours will also be made available to child care providers who complete GoNAPSACC training modules.

Professional Development, Training, and Resources
BCHW staff are also available to provide training and technical assistance on obesity prevention strategies for local communities. To ensure staff are well informed and can provide quality assistance, they plan to participate in professional development opportunities such as annual conferences of professional associations and other evidence-based training.

BCHW will continue to support Missouri communities in their obesity prevention efforts by providing professional development and training opportunities for key stakeholders. Additionally, technical assistance and resources are available to assist efforts in increasing regular physical activity and healthful eating. BCHW will also assist communities in assuring interventions are inclusive of individuals of all abilities.

The School Health Program (SHP) will continue to encourage school nurses to engage with students and families in addressing overweight/obesity in children. The SHP will sponsor education and professional development in best practices (e.g., Lead Nurse Collaborative Meeting, weekly office hours, sessions at the Coordinated School Health State conference, and ECHO (Extension for Community Healthcare Outcome) webinar series for school nurses). The SHP will also collaborate with stakeholders and organizational partners to make tools and resources available to school nurses, and facilitate connections between students and their families, schools, and communities. The SHP is partnering with Washington University on a study *Harnessing State-Wide Partnerships and Technology to Expand Access to Care for Eating Disorders in Adolescent Girls in the COVID-19 Pandemic and beyond*. The study is funded by the U.S. Department of Health and Human Services and is being piloted in three school districts.

The CCHC Program will continue to provide trainings for child care providers and health promotion presentations for children on the importance of nutrition and physical activity. Child care provider trainings will focus on physical activity and its positive effects on weight, physical and mental health, and the development of motor, social/emotional, and cognitive skills. Trainings will also address how to incorporate structured and free active play into daily routines, address AAP guidelines for screen time, and provide examples of age appropriate activities and games to promote physical activity. In June 2022, 25 CCHC Program trainers completed Nemours Physical Activity Learning Session (PALS) ‘train the trainer’ sessions, and are now equipped to provide physical activity trainings for child care providers in their respective counties. In January 2023, 43 CCHC Program trainers completed the Nemours Nourishing Healthy Eaters (NHE) in Early Care and Education settings ‘train the trainer’ sessions. They can provide trainings on best nutrition practices for children and adults, the role of nutrition in child growth and development, how child care providers can have a positive impact on a child’s developing nutrition habits, and specific nutritional considerations and challenges for infants, toddlers, and preschoolers. Considerations for infants and toddlers include responsive feeding, establishing breastfeeding-friendly environments, and adult practices that best support a child’s relationship with food. Considerations for preschoolers include developmental stages and common challenges in preschool aged children, mealtime practices, and engaging with families around food and child nutrition. Training and health promotion will also incorporate the 12345 Fit-Tastic! Healthy Lifestyles Initiative messaging and guidelines, which incorporate nutrition and physical activity guidelines for children in easy to utilize resources. The initiative is developed by the Kansas City Healthy Lifestyles Collaborative and funded by Children’s Mercy Hospital. Health promotion for children will also: provide fun and developmentally appropriate opportunities for physical activity and nutritional experiences, increase children’s knowledge on how physical activity and proper nutrition keeps their minds and heart healthy, and enable children’s involvement in fun activities through songs, books, structured and unstructured play that promote nutrition and physical activity. CCHC Program services will continue to provide evidence-based resources and educational materials for child care providers and the parents/guardians of children, provide resources and opportunities for collaboration with community-based organizations that promote physical activity and nutrition for children, and encourage family participation in all program services.

Partnerships
BCHW staff participate in coalitions and partnerships that help to advance progress towards the state’s goals and objectives to improve levels of nutrition and physical activity and to reduce obesity. Examples of groups in which staff are involved include: MOCAN, Missouri Convergence Partnership, Missouri Coordinated School Health Coalition, DESE Healthy Schools Project, and the Missouri Complete Streets Advisory Council. Staff have the opportunity to network and identify collaborative opportunities with other organizations working towards similar goals, share available DHSS resources, and leverage funding to increase the reach of their work. Through the MOCAN Schools Workgroup, BCHW staff are working to promote use of the Whole School Whole Community Whole Child framework in Missouri schools. The workgroup will share resources to assist schools in this effort. Another goal is to strengthen district wellness policies and practices that promote healthier school environments.

Through the Missouri Healthy Weight Advisory Committee, BCHW staff support work to increase the capacity of the health care workforce to provide evidence-based family-based treatment programs for children that are overweight and obese. Health care providers (registered dieticians/licensed clinical social workers/etc.) will be surveyed to identify existing capacity to provide family based obesity therapy. In 2022, the state's Medicaid program made it possible for providers to bill for obesity treatment for pediatric patients. The surveys will also identify where additional resources are needed to increase health care provider capacity to provide these services. The ultimate goal will be to establish a training and certification program to increase the providers that can provide these services.

The CCHC Program Specialist participates in coalitions and partnerships that support physical activity and nutrition in early childhood and increase collaboration of nutrition and physical activity initiatives across the state. These include the Missouri Council for Activity and Nutrition (MOCAN) Child Care Work Group, the Kansas City Healthy Lifestyles Collaborative Early Childhood sector, and the Missouri Breastfeeding Coalition.

The MCH Services Program will continue to contract with the 23 LPHAs that selected promoting physical activity and reducing and preventing obesity as a Priority Health Issue in their FFY2022-2026 MCH Services contract work plan. LPHA efforts to prevent and reduce obesity and increase physical activity among children and adolescents include:

- Knox County Health Department is working with their County Ball Association and various community event organizers such as the Bright Futures Fishing Derby and Family Prom to implement healthy food options in their concession stands and serving areas using the *Eat Smart in Parks* toolkit. The nutrition guidelines in the toolkit help set a standard for the foods and drinks offered in parks and contain measures that can boost the availability of healthy food choices. The health department has replaced sugary beverages with options with less sugar and some food items with "healthier" options. For example, they introduced whole-grain items and fruit to replace chips, toaster pastries, and cookies. Some health department staff volunteer in the concession stands and provide nutrition education to various leaders and patrons. In addition, the health department's Environmental Specialist is collaborating with the Farmer's Market vendors to provide education on storage, handling and preparation of produce being sold and how to choose fresh fruit and vegetable items as a consumer. The market is held every Friday through the Summer and Fall months.
- Mercer County Health Department is using the *Water Access in Schools* Toolkit from the Centers for Disease Control and Prevention (CDC) to implement a water access plan within schools to increase availability of free safe drinking water in gyms and other physical activity areas. They are also working with the Russ Derry Sports Complex to incorporate a playground that it is safe and inclusive for all children.
- Scotland County Health Department is working with the City of Memphis to implement safe drinking water filling stations in parks and recreational sites to encourage children and adolescents to drink more water when being active. They are also educating providers (schools, Head Start, and childcare providers) on the 12345 Fit-Tastic! Healthy Lifestyles Initiative and providing messaging materials as requested (bookmarks, handouts, and posters).
- Benton County Health Department has developed a community resource guide that identifies walking trails, parks, swimming pools/public beaches, bowling alley, skate park, YMCA, and other opportunities for physical activity among children and adolescents and is updated as needed and annually. The map includes images of these areas to make locating them easy. In addition, the health department has collaborated with Parents as Teachers and the local library to provide nutrition education classes for children and families on how to read nutrition labels, wash produce, and prepare a healthy meal.

SPM #1 Oral Health – Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year

Ordering information for oral health resources from the Office of Dental Health (ODH) and the Missouri Primary Care Association (MPCA) will be provided to all MCH funded home visitors to promote National Children's Dental Health Month, which is observed annually in February. National Children's Dental Health Month will also be highlighted in the Home Visiting Program's continuous quality improvement newsletter, *Quality Outlook*, and the *Weekly Update* emailed to all MCH funded home visitors and supervisors to provide links to materials, webinars, and other resources that highlight the importance of preventive annual dental care in children. The Missouri WIC Program will collaborate with ODH to procure infant and toddler toothbrushes to have them available in their local WIC clinics.

Additionally, literature is available to LPHAs, dental offices, and community outreach events such as health fairs. The importance of regular dental care is also stated within the context of the ODH's promotion of the use of dental sealants. The referrals and care coordination components of the Preventive Services Program (PSP), described in more detail below, also encourage regular dental visits for children, particularly those who have been identified as having an oral health need.

The ODH enjoys continued success with the PSP, which is an evidence-based fluoride varnish and oral health education program. PSP serves about 90,000 children each year. Each child receives an oral health screening by a dental professional, two doses of fluoride varnish, oral health literature and supplies, and oral health education. The oral health education is either provided by school staff or the dental professionals that volunteer to operate PSP. Educational materials are provided by the ODH (for each grade, K-12), but some schools choose to use their own materials. Due the Coronavirus pandemic, many schools were not allowing visitors to enter their school building. During that time, fluoride varnish was either applied by a trained school staff member or parents/guardians. Those restrictions have been lifted for most schools and PSP will continue regular operations. When PSP was developed over 16 years ago, only licensed dentists or hygienists could conduct the PSP oral health screening. Due to the workforce shortage and as an outcome of the Coronavirus pandemic, many dental professionals are not able to volunteer for PSP as they did before 2020 because they are still trying to catch up with providing services to their patients, most of whom were not able to visit them during COVID. Additionally, the dental health workforce has seen a 5-10% decline; dentists and hygienists are now working in other fields and thus are not able to volunteer for PSP because they have either not renewed their license or have other work commitments. The ODH's Oral Health Consultants will also be available to school nurses to advise on possible dental health needs. School nurses can take pictures of a child's teeth if there is a questionable issue, and an Oral Health Consultant will help determine the need for further dental care. During the Coronavirus pandemic, the ODH created narrated videos, specific to grade levels from Kindergarten to 12th grade that are available on the DHSS website and can be accessed by any Missourian.

Due to the workforce shortage among dental professionals as mentioned above, the ODH is currently working with the Association of State and Territorial Dental Directors (ASTDD), Kansas City University (KCU) and the Dunklin County Health Department to pilot a program to train the public health nurses on basic oral health screenings. ODH has received input from ASTDD to ensure this is allowed and moved forward with training. A dentist from KCU and ODH's Oral Health Consultant in that region provided the training to the nurses. LPHA nurses will visit local schools and conduct a basic oral health screening, offer oral health education, provide oral care supplies, and help with referrals and fluoride varnish applications. The LPHA will purchase fluoride varnish and since fluoride varnish application is reimbursed through Medicaid, the LPHA will be reimbursed and this helps sustain the program. The ODH will evaluate project outcomes and determine the feasibility of expanding to other areas suffering from workforce shortages.

To combat the workforce shortage and grow PSP, the ODH is working with the University of Missouri–Kansas City and Score One for Health. The group is discussing the possibility of medical students performing PSP screenings. This project will not only address the dental workforce shortage and how it relates to PSP but also provide a learning tool for medical students. The objective is these students will be accustomed to performing a quick visual oral health

assessment when they become practicing physicians, , thereby bringing possible issues to light before they require more intense treatment.

The ODH will continue distribution of Dental First Aid Kits. These kits include the newly updated *Oral Health Guide for Caregivers of School-Aged Children* and items to help school nurses in the event of a dental trauma. The ODH will purchase, assemble and distribute kits to the approximately 3,000 schools throughout Missouri.

The SHP will continue to coordinate with the ODH and other programs to provide evidence-based information, resources, and professional development to school nurses. These efforts will equip nurses with best practices to educate children and parents about oral health concerns as well as promote the need for annual dental visits and regular preventive practices. The SHP will continue to host the ODH during the statewide meeting of lead school nurses in an effort to recruit additional schools to offer school-based oral health programs. The SHP will offer a 60-minute orientation for all new school nurses on oral health programs and the role of the oral health consultant.

The ODH will continue to promote the use of dental sealants as an effective means of preventing decay on newly erupted molars. The ODH is actively seeking new partnerships to provide dental sealants in school-based clinics. In addition, the ODH is leveraging a CDC grant to work with two LPHAs and two dental health clinics to apply sealants in their clinics and at local schools. The ODH will also continue working with WIC Programs at LPHAs to support fluoride varnish application for high-risk children. The ODH will leverage another grant to contract with two dental clinics and two dental hygiene schools to provide teledentistry services to schools. These services will target counties with very few or no dentists and provide dental services to children who may not otherwise have access.

Through an agreement with DESE, the ODH will continue to provide free oral health screenings, fluoride varnish and oral care supplies to children at the Missouri Schools for the Severely Disabled. Registered Dental Hygienists will provide screenings, alert the school nurses when the child has an issue that needs immediate attention, and provide fluoride varnish, which has been shown to decrease dental decay with two or more annual applications. The ODH piloted an online screening form to be used to record and gather results of the screenings. This form will be used to create a report that will be available at the conclusion of FFY 2023.

The TEL-LINK Program will refer callers to community-based dental clinics to increase awareness of community resources to increase access to needed dental health services. The program will continue to provide outreach to the underserved population through effective marketing strategies.

The Child Care Health Consultation (CCHC) Program at DESE will continue to provide consultation and training for child care providers and health promotion for children in child care on the impact of oral health on physical health. Consultations will increase awareness of evidence-based policies and procedures that promote optimal oral health for children. Consultants will provide technical assistance during the implementation process. Trainings will increase the child care provider’s knowledge on oral health guidelines and promotion strategies, abnormal oral conditions among infants and young children, and specific implications for oral care for children with special health care needs. Health promotion for children in child care will provide developmentally appropriate and fun oral health education and help children understand why it is important to take care of their teeth, identify unhealthy snacks and beverages that could harm their teeth, and participate in hands on demonstrations of proper tooth brushing and flossing techniques. CCHC Program services will continue to provide child care providers and children in child care and their families with educational materials, toothbrushes, toothpaste, and floss to enhance their excitement around oral care and ability to participate in oral care at home. These educational materials will also increase parent/guardian awareness on the importance and recommended frequency of preventive dental checkups and other ways to promote oral health at home. CCHC services will continue to be inclusive of adults and children of all abilities, encourage family

involvement in program services, and provide referrals to outside community resources for children's oral health services.

The MCH Services Program will support LPHA efforts to:

- Provide education on the importance of adequate dental care on overall physical health;
- Collaborate with partners to provide screening, referral and direct provision of preventive dental services; and
- Increase the number of children, ages 1 to 17 years of age, receiving a preventive dental visit in the last year.

The MCH Services Program will continue to contract with the seven LPHAs that selected enhancing access to oral health care services for children as the Priority Health Issue for their FY 2022-2026 MCH Services contract work plan.

- Audrain County Health Department is collaborating with the WIC program to provide oral health screening and referral for WIC participants interested in the Fluoride Varnish program. A LPHA nurse provides an oral screening, applies fluoride varnish and oral health education as well as a warm handoff to Arthur Center Community Health for follow-up dental care. The Arthur Center is a Federally Qualified Health Center (FQHC) that provides high quality preventative and restorative oral health services on a sliding scale fee for children, youth and adults covered by MO HealthNet and/or under 200% of the federal poverty level. From October 1, 2022- June 12, 2023, the Health Department has screened 182 children and applied varnish to 83 children. In addition, the health department is working to increase the number of children in early childhood education settings that receive oral health education. Oral health education and oral hygiene supplies have been provided to 244 children in FFY2023 and these numbers will continue to increase.
- Wright County Health Department is collaborating with the WIC program as well as using the Immunization Service Visit at both office locations to provide oral health screening, apply fluoride varnish, and provide oral health education for children. In FFY2023, as of current, 195 children received an oral health screening and education and 102 received a fluoride varnish application. The health department has created oral health kits that include a toothbrush, floss and toothpaste and are providing these kits to all children ages 1-17 who visit the health department for services. 195 children received an oral health kit. In addition, the health department is networking with Head Start and Parents as Teachers, providing oral health education and oral health kits that can be provided to their clients.

Additional strategies will include providing education to the public, city officials, dental and medical professionals, and public health authorities about the safety and effectiveness of community water fluoridation for the prevention of dental caries. The ODH will also continue to improve the Missouri Oral Health Surveillance System to include updated fact sheets on topics of interest and regional reports compiling oral health statistics and related information.

The ODH will continue to create Social Media posts for DHSS programs and the LPHAs to use throughout the year. These Social Media postings are available on the Oral Health webpage and readily accessible by LPHAs. The ODH was selected by the ASTDD to receive technical assistance in order to increase our social media presence and to develop these social media postings.

The ODH will continue to disseminate and engage partners in ongoing discussion related to the Five-Year State Oral Health Plan and continue its efforts to:

- Increase access to dental care by providing education about the importance of maintaining the adult dental benefit among MO HealthNet recipients. Information is distributed to policymakers, dental providers, leaders, and oral health stakeholders via the DHSS website and partners like the Missouri Coalition for Oral Health and Missouri Dental Association;

- Contract with the MPCA to provide education and technical assistance to State Dental Directors from all FQHCs in Missouri. The MPCA assists the ODH with distributing educational materials regarding the importance of a dental health home, particularly for pregnant women and children;
- Support the development of the oral health workforce in Missouri through collaborations with the DHSS Office of Rural Health and Primary Care on incentive programs for dental professionals;
- Implement the “referrals” portion of PSP, linking children with an identified dental need to local dental providers. This will be coordinated through school nurses and other local champions; and
- Promote and educate dental providers on the importance of HPV vaccine in order to increase the HPV vaccination rate.

Other Title V MCH Activities Related to the Child Health Domain

Developmental Screening

The CCHC Program will continue to provide consultations and trainings for child care providers around health and safety topics, including social-emotional learning, language/communication, cognitive, and movement/physical development in children. Consultations and trainings for child care providers will focus on incorporating the use of: developmental monitoring tools and checklists, strategies that positively affect child development, and individualized health plans (IHPs) for children with developmental delays. Trainings for child care providers will include the CDC “Learn the Signs. Act Early.” (LTSAE) campaign materials with the updated developmental milestones checklists. Trainings will stress the importance of monitoring developmental milestones, and provide communication strategies that child care providers can use when communicating with parents/guardians regarding concerns with a child’s development. Health promotion lesson plans for children in child care will continue to support all domains of child development. CCHC Program services will continue to provide resources about child development and developmental monitoring and screening for child care providers and parents/guardians of children in child care. Parent/guardian participation in all program services will continue to be encouraged.

Inclusion Specialists will provide parents with a listing of child care providers, based on the geographical location requested by the parent, so that parents can choose child care that will meet the needs of their child. Enrolling a child in a program that meets the needs of that child will increase the likelihood of maintaining placement, which will support the educational needs of the child. Inclusion Specialists provide onsite consultation to assist child care providers and develop adaptations and strategies to include the child with special needs in everyday classroom activities. They will assist in setting achievable goals for the child’s ongoing development. Inclusion Specialists deliver group training to better increase the knowledge base of child care providers in Missouri on how to include children with special needs. Lastly, through the addition of a social-emotional learning project, specialists also deliver evidence-based training to child care professionals to help them understand how children develop socially and emotionally. Sessions also emphasize real and practical strategies to foster social-emotional development.

The Home Visiting programs’ contracted home visitors will use the Ages and Stages Questionnaire®- 3 (ASQ-3) screening tool to identify children’s developmental needs. Home visitors will provide referrals for children who score below the cut-off points indicating a need for: additional developmental assessment, information and activities, community support, or early intervention services through Missouri First Steps or Early Childhood Special Education to contribute to improved school readiness. Annual performance measure data will be collected on the percentage of ASQ-3 developmental screenings conducted at the specified time points of 9, 18, and 30 months of age. Annual performance measure data will also be collected on the percentage of completed referrals for children who score below the cut-off points on the ASQ-3.

Additionally, the Home Visiting Program’s contracted home visitors will continue best practices to screen all children,

birth to kindergarten entry, for social-emotional development using the Ages and Stages Questionnaire®: Social Emotional (ASQ:SE-2). Home Visitors will provide developmental activities for parents/children who score in the "monitoring" range and will assist families in accessing services as appropriate. The Home Visiting Program will provide all contracted home visitors with education on childhood mental health conditions and warning signs through a variety of communications including the Office of Childhood and the Home Visiting Program Weekly Updates as well as during annual professional development events.

The Newborn Health Program will partner with a wide variety of community health providers to distribute the *Pregnancy and Beyond* booklet as well as other educational materials that provide information on developmental screening. The program will track the distribution of these materials and obtain feedback from its partners on how the materials are being used and ways to improve them.

The Missouri WIC Program will continue to promote the public awareness campaign "*Talking is Teaching: Talk, Read, Sing*" to help parents recognize their ability to improve their children's early brain and vocabulary development. Training will be provided statewide to WIC agencies, home visitors, Head Start, Parents as Teachers, health care providers, library staff, and other community partners. The Program will create handouts that provide tips on fun and easy ways to improve a child's learning. Additionally, books developed as part of the LTSAE public health campaign will be distributed to stakeholders.

The Missouri WIC program will also continue to offer training and support to local agencies and community partners interested in implementing the WIC Developmental Milestones Program. *(See NPM #11 - Medical Home application narrative for additional details.)*

In August 2021, the DESE Office of Childhood was awarded a new grant, "ECCS Health Integration: Prenatal to 3 Program", in the amount of $255,600 per year for each of the next 5 years. This funding will support an integrated maternal and early childhood system of care that is equitable, sustainable, comprehensive, and inclusive of the health system. The system will also promote early developmental health and family well-being and increase access to family-centered care and engagement of the prenatal-to-3 year old population.

The MCH Services Program will support LPHA efforts to:

- Provide infant and early childhood developmental and social-emotional screening services;
- Provide developmental screening for children one to three years of age enrolled in LPHA home visiting programs;
- Participate in preschool and pre-Kindergarten screening;
- Provide direct school-health services, including developmental screening; and
- Refer infants and children with potential developmental delay or failure to meet expected developmental milestones.

The Childhood Lead Poisoning Prevention Program (CLPPP) will support Title V MCH strategies by actively providing information about the potential harmful cognitive and developmental effects that may occur following a child's blood lead level elevation. Information will be provided to:

- The general public;
- Health care providers, such as pediatricians;
- LPHA and health plan lead clinical case managers;
- WIC staff;
- Newborn Home Visiting Program families;
- DESE staff, including school nurses, Parents As Teachers (PAT), Head Start, and Early Intervention/First

Steps staff and
- Parents of children with elevated blood lead levels.

CLPPP will work to address social determinants of health by providing health literate and linguistically appropriate materials to diverse populations. CLPPP intends to conduct a health literacy review of three publications and translate at least three documents into languages based on identified population needs. CLPPP hopes to increase compliance with directions on harm reduction activities related to lead poisoning.

CLPPP will provide information about:

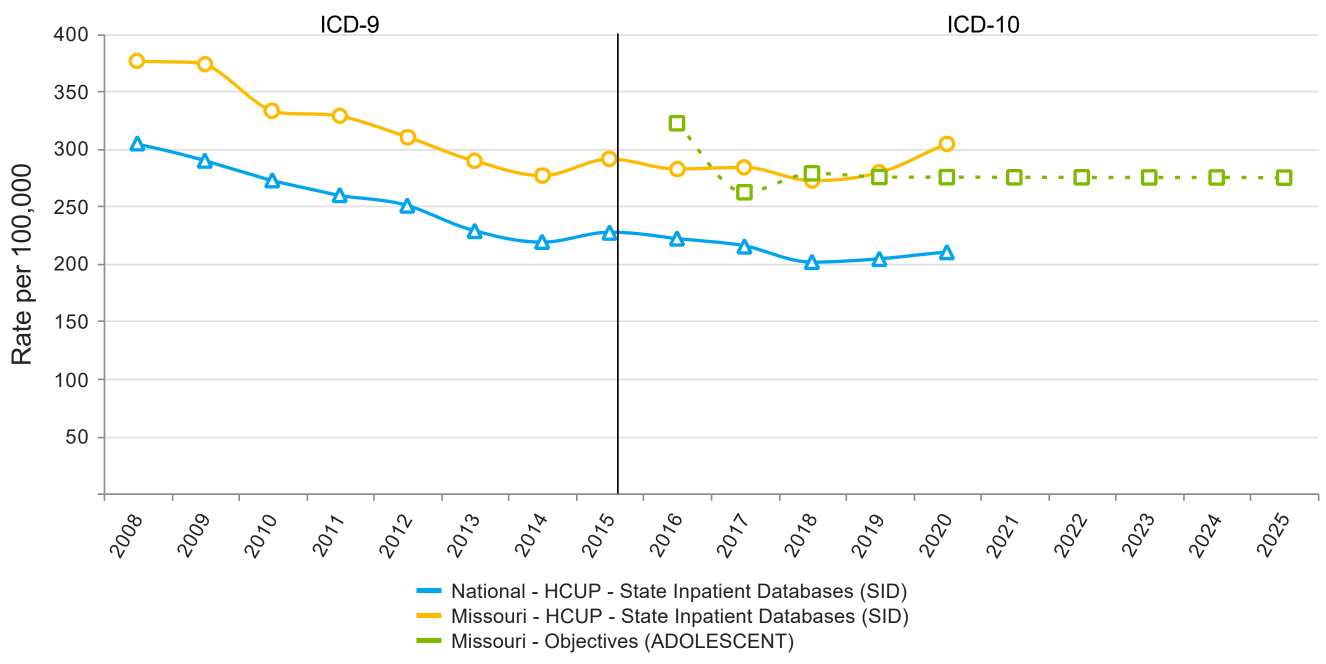
- Substances and environments that are likely to be lead exposure sources;
- The need for and ways to avoid/remove/prevent a child's exposure to environments or substances with lead;
- The need for blood lead testing for children under the age of 6 years per current CDC and American Academy of Pediatricians recommendations;
- Medicaid testing requirements;
- The recommended environmental and clinical follow up of children with elevated blood lead levels; and
- The recommended tracking of blood lead testing; and
- Extended developmental monitoring of children with elevated blood lead levels.

Missouri will continue to support and improve coordinated systems of care to address the needs of maternal, infant, and child populations that are at risk for or experience exposure to lead. The strong partnership between Title V MCH and the CLPPP enhances program activities and impact.

Adolescent Health

National Performance Measures

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Indicators and Annual Objectives



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	278.4	275.2	275.1	275	274.9
Annual Indicator	281.6	284.0	271.9	278.6	304.6
Numerator	2,211	2,226	2,130	2,175	2,371
Denominator	785,023	783,928	783,327	780,786	778,428
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2016	2017	2018	2019	2020

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	278.4	275.2	275.1	275	274.9
Annual Indicator	250.2	254.1	275.9	275.9	
Numerator	1,960	1,984	2,148	2,148	
Denominator	783,327	780,786	778,428	778,428	
Data Source	MO PAS	MO PAS	MO PAS	MO PAS	
Data Source Year	2018	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	274.8	274.8	274.7

Evidence-Based or –Informed Strategy Measures

ESM 7.2.1 - Percentage of high school students who reported distracted driving.

Measure Status:				Active
State Provided Data				
	2019	2020	2021	2022
Annual Objective			45	44.2
Annual Indicator	45.8	45.8	45.8	38
Numerator	722	722	722	197
Denominator	1,576	1,576	1,576	518
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2019	2019	2019	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	43.5	42.5	41.5

State Performance Measures

SPM 2 - Suicide and self-harm rate among youth ages 10 through 19

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			17.4	16.8
Annual Indicator	17.4		17.4	30.7
Numerator	1,200		1,200	274
Denominator	6,897		6,897	892
Data Source	YRBS		YRBS	YRBS
Data Source Year	2019		2019	2021
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	16.2	15.5	15.0

State Action Plan Table

State Action Plan Table (Missouri) - Adolescent Health - Entry 1	
Priority Need	
Reduce intentional and unintentional injuries among children and adolescents.	
NPM	
NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	
Objectives	
By 2025, decrease the rate of hospital admissions for non-fatal injury among adolescents, ages 10 through 19 from 250.2 per 100,000 (PAS 2018) to 247.7 per 100,000.	
Strategies	
Ensure health care providers have access to tools and best practices regarding injury prevention and are trained to use the tools in an evidence-based manner.	
Ensure high quality injury prevention counseling is embedded in programs for which Title V has authority.	
Educate partners regarding evidence-based policy and environmental strategies that prevent or reduce injury rates among children and adolescents, and the relative effectiveness of these policies and strategies.	
Educate partners regarding existing community resources for referrals or collaboration to support injury reduction and promote injury prevention.	
Build program and policy evaluation capacity.	
ESMs	**Status**
ESM 7.2.1 - Percentage of high school students who reported distracted driving.	Active
NOMs	
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

State Action Plan Table (Missouri) - Adolescent Health - Entry 2

Priority Need

Promote Protective Factors for Youth and Families.

SPM

SPM 2 - Suicide and self-harm rate among youth ages 10 through 19

Objectives

By 2025, reduce the suicide death rate among youth 10-19 years from 7.8% per 100,000 (CY 2019 Vital Statistics) to 7.72 per youth 100,000.

Strategies

Create supportive environments that promote connectedness and healthy and empowered individuals, families, and communities.

Foster positive public dialogue, counter shame, prejudice, and silence; and build public support for suicide prevention and mental health promotion.

Address the needs of vulnerable groups, tailoring strategies to match the cultural and situational contexts in which they are offered, and seek to eliminate disparities.

Coordinate and integrate existing efforts addressing adolescent health and behavioral health to ensure continuity of care.

Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems.

Collaborate with behavioral health agencies/partners to implement the Strengthening Families Protective Factors Framework.

Promote efforts to reduce access to lethal means among individuals with identified suicide risks.

Apply the most up-to-date knowledge base for suicide prevention.

Implement and spread evidence-based suicide and self-harm prevention strategies and programs.

Strengthen collaboration across agencies, develop new tools and capacity, and implement evidence-based change in suicide and self-harm prevention strategies.

Implement and spread evidence-based prevention and emergency mental health programs.

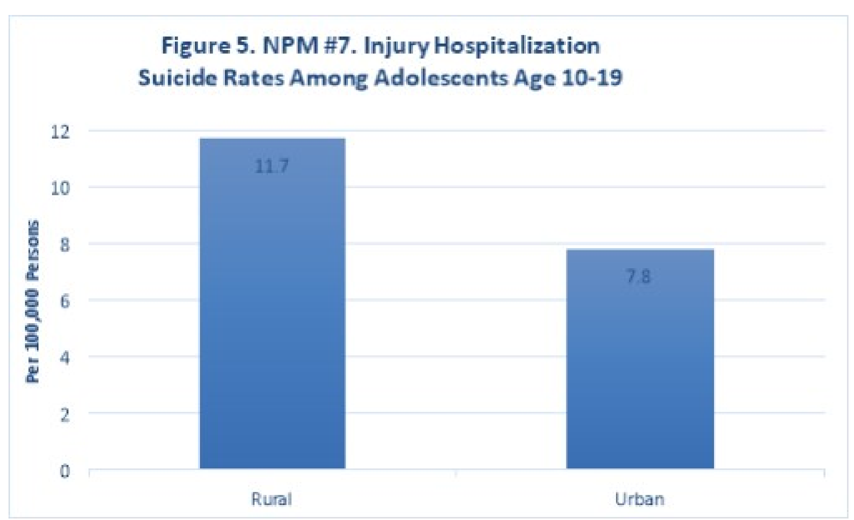
Build program and policy evaluation capacity.

Adolescent Health - Annual Report

NPM #7 Injury Hospitalization – Reduce intentional and unintentional injuries among children and adolescents

Please note that some of the strategies and activities listed below impact both the Child and Adolescent Health domains. To avoid duplication, the information will only be listed in this domain, for which it is anticipated to have a larger impact, but it should be noted that some strategies and activities may address a wider age range.

Among Missouri adolescents 10 to 19 years old, the rate of non-fatal injury hospitalizations was 277.3 per 100,000 in 2021 compared to 288.7 per 100,000 in 2020. The top three causes of injury deaths among Missourians ages 10 to 19 years old in 2020 were: 1) unintentional injuries, 2) homicide, and 3) suicide. Motor vehicle accidents were the number one cause of unintentional injury deaths in this age group, followed by accidental poisoning, and exposure to noxious substances. Suicide remains a public health issue of great significance in Missouri. For 2021, the overall suicide rate in Missouri for all ages was 18.7 per 100,000 compared to 14.0 per 100,000 for the US. According to 2021 Missouri Vital Statistics data, suicide was the 10th cause of death for all ages and the 3rd cause of death among adolescents 10-19 years old. Additionally, the 2021 suicide rate among Missouri adolescents aged 10-19 of 9.1 per 100,000 was higher than the 2020 rates (6.8 per 100,000) and the national rate (6.7 per 100,000). Suicide rates indicate higher risk in rural areas (Figure 5), presenting challenges for the provision of mental health services, as rural counties typically have fewer mental health resources than urban counties. Multiple prevention strategies in Missouri were implemented to address unintentional and intentional injuries.



The Bureau of Community Health and Wellness (BCHW) serves as the state lead for Safe Kids Worldwide and provides funding for 10 Safe Kids Coalitions. The coalitions, which are led by local public health agencies (LPHAs), non-profit entities, and local hospital systems, reach 60 counties to provide unintentional injury prevention services to children (0-19 years old). The coalitions offered a broad array of injury prevention educational activities for parents and children such as the National Safety Council's Defensive Driving Course (DDC). Teens ages 14 and up were encouraged to take DDC and learn state and local traffic laws, distracted driving prevention, and safe driving practices. Other topics addressed safety in the areas of teen driving, sports, medication, fire, and water. Additional injury prevention activities included: hosting prescription drug take-back events, conducting media campaigns with prevention messages, and working with policy makers to address gaps in policies that could prevent injuries. The coalitions worked closely with law enforcement officers, firefighters and paramedics, medical professionals, educators, parents, businesses, public policymakers, and, most importantly, adolescents, to reinforce teen driver safety. The coalitions

provided services to over 1,800 children and parents through 19 teen safety educational events. The Department of Health and Senior Services (DHSS) held quarterly conference calls with the Safe Kids coalitions. DHSS hosted the Safe Kids Missouri Leadership Workshop for all coalitions to gain knowledge of evidence-based interventions and network with other coalitions. Coalition leaders received information from the Brain Injury Association of Missouri, the Zero Suicide Prevention Program, Charlie's House, Opioid PreventEd, and Catholic Charities of Central and Northern Missouri.

The Injury Prevention Program continued to build program capacity and partnered with current Safe Kids Coalitions to implement evidence-based programs, identify gaps in current services, and increase the number of partners supporting injury prevention programs. The Injury Prevention Program continued to strengthen collaboration with TEL-LINK and Text4baby to provide information and resources about car seats and seat belts. Family engagement continued to be a priority for Safe Kids coalitions and DHSS provided technical assistance to further that effort. The coalitions continued to incorporate families into coalition activities.

The Injury Prevention program coordinates the Missouri Injury and Violence Prevention Advisory Committee (MIVPAC), which provides expertise and guidance to the Injury Prevention Program and establishes injury prevention as a state priority. The committee consists of representatives from state, local and regional government agencies, non-government bodies, and consumers. The committee's goal is to reduce the morbidity and mortality of children (0 -19 years old) due to injury and violence. MIVPAC completed and implemented its strategic plan. The plan includes strategies such as: utilizing the MIVPAC website to share and promote injury prevention initiatives, maintaining an updated list of MIVPAC members, sharing and promoting social media messages developed by MIVPAC members, providing monthly communication to committee members, partners, and families, promoting injury prevention events, and gathering data on intentional and unintentional injury.

The Adolescent Health Program (AHP) continued to implement evidence-based teen pregnancy prevention and positive youth development programs across Missouri's highest-need areas in conjunction with the Personal Responsibility and Education Program (PREP) Grant and the Sexual Risk Avoidance Education (SRAE) Grant. These programs (Teen Outreach Program (TOP), and Making Proud Choices) continued to improve not only the knowledge of Missouri's youth, but also their self-efficacy, health outcomes, and school outcomes.

The AHP continued working towards having adolescent input. The AHP team added an adolescent/youth voice in the Missouri Council for Adolescent and School Health (CASH). The AHP now requires Youth Advisory Councils (YAC) or youth advisors as part of all teen pregnancy prevention contracts. Each contractor was required to either start a YAC, add youth to an existing council, or hire youth as advisors to their agency this year. AHP continued to provide technical assistance and resources to contractors to grow skills related to developing YACs and youth advisors, as well as the youth/adult relationship education needed over the next few years. Columbia/Boone County Public Health & Human Services hired several youth community health workers (CHW). They have been invaluable assets to the program and the department. The youth CHWs have: 1) attended TOP club meetings and participated in ongoing discussions, 2) given input on youth-oriented campaigns, 3) helped revamp materials to better reach their peers, 4) highlighted needs that otherwise would have been overlooked, and 5) raised awareness on mental health after receiving the Youth Mental Health First Aid training. Moreover, other areas of the department have asked to utilize the youth CHWs, including in the community health assessment process. As a result of this work, one of the youth CHWs presented at the 2023 AMCHP conference.

The MCH Services Program continued to contract with the 19 LPHAs that identified the reduction of intentional and unintentional injuries among adolescents as a Priority Health Issue in their FFY 2022-2026 MCH work plans. The program continued to support LPHA efforts to prevent and reduce injury related to:

- Fire and water safety
  Hickory County Health Department increased provider and individual knowledge by hosting a Fall Family Fun

Festival (*Picture below*). The health department collaborated with community stakeholders to provide education and resources on various child health and safety priority issues including water safety. As a result, 25 women of childbearing age, and 45 children and adolescents increased their knowledge on water safety as evidenced by a verbal survey.

- Motor vehicle safety/accidents
- Child abuse and neglect
    - The MCH Services Program collaborated with MOKidsFirst and offered Darkness to Light's Stewards of Children training to all LPHAs. Through real people and real stories, the training showed adults how to protect children. The framework of the training is built off the foundation of The 5 Steps of Protecting Children. 58 adults attended the training and reported increase in awareness and knowledge.
- Violence
    - The Kansas City (KC) Health Department provided advocacy training and support services to 57 parents through the Parent Leadership Training Institute. During the institute, a staff member at the Kansa City Health Department created a children's book titled "Just Like Me." In addition, the health department helped eight youth serving organizations incorporate evidence-based education and trained 14 youth serving organizations to implement the violence prevention curricula and KC Blueprint strategies. They also subcontracted with youth ambassadors to establish a social media presence on Facebook, Instagram, Tik-Tok, and Snapchat. The youths created and shared violence prevention messages that reached about 15,968 youths.
- Lead poisoning

Young Children Specific

The Child Care Health Consultation (CCHC) Program provided consultations and trainings for child care providers and health promotion for children in child care on a variety of injury prevention topics to promote safe child care environments, encourage healthy and safe behaviors, and prevent injuries among children. Consultations for child care providers assisted in the assessment of healthy and safe environments using evidence-based tools, development and review of policies, implementation of health and safety procedures, promoting active supervision, and utilizing safe and developmentally appropriate equipment in the indoor and outdoor environments of the child care facility. Training and consultation topics included abuse and neglect, mandated reporting, shaken baby syndrome, emergency preparedness, CPR/First Aid, medication administration, poisoning prevention, lead poisoning prevention, fire safety, gun safety, Halloween safety, injury prevention, motor vehicle and car seat safety, outdoor and playground safety, safe sleep, stranger safety, water safety, and sun safety. The CCHC Program provided a total of 1,638.5 hours of consultation and training for child care providers, and 346 hours of health promotion presentations for children in child care on safety and injury prevention. CCHC Program services continued

to provide children in child care with meaningful experiences regarding health and safety and injury prevention that can be implemented in their lives outside the child care facility, and provided educational materials for their parents/guardians. All CCHC program services continued to be inclusive and promote family involvement in all services. The capacity for LPHAs to provide CCHC Program services was severely impacted by the COVID-19 pandemic.

Safe Kids Coalitions addressed priorities including child passenger safety, bicycle safety, crib safety, TV and furniture tip-over, pedestrian safety, poisoning, farm safety, and other areas based on community needs. The coalitions offered a broad array of activities including: providing cribs and car seats, offering parent education on child safety, conducting car seat checks, certification training for child passenger safety technicians (CPST), conducting media campaigns with prevention messages, and working with policymakers to address gaps in policies that could prevent injuries. The coalitions provided services to over 68,500 children and parents through over 800 educational events. Over 2,600 child safety seats were distributed, and over 3,000 car seat checks were conducted.

The DHSS Injury Prevention Program Manager represented District 5 (Central District) on the Missouri Child Passenger Safety Advisory Committee. Responsibilities included: maintaining regular contact with all CPSTs/inspection stations in the district, being available to sign off on seats for CPST/instructor recertification, mentoring new instructors, being the main point of contact when the Missouri Department of Transportation orders car seats for the area inspection stations, recruiting new inspection stations, and attending CPS Advisory Committee meetings. The MCH Director, Injury Prevention Program Manager, MCH Program Manager, and MCH District Nurse Consultants continued to partner with safety advocates to prevent intentional and unintentional injuries. They served on statewide and regional safety coalitions such as the Missouri Coalition for Roadway Safety state and regional coalitions and the Occupant Safety Subcommittee. Additionally, the MCH Director continued to participate on the Missouri Brain Injury Advisory Council, MIVPAC, and CASH.

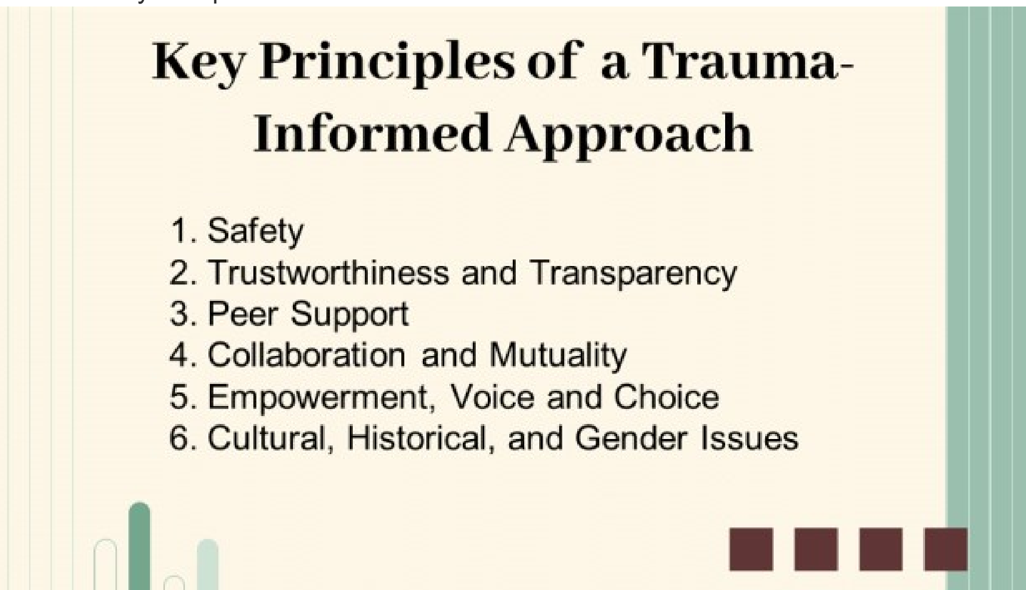
The Childhood Lead Poisoning Prevention Program (CLPPP) continued to provide education and support to LPHAs, health care providers, and families of children under the age of six years old through identification, reduction and remediation of potential lead hazards. To further support messaging on child-related topics, the CLPPP focused on building relationships with other child health and wellness focused agencies through the creation of a Lead Advisory Committee. The CLPPP continued to promote childhood blood lead screening and testing, and efforts led to 63,091 blood lead tests reported for children under six years of age, an increase of 10,636 from FFY 2021. In FFY 2022, five children were reported to have undergone chelation therapy.

SPM #2 Suicide and Self-Harm – Promote Protective Factors for Youth and Families

It is normal for children and adolescents to experience some emotional distress as they develop and mature. However, studies such as the Adverse Childhood Experiences (ACEs) show that the toxic stress and the challenges young people face can have a significant impact on their long-term health. According to the 2021 Youth Risk Behavior Surveillance Survey (YRBSS), 32.5% of high school students in Missouri reported being sad or hopeless almost every day for two or more weeks in a row, causing them to withdraw from activities in the last 12 months. According to the National Survey of Children's Health (NSCH) 2020-2021 data, 44.5% of Missouri children between 3-17 years old who had a mental/behavioral condition received treatment or counseling from a mental health professional in the last 12 months compared to 51.6% nationally. Among children that were publicly insured only, 41.2% received treatment or counseling, which is lower in comparison to 51.8% nationally. There were comparable percentages among children with private health insurance only, with 48.6% in Missouri and 53.1% nationally. Missouri college graduate households had a greater percentage of children 3-17 years old who received treatment or counseling (56.5%) than any educational attainment group for which there is data at both the state and national level. Among children from households with some college or technical school, 35.8% received treatment or

counseling compared to 49.3% at the national level. Among Non-Hispanic White children with a mental/behavioral condition, 48.2% of Missouri children received treatment or counseling, which was slightly lower than the 53.1% nationally. For Missouri children with a mental/behavioral condition in a household with two, currently married parents, fewer children (43.9%) received services compared to nationwide (51.8%). The proportion of children (6-11 years) that received treatment or counseling was similar in Missouri (45.4%) and nationally (45.7%). Among 12-17 year olds, a lower percentage of Missouri (48.8%) children received counseling or treatment than nationwide (58.1%). Partners across Missouri worked to improve protective factors, access to mental health treatment, and the quality of support services and staff working with youth who have experienced trauma and multiple ACES.

The School Health Program (SHP) continued to partner with the Department of Mental Health (DMH), Department of Social Services (DSS), Department of Elementary and Secondary Education (DESE), and other organizations to identify training and resources and to facilitate a connection with school districts across Missouri. The SHP supported professional development for school health staff to implement trauma informed approaches and best practice recommendations for creating safe spaces for all students to attend school, including LGBTQ and other at-risk students. One of the webinar topics was "*COVID-19, Trauma and How to Help the Student Cope.*" (*Picture below shows a slide from the presentation.*) In addition, they shared an evidence-based brief on components of a trauma informed school health office. The SHP staff also shared simple posters on calming strategies, making positive connections with students, and mental wellness. Feedback from school nurses showed they value the tools, as they are quick and easy to implement.



Through the Show Me School Based Health Alliance partnership, the SHP supported school based clinics to provide services including mental and behavioral health on school campuses or near schools. These school based clinic services are effective in providing comprehensive care especially when they are established in partnership with a Federally Qualified Health Center (FQHC).

The Adolescent Health Program (AHP) continued to focus on Social-Emotional Learning (SEL), protective factors and Positive Youth Development (PYD) through implementing TOP Clubs across Missouri. TOP participants build connectedness with their facilitators, schools and communities. These implementation sites continue to be inclusive, safe spaces with caring, responsive and knowledgeable facilitators. More than 95% participants reported feeling physically safe at TOP and that their facilitators support and care about them. In the 2021-2022 academic year, over 600 youth from 30 communities participated in TOP. As part of the program, the youth gave back to their

communities and completed nearly 13,000 hours of community service learning (CSL). CSL options are chosen by the youth and vary from community to community, but some choices have included working at the foodbank, volunteering with youth or elderly, teacher appreciation, food drives, or just spreading kindness (Marquand Zion picture below).

Marquand Zion

The AHP piloted a new program with long-time partner, Wyman, Inc. This program, Teen Connection Project (TCP), focuses on building communication skills, SEL, and developing connections between high school aged youth and the peers and adults in their lives. These protective factors meld well with achieving the goals of Missouri's Title V Block Grant. Wyman has piloted this program, including a rigorous evaluation, in parts of Missouri and across the country. With external funding, three schools piloted TCP and 55 youth completed the program.

The AHP continued to work on adult/child relationships through the Connect with Me campaign. This campaign encourages parents/guardians, teachers, coaches, and all adults to have stronger relationships and deeper conversations with the youth they care about. Topics covered in the conversation starter cards for this campaign include trauma, healthy body image, and taking action. In FFY22, the cards included a mental health and diversity section. The AHP continued working to expand this campaign to include a phone app, which will expand the programs outreach capabilities and the variety of topics available. The app will be launched in 2023.

Missouri is part of the National Network of State Adolescent Health Coordinators (NNSAHC), a community and resource to communicate ideas, build knowledge, and share expertise. Missouri's SAHC served as the NNSAHC President through the spring of 2023. The SAHC reached out to this network to gather ideas on addressing adolescent mental health and suicide prevention, and the idea for a mental health toolkit was sparked.

DHSS participated in the second cohort of the Children's Safety Networks Child Safety Learning Collaborative (CSLC) to reduce fatal and serious injuries among infants, children, and adolescents. The CSLC concluded in October 2021. The CSLC strategy team, which included the MCH Director, the Injury Prevention Program Manager, the AHP Manager, and the Manager of Trauma-Informed Treatment at the DMH, continued to collaborate to improve Missouri's efforts to address suicide and self-harm. The Injury Prevention Program, in partnership with the AHP, are piloting the Mental Health Crisis Toolkit for Missouri families. The toolkit provides comprehensive guidance on helping youth experiencing a mental health crisis. DHSS distributed more than 900 toolkits to 14 school districts. These schools/districts will continue to provide the toolkit to parents and guardians of youth that the school

personnel feel may be experiencing a mental health crisis. School personnel and families are being asked to complete a survey requesting feedback on the effectiveness of the toolkit, its components, as well as any additions that would be helpful.

The MCH Services Program supported LPHAs and/or community partner efforts to provide education, screening, and referral for adolescent mental health needs. The program continued to contract with the 30 LPHAs that identified prevention and reduction of suicide and/or self-harm among their local adolescent populations as a Priority Health Issue in their FFY 2022-2026 MCH work plans. These efforts include, but are not limited to, preventing substance use, preventing and reducing the impact of toxic stress, and building resiliency. Examples of LPHA contract activities included:

- The City of Independence, Montgomery, Gasconade, Pettis, Nodaway, and Ray County Health Departments increased provider and community education by increasing the number of certified Youth Mental Health and First Aid instructors within their counties. This has increased trainings offered to parents, grandparents, school staff, childcare and medical providers and anyone else who provides services to adolescents and their families.
- Montgomery County Health Department has increased the number of children and women of childbearing age that receive mental health resources and counseling services by partnering with Missouri Girls Town Foundation to provide free counselling sessions once a week at the health Department. Ninety-eight free counseling sessions were provided to youth and women of childbearing age.
- Jefferson County Health Department increased community and individual knowledge in regards to mental health by creating the Jefferson County Teen Coalition Group. The group meets to discuss health and wellness issues they observe in their schools and develop an advocacy plan to address them. The health department uses various social media platforms and digital engagement to reach the community. Lastly, the health department implemented the Healthy Choices Program, a five-week teen wellness program focusing on all aspects of wellness (physical, emotional, and resiliency). This program included many aspects of learning how to make healthy decisions. Topics highlighted included: identifying common stressors in daily life and finding coping skills to deal with stressors, physical activity options, how to shop healthy, how to read nutrition labels, and more. This was implemented in one school district in collaboration with the PE teacher and reached the entire 7th grade class.
- The City of Independence and Christian County Health Departments increased community awareness of mental health by developing mental wellness messaging. The City of Independence placed two billboards within the county, while Christian County used a digital billboard that rotates several mental health messages.
- Andrew County Health Department increased and strengthened collaboration across youth serving agencies, specifically by collaborating with schools, law enforcement, and first responders to implement the Handle with Care Program. This program enables law enforcement and first responders to notify schools that a child may have been exposed to trauma and to handle them with care. Trauma may include anytime a child is present when: a household member is arrested, a search warrant is served in their residence, a drug/alcohol overdose or death/suicide of a family member occurs, and/or when a child experiences incidents such as domestic or community violence, physical and/or sexual abuse, house fires, and car wrecks.

The Child Care Consultation (CCHC) Program provided 230.25 hours of trainings and consultations to help child care providers identify children with mental health needs, promote evidence based protective factors for youth and families, and address mental illness in children in child care prior to reaching adolescence. Training topics for child care providers that focused on mental health and wellness of children included trauma-informed care, resilience, identification of depression and anxiety in preschool aged children, divorce, grief, separation anxiety, social and emotional learning and development, positive behavior support, positive discipline, developing healthy relationships,

and substance abuse awareness. Training topics for child care providers that focused on staff mental health and wellness included suicide prevention and awareness, trauma-informed care, resilience, self-care, stress management, the relationship between physical health and mental health, substance use awareness and prevention, and de-escalation in times of crisis. Consultations with child care providers promoted the implementation of policies and procedures that optimize the mental health of staff and children, and provided referrals to outside resources. As a result of these trainings and consultations, child care providers have increased access to information and resources that promote early identification of mental health needs and protective factors that can be implemented for children, child care providers, and families.

The CCHC Program also provided 111.25 hours of health promotion of mental health among children in child care. Topics included bullying, emotional expression and regulation, anger management, sleep, screen time, empathy, self-esteem, celebrating differences and diversity, and living tobacco and drug free. As a result, children in child care were provided with meaningful experiences and coping strategies to benefit their lives inside and outside of the child care setting to enhance their ability to promote their own mental health and the mental health of their peers. CCHC Program services also continued to provide evidence-based mental health resources for families of children in child care, and encouraged family participation during all CCHC Program services. The capacity for LPHAs to provide CCHC Program services was severely impacted by the COVID-19 pandemic.

NPM #7 Injury Hospitalization – Reduce intentional and unintentional injuries among children and adolescents

Please note that some of the strategies and activities listed below impact both the Child and Adolescent Health domains. To avoid duplication, the information will only be listed in this domain, for which it is anticipated to have a larger impact, but it should be noted that some strategies and activities may address a wider age range.

The Bureau of Community Health and Wellness (BCHW) serves as the state lead for Safe Kids Worldwide and provides funding for 10 Safe Kids Coalitions. The coalitions reach 60 counties to provide unintentional injury prevention services to children (0-19 years old). The coalitions are led by local public health agencies (LPHAs), non-profit entities, and local hospital systems. They work to increase knowledge, attitudes, and skills to address priorities such as teen driver safety, sports safety, medication safety, fire safety, and water safety. The coalitions offer a broad array of educational activities such as the National Safety Council's Defensive Driving Course (DDC). DDC increases parent and child awareness and knowledge on injury prevention priorities. Teens ages 14 and up are encouraged to take the DDC and learn state and local traffic laws, distracted driving prevention, and safe driving practices. A Drivers Education Program is also offered to better prepare youth for driving. The program is taught by certified National Safety Council instructors. The complete program consists of six modules, each module has been created to increase in complexity as students master each driving skill. In order to pass this course and receive their certificate of completion, Students must pass all six modules to receive a completion certificate. Additional injury prevention activities include: participating in health and safety fairs, providing education through school and community events, hosting drug take back events, conducting media campaigns that incorporate prevention messages, and working with policymakers to address gaps in policies that could prevent injuries. The coalitions work closely with law enforcement officers, fire fighters and paramedics, medical professionals, educators, parents, businesses, community agencies, public policy makers, and, most importantly, adolescents, to reinforce teen driver safety. The Department of Health and Senior Services (DHSS) will host quarterly conference calls and offer a one-day workshop for all coalitions to gain knowledge of evidence-based interventions and network with other coalitions.
The Injury Prevention Program will continue to build program capacity and partner with Safe Kids coalitions to provide programs, identify gaps in current services, and increase the number of partners that support injury prevention programs. The Injury Prevention Program will continue to collaborate with TEL-LINK and Text4baby to provide information and resources about car seats and seat belts. The Injury Prevention Program will promote ThinkFirst Missouri traffic safety programs, which include group presentations delivered in schools, worksites, and community settings. Presentations feature compelling testimonies from Voices for Injury Prevention (VIP) speakers. Having sustained a brain or spinal cord injury from a motor vehicle crash, VIP speakers present serious yet motivational messages about the consequences of life-altering injuries and encourage audiences to take personal responsibility and make safer choices. A new traffic safety program, ThinkFirst for Kids, has been developed. ThinkFirst for Kids Missouri will partner with Safe Kids Columbia to develop and present on passenger and pedestrian safety, bike safety, ATV safety, water and fire safety in schools and community settings. Presentations will be tailored to accommodate the needs and size of the audience and reach approximately 1,000 children and families. Presentations will be flexible to fit the needs of the community and may be presented at after school programs, classrooms, school assemblies, or other settings where K-8th graders gather. The program will also incorporate the MODOT Smart Riders program for elementary-aged students. Family engagement will also be a priority for Safe Kids coalitions, and coalitions will continue to incorporate families into coalition activities. DHSS will provide technical assistance to further that effort.

The Injury Prevention Program will continue to coordinate the Missouri Injury and Violence Prevention Advisory Committee (MIVPAC), which provides expertise and guidance to the Injury Prevention Program and establishes

injury prevention as a state priority. The Committee consists of representative members from state agencies, local and regional government agencies, non-governmental bodies, and community members. Many Title V funded programs from DHSS participate on the committee, such as MCH Services Program, Adolescent Health Program (AHP), and Genetics & Healthy Childhood Program. The Committee's goal is to reduce the morbidity and mortality of children (0 -19 years) due to injuries and violence. MIVPAC will continue implementing the strategic plan, which includes strategies to promote partnerships and collaboration to improve injury prevention efforts and promote MIVPAC as the resource for best-practice recommendations to address injury and violence prevention.

The MCH Services Program will continue contracts with 23 LPHAs that identified the reduction of intentional and unintentional injuries among adolescents as the Priority Health Issue in their FFY 2022-2026 MCH work plans. The Program will continue to support LPHA efforts to prevent and reduce injury related to:

- Fire and water safety;
    - The Hickory County Health Department is working with the Sea Tow Foundation's Life Jacket Loaner Program to implement life jacket loaner stations in state parks that have water access points. The first loaner station will be implemented by the end of FFY2023 and will be located at the Hermitage Campground Boat Ramp. Those participating in water activities may borrow the life jackets at no cost and are asked to return them when they are finished. The Camden County Health Department is working on a similar program.
    - The Hickory County Health Department is also working to increase awareness of water safety initiatives among local businesses and partners. They will provide updates in the Chamber of Commerce newsletter and the Lake Area Vacation Guide. Recent updates have included information on the Wear It Campaign addressing life jacket education as well as the Sober Skipper Program. Plans to increase individual knowledge and skills around water safety are underway; boat rentals/marinas and campgrounds will include life jacket safety education with each rental.
    - The Camden County Health Department partners with the Missouri State Highway Patrol-Water Patrol Division to provide water safety education to preschool and school-aged children and adolescents.
- Motor vehicle safety/accidents;
    - The Sullivan County Health Department continues to partner with Think First Missouri to bring the *ThinkFirst for Teens School Assembly Program* to schools. The Program is offered free of charge and provides a high-impact injury prevention message from a VIP Speaker. The Green City R-1 School District hosted this assembly and 50 high school students were in attendance. In addition, the health department is partnering with medical providers as well as the Division of Motor Vehicle in the county to provide them with Safe Driving Bags that include the following: CDCs Parents are the Key to Safe Driving, GDL System Planning Guide, Eight Danger Zones for Teens Behind the Wheel, AAP Parent-Teen Driving Agreement, Passport to Safe Driving, First Impact Zoom Schedule, and promotional materials provided by MODOT.
    - The Moniteau County Health Department will continue to provide education and safe driving resources to those who come to the health department to get a birth certificate for the purpose of obtaining a permit/driver license. Since March of 2023, the health department has provided five parents and new teen drivers with education and resources.
- Child abuse and neglect;
    - The MCH Services Program, in partnership with MO KidsFirst, will continue to offer and/or support and promote partner offerings of the Stewards of Children training for LPHAs and other community partners. The Stewards of Children framework teaches how to prevent, recognize, and react responsibly to child sexual abuse. The framework is built on the foundation of The 5 Steps to Protecting Children and uses real people and their stories to show how to protect children. It is

available in English and Spanish.
    - The Schuyler, Putnam, and Clark County health departments are working with organizations serving youth to determine if they have child-adult contact policies and if not, helping them to develop policies and provide staff trainings. In addition, these health departments plan to host Parent Café's in their local communities. Parent Cafés are structured, small group conversations, to facilitate transformation and healing within families, build community, develop peer-to-peer relationships, and engage parents as partners in programs that serve them. Participants of café's often report reduction in stress, improvements in their well-being and enhanced support networks.
- Violence
    - The Kansas City (KC) Health Department will work with the KC Blueprint for Violence Prevention and Healthy Communities. KC Blueprint was developed by the Violence Free Kansas City Committee, a citywide multisector collective impact effort of public and private entities with the mission to ensure that violence prevention and deterrence efforts are coordinated and rooted in public health and community resilience approaches. The goal of the KC Blueprint is to reduce incidence of violence and trauma affecting youth and families and ultimately heal the city together. (KCBlueprint, 2020)
- Lead poisoning
    - The Johnson County Health Department continues to work with local child care providers to develop lead testing policies and provide on-site lead testing for children along with education and referral to resources. Child care providers that develop policies and practices will be recognized by the health department with a "seal of greatness".

Young Children Specific
The Child Care Health Consultation (CCHC) Program will continue to provide consultations and trainings for child care providers and health promotion for children in child care on a variety of injury prevention topics to promote safe child care environments, encourage healthy and safe behaviors, and prevent injuries in children. Consultations for child care providers will assist in the assessment of healthy and safe environments using evidence-based tools, development and review of policies, implementation of health and safety procedures, promoting active supervision, and utilizing safe and developmentally appropriate equipment in the indoor and outdoor environments of the child care facility. Training and health promotion topics will include, but not be limited to: abuse and neglect, mandated reporting, behavioral health, emergency preparedness, CPR/First Aid, active supervision, medication administration, poisoning prevention, lead poisoning prevention, fire safety, gun safety, injury prevention, motor vehicle and car seat safety, playground safety, safe sleep, stranger safety, water safety, and sun safety. Health promotions will continue to provide children in child care with meaningful experiences regarding health and safety and injury prevention that can be implemented in their lives outside of their child care programs, and provide educational materials for parents/guardians. All CCHC Program services will continue to be inclusive and promote family engagement in safe and healthy behaviors.

Safe Kids coalitions will address priorities including child passenger safety, bicycle/helmet safety, crib safety, TV and furniture tip-over, pedestrian safety, poisoning, water, home safety, and other areas based on community needs. The coalitions will offer a broad array of activities including: providing cribs and car seats, offering parent education, conducting car seat checks, facilitating training for certification of child passenger safety technicians (CPST), conducting prevention media campaigns, and working with policy makers to address gaps in policies that could prevent injuries.

The DHSS Injury Prevention Program Manager will continue to: represent District 5 (Central District) on the MO Child Passenger Safety Advisory Committee, maintain regular contact with all CPSTs/inspection stations in the district to provide resources, mentor new CPST, be the main point of contact when the Department of Transportation, orders

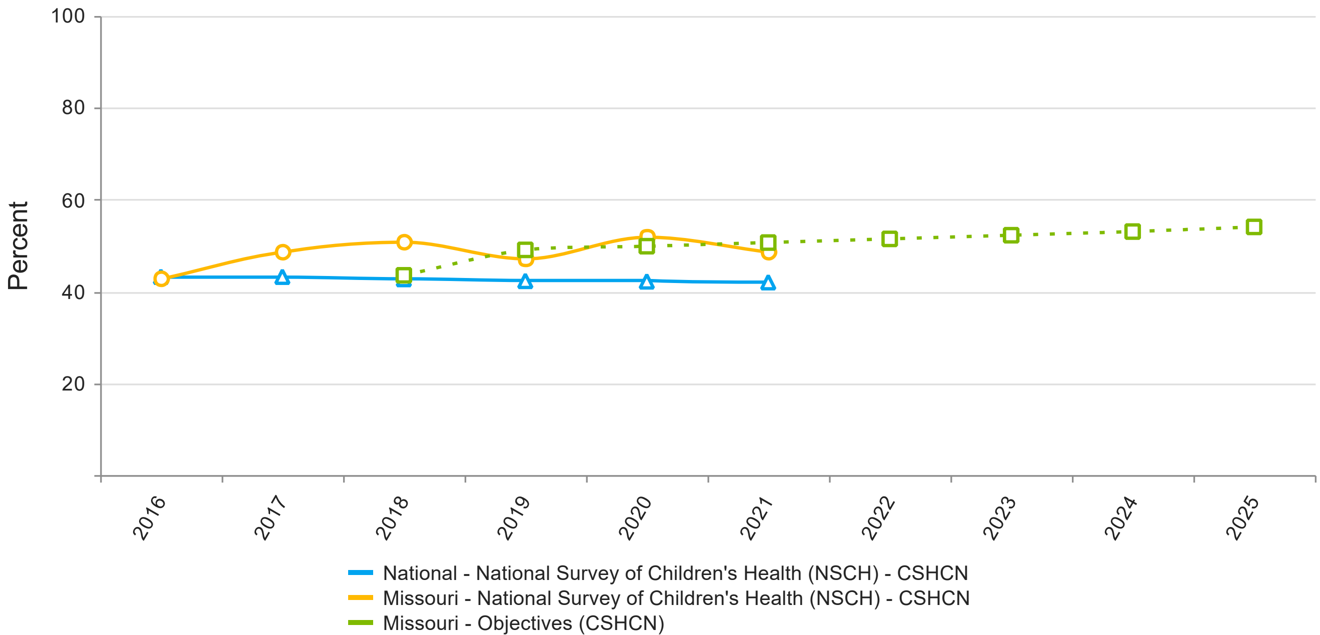
car seats for the area inspection stations, recruit new inspection stations, and attending CPS Advisory Committee meetings. The MCH Director will continue to participate on the Missouri Brain Injury Advisory Council, MIVPAC, and the MO Council for Adolescent and School Health (CASH). The MCH Director, Injury Prevention Program Manager, MCH Program Manager, and MCH District Nurse Consultants will continue to serve on statewide and regional safety coalitions, such as the Missouri Coalition for Roadway Safety state and regional coalitions and the Occupant Safety Subcommittee, and partner with safety advocates to prevent intentional and unintentional injuries.

The violence prevention team in the Office on Women's Health (OWH) will leverage the Rape Prevention and Education Grant to promote shared risk and protective factors for violence prevention to prevent teen dating violence, sexual violence, and harassment among the middle school population in the state.

Children with Special Health Care Needs

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	43.5	49	49.8	50.6	51.4
Annual Indicator	48.6	50.6	46.9	51.9	48.5
Numerator	144,848	148,654	141,727	149,881	135,203
Denominator	298,327	293,652	301,956	288,780	278,712
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	43.5	49	49.8	50.6	51.4
Annual Indicator	50.6	46.9	51.9	51.9	
Numerator	148,654	141,727	149,881	149,881	
Denominator	293,652	301,956	288,780	288,780	
Data Source	NSCH	NSCH	NSCH	NSCH	
Data Source Year	2017_2018	2018_2019	2019_2020	2019_2020	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	52.2	53.0	54.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			1,800	2,000
Annual Indicator	1,682	1,822	1,057	637
Numerator				
Denominator				
Data Source	MO DHSS Programs	MO DHSS Programs	MO DHSS Programs	MO DSS Programs
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	2,400.0	2,800.0	3,000.0

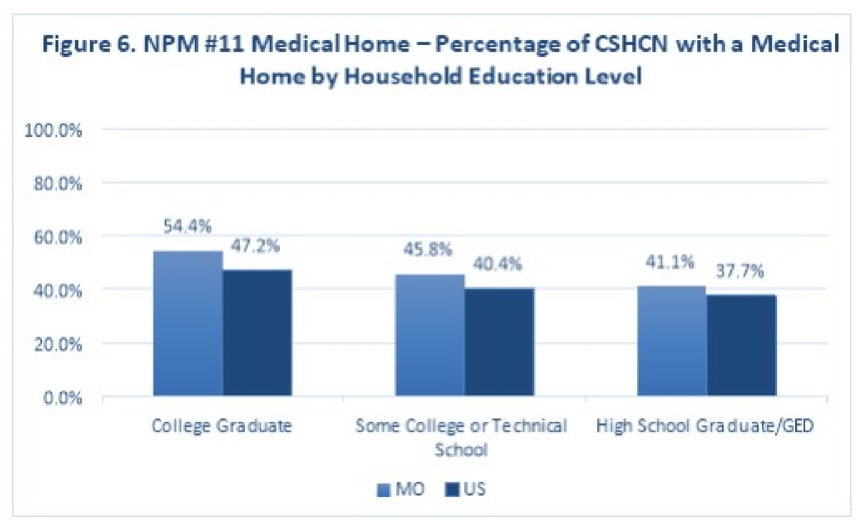
State Action Plan Table

State Action Plan Table (Missouri) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
By 2025, increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home from 50.0% (NSCH 2017-2018) to 51.0%.	
Strategies	
Promote evidence-based management of acute, chronic, and/or complex child and adolescent medical conditions.	
Promote coordinated systems across the child/family care continuum by promoting the medical home approach to care.	
Partner and collaborate with various stakeholders to integrate the medical home approach across all population health domains.	
Provide education and outreach on the importance of medical home to DHSS programs, subcontractors, and partners that serve families with children in the household.	
Build program and policy evaluation capacity.	
ESMs	**Status**
ESM 11.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

NPM #11 Medical Home – Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs

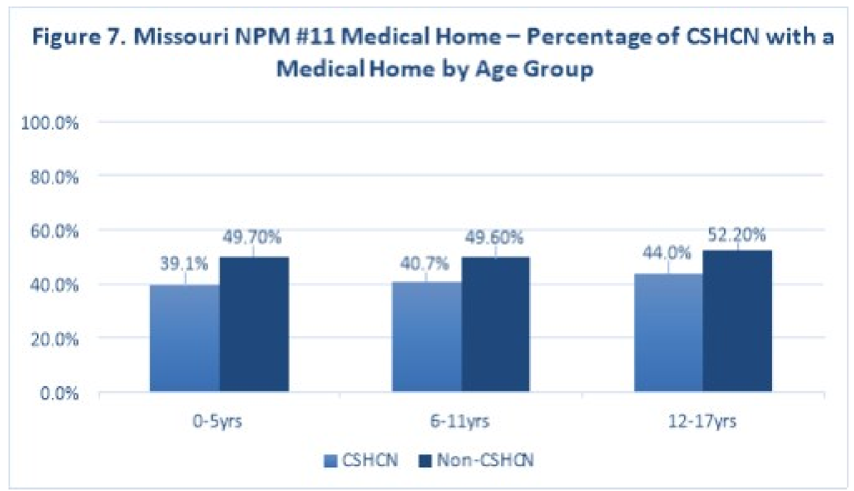
Please note: for clarity in this domain narrative, "cyshcn" refers to all children and youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount beyond that required by children generally. "CYSHCN" refers to the Children and Youth with Special Health Care Needs Program.

According to the 2020-2021 National Survey of Children's Health (NSCH), an estimated 48.5% of Missouri cyshcn had a medical home in comparison to 42.0% nationwide. The percentage of cyshcn with a medical home varied by socio-demographic characteristics. Non-Hispanic White cyshcn in Missouri (51.1%) had a medical home more frequently than their national counterparts (46.3%). Additionally, college graduate households in Missouri had a notably higher proportion than high school graduate or GED households (Figure 6). Nationally, children 0-5 years were less likely (39.1%) to have a medical home compared to 12-17 year olds (44.0%). In Missouri, younger children had a medical home less commonly (Figure 7). Cyshcn with only public insurance were less likely to have a medical home (44.1%) than their privately insured counterparts (54.3%). However, the percentage for Missouri cyshcn with only public insurance that had a medical home was higher than their national counterparts (36.5%). Single parent households (40.0%) in Missouri had a lower proportion of cyshcn with a medical home than their two-parent, married household counterparts (54.7%).



Nationally, among children without special health care needs, 47.7% received care through a medical home compared to 50.4% in Missouri. Both percentages are below the HP2030 target of 53.6%. Similar to cyshcn, the proportions of Missouri children without special health care needs also varied by socio-demographic characteristics. Non-Hispanic Whites (53.3%) had the highest proportion receiving care within a medical home compared to Hispanics (30.8%) and non-Hispanic Blacks (46.8%), this was higher than at the national level where only 37.1% of Non-Hispanic Blacks had a medical home. Missouri children without special health care needs from single parent households (50.1%) less frequently had a medical home than their counterparts from two-parent, married households (53.8%). Furthermore, children without special health care needs with private insurance only (59.5%) were more likely to receive care in a medical home than uninsured children (18.7%) and children with public insurance only (40.3%). College graduate households in Missouri (59.8%) had a higher proportion of children without special health care needs with a medical home than some college or technical school (48.8%) and high school graduate or GED

households (36.5%). This proportion was slightly higher than the national proportion for college graduate households who have a medical home (59.4%).



Medical Home Strategies

SHCN Initiatives

The Bureau of Special Health Care Needs (SHCN) Service Coordinators conducted comprehensive assessments in collaboration with participants and their families to identify strengths and address needs. Service coordination is an essential service for people with complex health conditions and needs. Service coordination provided through SHCN is culturally competent, collaborative, proactive, comprehensive, and provides assessment through home visits and linkage to resources that enable individuals to obtain the best possible health and greatest degree of independence. The primary mechanisms of service coordination are individualized assessment, planning, implementation, monitoring, and transitioning. In State Fiscal Year (SFY) 2022, 98% of SHCN participants enrolled in the CYSHCN Program, Healthy Children and Youth (HCY) Program, and Medically Fragile Adult Waiver (MFAW) Program reported having a medical home. For participants/families without a medical home, Service Coordinators provided educational materials to help participants obtain coordinated, ongoing, comprehensive care. SHCN utilized professional interpreters for phone conversations and home visits. SHCN had multiple documents available in various languages including: Arabic, Bosnian, Burmese, French, Russian, Somali, Spanish, and Vietnamese. SHCN Service Coordinators assisted participants/families in navigating the complex health care system. They collaborated with external agencies and support systems to ensure coordinated care for participants/families, including access to information systems for shared data. Service Coordinators were regionally based throughout the state, ensuring easy access for participants/families and expertise in local resources. In addition, for youth who received in home services and were aging out of the HCY Program, SHCN collaborated with management staff of the Department of Health and Senior Services (DHSS) Division of Senior and Disability Services (DSDS) and the Department of Mental Health (DMH) to increase coordination among state agencies delivering adult home and community-based services. In Missouri, services for children are more robust than services for adults. Furthermore, adult services are fragmented among three state departments with separate service structures and eligibility processes. For participants who would be eligible for the MFAW Program after their 21st birthday, SHCN Service Coordinators took the lead in working with them to schedule transition meetings with staff from DSDS, the Department of Social Services (DSS), and DMH. The transition meetings were coordinated to accommodate the participant's/family's needs and each agency representative explained the services available through their agency and encouraged them to ask specific questions regarding their situation and needs. Transition meetings helped participants/families make informed decisions as they obtained information and identified available resources.

In Missouri, people who are elderly, blind, or disabled are given the option to utilize Medicaid through Managed Care or fee for service. Medical reviews are conducted to determine if individuals qualify to 'opt out' of Managed Care Medicaid. However, individuals utilizing SHCN services through the HCY or CYSHCN programs are exempt from the medical review and are automatically qualified to choose either Managed Care or fee for service. Ongoing communication between MO HealthNet (Missouri Medicaid), Managed Care Companies, provider agencies, and SHCN is required to ensure effective service provision. Individuals may switch between Managed Care Companies and/or fee for service Medicaid, which may inadvertently impact their services. Not all fee for service Medicaid provider agencies are contracted with all Managed Care Companies, so families need to prioritize and choose the option that enables them to utilize the providers who are most important to them. For participants enrolled in the HCY Program, SHCN assisted with authorization of in-home services to avoid gaps in services when changes in coverage occurred. In addition, for participants who do not receive in-home services through the HCY Program, SHCN provided MO HealthNet enrollment information on a weekly basis to ensure participants of the CYSHCN Program were provided the opportunity to choose between Managed Care Medicaid and fee for service Medicaid. The coordination of care for these individuals is extensive, but necessary to ensure access to essential services.

In SFY 2022, Service Coordinators for the CYSHCN and HCY programs completed the Service Coordination Assessment (SCA) with program participants and their families. The SCA includes components consistent with the Federal data collection regarding participants and families reporting partnering in decision-making. A total of 94% of SHCN participants and families enrolled in the Adult Brain Injury (ABI), CYSHCN, HCY, and MFAW programs reported they were 'very satisfied' with SHCN services. SHCN collaborated with partners to coordinate services for participants. SHCN Service Coordinators and Family Partners referred participants and families to MO HealthNet and assisted them in navigating the Medicaid system. The SCA also included components that assess insurance availability for medical, vision, and dental services. The SHCN information system linked with the DSS data system to obtain the current Medicaid status of participants. In addition, SHCN received referrals from the Missouri Balanced Incentive Program, also referred to as Missouri Community Options and Resources (MOCOR), for cyshcn.

Service totals for SHCN SFY22 included:

- CYSHCN Program served 738 individuals.
- HCY Program served 1,190 individuals.
- Family Partnership served 9,496 individuals.

SHCN staff and programs continued to operate with several adjustments due to COVID-19; ensuring coordinated, comprehensive and ongoing services continued for participants and families. Continuing modifications initiated in March 2020, home visits were suspended, and replaced with phone contacts for most of FFY 2022. SHCN staff collaborated with MO HealthNet staff to implement services in accordance with Centers for Medicare and Medicaid Services (CMS) approval. In addition to suspending in-home visits, the following allowances were approved for Missouri in-home services: 1) acceptance of verbal consent rather than handwritten signatures, 2) when no other caregiver was available, personal and attendant care could be provided by family members who did not live in the same residence and were not legally responsible for the participant or employed by an agency, 3) private duty nursing could be provided by family members who were licensed nurses and employed by an agency, including those who lived in the home and were legally responsible for the participant, and 4) graduate nurses were allowed to provide private duty nursing services. These state plan and waiver modifications required collaboration with MO HealthNet, as well as other state programs, to ensure consistency in allowances to reduce confusion for individuals who received services through multiple programs. Operationally, SHCN continued to make modifications to processes and procedures to enhance efficiency, with part of the workforce working remotely and part of the workforce returning to the office. In August 2022, home visits resumed and SHCN started following pre-pandemic

protocols to obtain handwritten signatures of participants/responsible parties.

SHCN administered the MO Kids Assistive Technology (KAT) contract, for improved access and independence of cyshcn. In FFY 2022, the assistive technology services and devices provided through KAT were coordinated with a total of 65 entities (families, medical professionals, service coordinators, and schools) for 26 children across Missouri. Projects included communication and mobility devices, hearing and visual devices, seating and mobility enhancements, and home and vehicle modifications. KAT was able to leverage funds from 15 different sources, totaling $131,853 to supplement Title V MCH funds. Communication with families, contractors, and service coordinators ensured that the projects were completed satisfactorily in accordance with the Americans with Disabilities Act.

SHCN Family Partners

SHCN Family Partners collaborated with key stakeholders to increase access to care for cyshcn by educating families about the importance and benefits of a medical home. Family Partners disseminated information to families through E-Newsletters and emails to keep families informed about activities and important information regarding family support. Information regarding the importance of a medical home for all children was included in the E-Newsletters. Family Partners gathered input from families to determine the effectiveness of the information shared. Communication included information and tools centered on the life course to assist families in exploring their options for resolving issues, overcoming barriers, creating a vision for the future, and connecting with resources they need to make their vision for a good life possible. Family Partners assisted families to resolve and overcome barriers that arise when taking care of cyshcn. For example, they shared ideas on how to make it easier to travel with a person who has special health care needs or prepare for a conversation with a medical provider.

The Southeast Family Partner:

- Served as the AMCHP Family Delegate for Missouri;
- Participated in family engagement activities within SHCN programs and Title V MCH; and
- Participated in the annual block grant review in November 2021 and the virtual AMCHP Conference in May 2022.

The Southwest Family Partner:

- Served as a family advocate for the Pediatric Palliative Care (PPC) Task Force through the National Coalition for Hospice and Palliative Care, which is funded by a grant from the Cameron and Hayden Lord Foundation. The task force focuses on identifying field priorities, setting field strategies, and coordinating with organizations across the country to route resources to PPC activities designed to improve national alignment and impact. It is not the intention or role of the task force to implement these projects directly, but rather to offer a road map for improving children's access to high-quality palliative care; and
- Served as member of the Council for Adolescent and School Health (CASH). These meetings provided the opportunity to offer the family perspective as well as network with other professionals around the state ranging from social workers to school counselors.

The Northwest Family Partner:

- Served as secretary for the Missouri Parent Advisory Council (PAC). The purpose of the PAC, through Missouri's Early Care and Education Connections in the Office of Childhood (OOC) at the Department of Elementary and Secondary Education (DESE), is to engage and empower Missouri families. Members of the PAC are family leaders and have experience working with agencies that provide services to at-risk families with young children. Every PAC member receives training in Strengthening Families™ and the *Protective Factors Framework through Strong Parents, Stable Children: Building Protective Factors to Strengthen*

Families; and
- Participated in family engagement activities within SHCN and Title V MCH programs.

The Northeast Family Partner:
- Served on the advisory committee for the Heartland Genetics Service Network to provide the family perspective. The Heartland Regional Genetics Network is focused on ensuring the best possible outcome for individuals with heritable conditions and optimizing the health of the population throughout the life cycle by improving understanding and awareness of genetics, expanding access to healthcare, and translating new findings to improve the quality of care within an eight-state region;
- Served as a member with the HOPE (Healthy Outcomes through Prevention Education) for Franklin County Coalition, which focuses on healthy schools and communities by promoting alcohol, drug, and suicide prevention; and
- Continued to work with the St. Louis Resource and Respite Coalition to collaborate with over 50 organizations to assist families of cyshcn.

The Family Partners for Deaf and Hard of Hearing:
- Connected with families as they navigated programs and resources after their children were diagnosed with hearing loss. The Family Partners shared additional resources and provided parent support;
- Continued to develop connections with professionals across the country by participating in Hands & Voices-Family Leadership in Language and Learning Center (FL3) and Family-to-Family Communities (F2FC) Deaf-Blind Communities Project events;
- Served as a member of the Special School District Parent Advisory Council (SSD PAC) executive committee and gained knowledge and insights regarding processes of special education and became a voice for other families by sharing concerns and providing feedback at PAC meetings;
- Facilitated F2FC meetings for Families with Children who are Deaf-Blind with Complex Needs Support Group; and
- Participated in a Hands & Voices-FL3 Learning community that created and tested a survey to measure the success of family-to-family support.

The Missouri Family-to-Family Health Information Center uses the Life Course Framework in the development of a networking folder. This framework is used in webinars, which can be viewed by anyone at any time through archives, or viewed at host sites where families and professionals can learn from each other and discuss how the topics affect their lives. The Life Course Framework encourages families to create their vision for the future and supports professionals in thinking about how they are supporting and meeting the needs of cyshcn and their families. SHCN continued to support the dissemination of the folders and Life Course materials for families of cyshcn.

Dental Home

The Office of Dental Health (ODH) continued to implement the Preventive Services Program (PSP) in Schools for the Severely Disabled under its ongoing agreement with DESE. The PSP provides an oral health screening by a dental professional, two doses of fluoride varnish for protection against tooth decay, and a referral to a local dental provider for care among children identified with a dental need. The referrals are designed to ensure identified needs are addressed and to link children to a dental home. Dental visits are recommended at least once or twice a year for all children and are especially important for children with special needs as they may have behavioral, dietary, or physical complications that affect their dental health.

Ordinarily, the PSP educates children about good oral hygiene at an educationally appropriate level. For the Schools

for the Severely Disabled, oral health education is directed toward parents and caregivers. Part of this education is an emphasis on connecting children to a dental home, regardless of whether a dental issue is identified by the ODH at the time of the screening. Children also receive toothbrushes and toothpaste, which may be left at school or taken home. The target each year is to reach all 34 schools and serve approximately 300 students. Due to Coronavirus, a lower number of students received services because schools restricted visitors and/or parents did not consent for the service. The ODH's Oral Health Consultants were available to advise on any dental issues observed. Oral health supplies, education, literature and fluoride varnish were available to any child who did not receive services due to the pandemic. Approximately 375 children were screened and/or received a fluoride varnish application. In FY22, ODH staff worked on a new data collection system in order to better assess the ODH's work in these schools. For example, if a school has a higher consent rate, ODH will work with that nurse to compare consent techniques at that school with a school with a lower-consent rate. The report will be shared with DESE to better understand the oral health needs of the cyshcn population attending Schools for the Severely Disabled.

The ODH is working with the Missouri Coalition for Oral Health, which is coordinating collaborative efforts with the Missouri Developmental Disabilities Council, DMH and the University of Missouri-Kansas City (UMKC)-Dental School, to educate dental professionals. This will promote access to care to cyshcn by increasing understanding of the dental needs of the cyshcn population, which will increase confidence in working with this population.

The Elk's Mobile Dental Program (EMDP) provides specialized dental services to individuals with Intellectual and Developmental Disabilities (I/DD). The EMDP operates in 17 locations around the state, including in many rural areas where access to a dental home for individuals with I/DD is limited. Furthermore, the Elk's team is specially trained and equipped to serve individuals with I/DD, which increases regular and urgent dental treatment. The mobile unit is wheelchair accessible and sets up in a central location to reduce the burden and disruption of transporting individuals with I/DD. Historically, General Revenue has been available to support the Elk's Mobile Dental Program and pays for about 950 patient visits and 9,000 procedures. The FY22 approved state budget included funding for the Elk's program so that they were able to provide this crucial service. In addition to state funds, the Elk's Benevolent Trust, a non-profit organization, provides financial support for the program. The Elk's Benevolent Trust provides supplemental funding so adults and children with disabilities receive needed dental care. For FY22, 430 individuals received approximately 3599 procedures, valued at $191,870. It is important to note that the EMDP also accepts Medicaid, which helps to stretch the funding. For some individuals, EMDP is their dental home due to the shortage of dental professionals that are willing to accept Medicaid and/or the reluctance of many dental teams to treat individuals with I/DDs. Through a program not funded by Title V MCH, the ODH collected data from the Elk's visits in 2019, 2020, and 2021. The data was used to create the *Elks Report*. The report surveyed 508 cyshcn in 2019 and 2020 and this marked the first time in Missouri that cyshcn-related dental health data was collected, analyzed, and disseminated in a formal report. This report is the only place to access dental information for cyshcn. The results of the survey showed more work needs to be done to provide oral health care to cyshcn. The report found that 52.4% of those surveyed had unsatisfactory dental hygiene, 80% had tooth decay and 42% had untreated decay.

Early Childhood Professionals
The OOC-Quality Programs Section within DESE provided inclusion referral services, technical assistance, and training throughout the state to help families and caregivers of cshcn. United 4 Children contracted with DESE in FFY22 and provided 630 on-site visit hours, which is a little over double the hours provided last year. They had 116 remote-only general technical assistance visits and 400 remote-only child-specific visits. An average of 86.5% of children served maintained or found new placement, a slight increase from last year. Inclusion specialists provided 8,862 direct outreach contacts to licensed, regulated or registered child care professionals, referring agencies, and school districts, including direct email outreach.

Inclusion specialists provided a variety of services for cshcn including:

- Assisted families with locating appropriate child care that successfully supports the individual needs of their child;
    - This included providing the families with a list of licensed or regulated child care facilities that can work with their child. This facilitates easy decision-making without the time and frustration of an extensive search.
    - When the list did not produce a facility that can accommodate a specific need, the specialists reached out to a program to discuss the requirements of the child in need of care. Inclusion specialists make site visits to strategize how the facility can make minor adaptations in order to successfully include the child.
    - Specialists offered follow up technical assistance until the facility is fully equipped to meet the needs of the child.
- Provided training to child care professionals and families of children with special needs to develop the necessary knowledge and skills to appropriately meet the needs of the child in care. Each participant filled out a pre and post evaluation form to determine the change in knowledge. There was an average knowledge increase of 23%;
    - A total of 292.5 hours of training were provided.
- Connected families with other community resources; and
- Provided general classroom, as well as child specific, observations. After the observations, the specialists provided technical assistance to the child care providers regarding the needs of the group or child. They helped develop strategies and offered training to further the knowledge and skills of the caregivers.
    - A licensed group home provider in the Central Northwest Region reached out for assistance in caring for several children who had experienced trauma. The specialist visited the program in person and quickly realized several barriers. There were some safety concerns as children were testing limits and unclear about all the rules. Staff struggled to get the children to focus on verbal directions when the kids were fighting over desired toys. Staff gave verbal directions from a chair across the room. The specialist provided visual problem-solving cards to help the children solve common classroom disputes and modelled supports to the provider. Afterwards, the provider was able to implement a positive reinforcement system.
    - A center in the Eastern Region reached out about a preschooler with whom teachers were seeing some challenging behaviors. The child's parent and center director thought that the child might have Autism. The specialist sent the Ages and Stages Questionnaire (ASQ) to the parent and the director. This was the first time that the center had a child who had communication and language delays. The specialist sent resources to the parent and a training on Autism Spectrum Disorder (ASD) was held in May 2022 for center staff in response to the center director's request. The specialist also observed the child at the center and proposed suggestions for visual supports and alternative seating to help support the child throughout the day.

The Quality Initiatives Section continued to provide inclusion services to support cshcn, which includes children with a perceived developmental disability and/or delay, health/mental health, or behavior issue. The inclusion specialists assisted families in locating appropriate care by providing resources and assistance so that families were educated to make decisions in the best interests of their family. They offered technical assistance to child care programs so that cshcn could maintain placement as they grow and develop, thereby reducing preschool expulsion. Inclusion specialists trained child care providers as new caregivers entered the workforce and as the needs of their programs changed based on enrollment.

While providing inclusion services to families and children, specialists identified that many of the children with

behavior concerns have also experienced some form of trauma. Developing the child care workforce to better identify the signs of trauma in children helps providers better meet the needs of the children in their care. Inclusion specialists delivered evidence-based training to child care providers and families in order to educate them on the effects of trauma in early childhood and to identify how children's behaviors may be affected by trauma. The training further addressed the stress placed on children in the foster care system and ways caregivers can support children as they transition between homes.

The current Inclusion Support (IS) project was expanded to include the addition of another inclusion specialist and the addition of a Social-Emotional Learning (SEL) project, which is an additional component of the larger IS project. The IS project provides an element of prevention in the training delivered to teachers, and in the knowledge teachers gain from on-site consultation that can be applied to new challenges. However, the primary focus of the IS Project is intervention. Inclusion specialists are asked to help a family or provider respond appropriately to a challenge occurring at a specific point in time. To most effectively prevent preschool expulsions, and the short and long-term dangers they represent, a comprehensive and proactive intervention is needed. Inclusion Specialists are asked to help a family or a provider respond appropriately to a challenge occurring with a particular child or situation. In FFY 2022, a total of 13 programs with 19 classrooms enrolled. Seven programs completed the project and the other programs completed the full-day training requirements. Training dates, hours, and number of people trained are outlined in the table below. 100% of attendees who completed the pre- and post-training survey reported gaining knowledge. There was an average of 37% knowledge gained in reference to the training objectives.

Date	Title	Hours	Number of Participants
12/4/2021	Inclusion Social Emotional Early Childhood: Developmental Monitoring, Screening, and Building Posit (SEEC session 1)	7	35
12/11/2021	Inclusion Social Emotional Early Childhood - Session 2 Creating Supportive Environments (SEEC session 2)	7	29
1/15/2022	Inclusion SEEC Session 3: Social Emotional Teaching Strategies	7	15
1/29/2022	Inclusion SEEC Session 4: Individualized Interventions	7	19
6/23/2022	Trauma Informed Strategies	2	3
8/25/2022	Embedded Learning Opportunities (SEEC)	2	4
Total		**32**	**105**

The SEL Project provides this support. A few of the main components of the program are:

- Four, daylong initial training sessions (one day a week for four weeks). The training focuses on an understanding of how children develop socially and emotionally, and how teachers can facilitate this development in practical ways. It is based on the research-based Pyramid and Conscious Discipline models.
- With family consent, the ASQ: Social-Emotional (ASQ: SE) is administered to all children enrolled in classrooms participating in the project to identify children at greater risk of social-emotional delay. This involves coordination with the Missouri Milestones Matter (MMM) Project discussed in the Child Health domain.
- Completion of classroom action plans that address environment, relationships, and social emotional teaching strategies. Three specific pro-social skills have been identified and taught to children. The action plan outlines individualized, specific steps to be taken.
- Completion of individual plans for children identified as being at-risk.
- A minimum of four on-site observation/consultation visits from a Project Specialist over a nine-month period to

facilitate implementation of plans, and support teachers through challenges that arise. Progress towards goals is made in between visits with sessions focusing on coaching specific strategies, observation for specific children, etc.

- Two Saturday half-day follow-up meetings to network and problem-solve with other participants.
- Administration of ASQ: SE at the conclusion of the project to all children who were screened at the beginning of the project and are still enrolled in the classroom.
- If all training/meeting components are completed, each participant receives a total of 32 approved training clock hours.
- Participants receive a comprehensive training manual and hands-on materials related to curriculum implementation.
- Program administrators attend a half-day session so they can support teachers' learning.

The Child Care Health Consultation (CCHC) program provided training and consultation for child care providers at regulated and unregulated child care facilities on topics around health and safety, which included topics related to cshcn, such as ASD, asthma, diabetes, food allergies, seizure disorders, traumatic brain injuries, and inclusion of chscn in child care activities. The CCHC Program provided a total of 173.75 hours of training and consultation for health care providers on cshcn, inclusion, health care access, health policy and regulation, developmental screening, and referrals to outside resources- such as WIC and MO HealthNet. Consultations assisted in the development of individualized care plans in collaboration with the child's parents/guardians and other health care professionals. The CCHC Program also provided 11.5 hours of health promotion for children in child care. CCHC staff provided health and safety lessons on topics related to cshcn, delivered with fun, developmentally appropriate, and engaging presentations. Health promotion on SEL included bullying, positive behavior support, self-esteem, celebrating differences, and empathy.

CCHC program services continued to be inclusive of adults and children of all abilities. The CCHC program encouraged family engagement in program services by inviting parents/guardians to attend all program services, especially those pertaining to their children. The CCHC program increased access to information and resources regarding the physical and emotional care of cshcn, and promoted family participation in community-based organizations. As a result of these trainings, the physical, social, and emotional health of cshcn in child care environments was optimized. Child care providers also reported being more knowledgeable about developmental screening and monitoring, which helped with identifying developmental challenges and referring families to services within their community. The capacity for LPHAs to deliver CCHC Program services was severely impacted by the COVID-19 pandemic.

Title V MCH funded Home Visitors encouraged enrolled families to access a regular source of healthcare and assist families in locating medical resources.

School Health
School nurses are a component of a medical home; assuring that students have insurance, and that those children with a potential for a life threatening event (such as a seizure, asthma flare, anaphylaxis event, alteration in blood sugar level), or a special health care procedure (such as gastric feeding, catheterization, or dressing change) have written procedures and emergency action plans in place. These plans are developed in collaboration with the parent/guardian and approved by a medical provider.

The School Health Program (SHP) provides consultation, training, resources, and support to Missouri's school nurses on any topics they encounter. The SHP prepares an annual summary report from data collected by school nurses in the public, charter, private, and parochial schools. This data includes the nurse to student ratio, the number

of students with special health care needs and/or chronic health conditions, and an assessment of student insurance status. This report is shared with stakeholders to inform them about the needs of students and school nurses. School nurses are also educated with information about MO HealthNet and other community health resources, such as federally qualified health centers (FQHCs), for working with families to improve access to healthcare services and resources in a medical home model. The SHP continued to conduct an annual workshop for new health office staff. This three-day workshop provides training on hearing and vision screenings, managing chronic health conditions in the school setting, guidance for writing emergency management and 504 plans, being a part of the Individual Education Plan(IEP) team, and developing individualized health care plans for students. In 2022, the SHP offered a three-part session on the role of the school nurse in special education with a focus on the Individuals with Disabilities Education Act (IDEA) and the school nurses role in supporting documentation to the IEP team. The SHP also provides guidance to all school nurses referencing the "*Manual for School Health Guidelines,"* which includes a matrix of health care procedures permissible in the school setting. The SHP continued to ensure that sessions offered at the annual School Nurse Leader Collaborative, Spring School Nurse Association Conference, and the Coordinated School Health Coalition Conference were applicable to school health services, supported best nursing practices, and actively promoted the role of school nurses in care coordination.

The SHP partnered with school board and principals' associations, the Missouri Family and Community Trust, and the DSS MO HealthNet Division to promote access to care via Medicaid enrollment and awareness of FQHCs.

The SHP continued to identify and support professional development opportunities for school health services staff by way of trainings, workshops, webinars and regional conferences to address Medicaid enrollment, Medicaid managed care, and chronic health conditions.

The Missouri School Boards' Association (MSBA) leads an initiative to routinely include special services representatives and nurses on schools' emergency planning teams and for schools to consider the nature of disabilities and medical conditions represented by students and staff when creating, reviewing, and implementing emergency response plans. The SHP continued to engage and partner with MSBA on the emergency planning process for cyshcn. The SHP encouraged the utilization of MSBA's Emergency Planning for CYSHCN Task Force resources to inform and support districts in improving their emergency planning process by considering the unique needs of each person within the school community. The Emergency Planning for Students with Special and Functional Needs within the Context of School and Community Planning was created and distributed to schools throughout the state. The guide has been presented at the Missouri Coordinated School Health Coalition Conference and the committee plans ongoing review of the guide to determine if revisions/updates are needed.

Newborn Screening

Since April of 2017, information about the importance of a medical home for children with and without special health care needs has been included in the Newborn Screening booklet, which is distributed to new and expectant parents. The Newborn Screening booklet is distributed upon request to birthing hospitals, pediatric hospitals and clinics, LPHAs, WIC clinics, businesses, neonatal intensive care units, and health care providers at high schools, obstetrician and gynecological clinics, home birthing centers, and prenatal classes. On average, approximately 4,000 booklets are requested by these entities per month.

The Missouri Newborn Hearing Screening Program (MNHSP) collaborated with the Family Partnership Program to engage families in the Missouri Early Hearing Detection and Intervention (EHDI) system. Family Partners for families with children who are deaf or hard-of-hearing (FP-DHH) contacted parents of infants newly diagnosed with permanent hearing loss to provide parent-to-parent support, review resources, and ensure awareness of the importance of the medical home in the care of a child who is deaf or hard-of-hearing (D/HH). FPs enrolled 29 families into the FP EHDI family-based email outreach that provides regular information about resources and other

supports to families with children who are D/HH. The MNHSP and FP-DHHs collaborated with the Missouri School for the Deaf (MSD) to refer 14 families to the MSD Families First Program. Families First offers free home-based early intervention services to families with children who are D/HH.

Childhood Lead Poisoning Prevention
The Childhood Lead Poisoning Prevention Program (CLPPP) staff continued to work with LPHA and MO HealthNet lead case managers to coordinate clinical and environmental services for families of children with elevated blood lead (EBL) levels to strengthen the role of the primary care provider within the public health domain. To further strengthen coordination between clinical and environmental services, CLPPP hired a nurse to expand the impact of training and outreach to our partners. The CLPPP staff convened a Lead Advisory Committee to offer additional recommendations on lead and its impact on Missourians.

Supporting these individual and public health relationships with a variety of clinical and environmental expertise result in EBL levels declining more rapidly, therefore preventing further undesirable health effects. These supportive activities included:

- Leading education to health care providers, LPHAs, WIC programs, and during community events;
- Documenting case managers, physicians, and other clinicians names and phone numbers in the records of children with EBL levels;
- Including family partners and representatives of various clinical and environmental disciplines when designing and planning new program strategies;
- Developing strategies to increase the efficacy of care coordination by sharing and documenting pertinent case management information and actions across disciplines and with family/caregiver input; and
- Working with family partners to review program materials, and planned activities.

In addition, CLPPP partnered with Title V MCH programs, health care providers, and DESE to establish well-coordinated efforts to provide early evaluation and referrals for services as well as ongoing monitoring and services for children with lead poisoning. Schools should have an early and ongoing role in the appropriate and timely follow-up of children who have an EBL history. Schools can request, collect, and record blood lead level information for all children in their district. Therefore, increasing timely referrals to DESE allows children who have an EBL history to have a variety of expanded and ongoing evaluation, monitoring, and intervention services available to them such as: school nurses, Parents as Teachers, First Steps Early Intervention Programs, Head Start Programs, and other special services that develop IEPs. DESE program staff provided lead awareness education for all families/children in their districts from birth to high school graduation regarding the potential adverse effects of lead on the developing infant and child. Additionally, they shared information on services available to help decrease the potential ongoing exposures and detrimental effects of lead. They worked with children’s medical providers to assure that initial and ongoing health, developmental, behavioral, and cognitive assessments/evaluations were performed. DESE program staff either performed or referred children for child health and developmental evaluations, intervention services needed due to lead exposure prior to and/or during their school years, and other programs available through the school district.

The CLPPP staff also focused on lead hazard reduction in dwellings linked to a child with an EBL, including contracting with a licensed lead abatement firm in compliance with procurement processes. The program assisted low-income homeowners and subsidized housing landlords to perform lead hazard reduction in dwellings linked to a child with an EBL. Funding was used to supplement training costs to encourage contractors to become licensed in lead abatement in areas of the state that lacked capacity. A recent national study shows that every dollar spent on lead hazard reduction has a $17 - $250 return on investment over the life a child.

Local Public Health Agencies (LPHA)
The MCH Services Program continued contracts with the LPHAs to support a leadership role for LPHAs at the local level to:

- Build community-based systems and expand the resources those systems can use to respond to priority MCH issues;
- Provide and assure mothers and children (particularly those with low-income or with limited availability to health services) access to quality MCH services;
- Reduce health disparities for women, infants, and children, including those with special health care needs;
- Promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for low-income, at-risk pregnant women; and
- Promote the health of children by providing preventive and primary care services for low-income children.

The MCH Services Program collaborated with the CYSHCN Program, specifically the Family Partners, to provide a training regarding Medical Home to LPHA contractors. Fifty-one LPHA staff attended and reported an increase in knowledge and resources after the training.

The LPHAs' efforts to fulfill the purpose of the MCH Services contract include activities and services that address the needs of cyshcn. One LPHA is working on the priority health issue of children with and without special health care needs to ensure coordinated, comprehensive, and on-going health care service for children, provide education about special health care needs, and promote the medical home approach. The Tri-County Health Department assessed children ages 0-5 for medical home status during the child's WIC visit. They plan to develop this screening tool to add a referral component. The health department has implemented an electronic health record, CureMD, to maintain accessible, comprehensive, and complete health records that can be shared with other providers. Implementation has increased the number of insurance plans the health department can accept and bill. The MCH Services Program conducted extensive research and created a "Care Notebook" to assist families and caregivers in maintaining a record of their child's care, services, and providers. The Care Notebook can be taken to all medical appointments, therapies, conferences, and vacations. The Care Notebook is in the piloting phase during FFY 2023.

State Agencies and Partners
In addition to the programs at DHSS, there are several other initiatives that contribute to Missourians receiving coordinated, comprehensive, and ongoing health care services throughout the state. In October 2011, the CMS approved Missouri's State Plan Amendment (SPA) establishing Medicaid reimbursement for health homes, making Missouri the first state in the nation to have an approved SPA for health home services. This first SPA established Community Mental Health Center (CMHC) Healthcare Homes serving individuals with serious mental illness. A companion SPA establishing Primary Care Health Homes (PCHH) in Missouri was approved in December 2011. Both SPAs were effective January 1, 2012. MO HealthNet, DMH, and the community mental health systems collaborated to establish 'health homes' throughout the state's 29 CMHCs. Missouri's CMHC Healthcare Home Program was selected to receive the American Psychiatric Association's 2015 Gold Achievement Award in the category of community-based programs. The PCHH initiative provides intensive care coordination and care management as well as addresses social determinants of health for medically complex individuals. One aspect of the program includes the implementation and evaluation of the Patient Centered Medical Home (PCMH) model. The program emphasizes the integration of primary and behavioral health care in order to achieve improved health outcomes. In addition, MO HealthNet employs Registered Nurse Case Managers in the Evidence-Based Decision Support Unit. The unit established a pilot case management project made up of a multidisciplinary team that includes clinicians. The purpose of the pilot is to build infrastructure to support participants. Participants are selected for the pilot by utilizing an algorithm that determines participants with high needs and expenditures. The initiative builds a collaborative resource network to identify available resources. Care plans are developed for each of the participants

in the case management program.

Missouri’s pediatric hospitals also provide services that support comprehensive, coordinated, and ongoing healthcare. The Journey’s Program at the University of Missouri Children’s Hospital helps coordinate care provided by a child’s health care professionals, community, and family to meet the physical, emotional, and spiritual needs of the child and family as they cope with complex medical conditions. Children’s Mercy Hospital in Kansas City and St. Louis Children’s Hospital provide family-centered care coordination through the Beacon Program and Clinic and the Pediatric Advanced Care Team (PACT) respectively.

Children with Special Health Care Needs - Application Year

NPM #11 Medical Home – Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs

Please note: for clarity in this domain narrative, "cyshcn" refers to all children and youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount beyond that required by children generally. "CYSHCN" refers to the Children and Youth with Special Health Care Needs Program.

The Bureau of Special Health Care Needs (SHCN) will continue to provide service coordination and conduct comprehensive assessments for participants/families, regardless of financial status. For participants/families who do not report having a medical home, Service Coordinators will provide educational materials to help them obtain coordinated, ongoing, and comprehensive care within a medical home. SHCN staff will receive training regarding the definition, principles, and key components of service coordination. SHCN staff and staff from contracted agencies will continue to discuss emergency planning with participants/families and provide them with materials to prepare for emergency situations to ensure safety and well-being during inclement weather and other potential situations. To ensure culturally competent services, SHCN will continue to utilize professional interpreters for phone conversations and home visits. Educational materials, forms, and letters will be translated and available in various languages to accommodate the population served. In addition, staff and Service Coordinators of contracted entities will have opportunities to participate in conferences and trainings focused on cultural diversity.

SHCN will continue to collaborate with the Department of Social Services (DSS), the Department of Mental Health (DMH), and the Department of Elementary and Secondary Education (DESE), as well as other external partners and agencies to: 1) obtain information about children and youth with special health care needs (cyshcn) who transition within the systems of care and 2) link participants/families with appropriate services. Service Coordinators will continue to discuss life transitions with participants/families to help prepare for changes and navigating systems and supports. For youth who receive in home services and are aging out of the Healthy Children and Youth (HCY) Program, SHCN will begin discussing options for adult services with the participant/family at least one year prior to the participant's 21st birthday. In addition, SHCN will provide a list of participants who are aging out of the HCY Program with the Department of Health and Senior Services (DHSS) Division of Senior and Disability Services (DSDS)-Long-Term Services and Supports and DMH. SHCN will offer to conduct multi-agency transition meetings for participants who would be eligible for the Medically Fragile Adult Waiver (MFAW) Program after their 21st birthday in an effort to help them make informed decisions regarding services. SHCN staff and staff from contracted agencies will continue to access the MO HealthNet (Missouri Medicaid) information systems to determine the MO HealthNet status of participants and will refer participants/families who do not have MO HealthNet to DSS. In complex situations, SHCN will assist families by contacting DSS to expedite MO HealthNet applications and assist in resolving MO HealthNet access issues.

Service coordination is essential for people with complex conditions and needs. Service Coordinators for the Children and Youth with Special Health Care Needs (CYSHCN) and HCY programs will continue to complete Service Coordination Assessments (SCA) in collaboration with participants and families to address strengths and needs, which drives service plan development and implementation. The assessment tool includes medical home components that address whether a participant has:

1. A usual source of medical care when sick;
2. A usual source of preventive health care;
3. Visited a physician or specialist within the past year;
4. Health care providers that share information with each other and/or with non-medical providers;

5. Medical providers who spend enough time during visits, listening carefully, considering values and customs, providing needed information, and making the participant/family feel like a partner;
6. Knowledge on who to call for services;
7. The ability to get referrals when needed;
8. Received most services in the local community;
9. Adequate insurance to pay for needed services;
10. Access to language or mobility accommodations; and

The assessment tool also includes a component to assess if the participant/family feels like a partner with their SHCN Service Coordinator in making decisions regarding their services. In addition, the tool includes components to assess if participants/families are satisfied with general health services (physicians, hospitals, therapist, etc.), in-home provider agency services, and SHCN services. The SCA includes information regarding medical, dental, and vision insurance. SCA components related to adequate health insurance for cyshcn assess the following: if the insurance offers benefits and services that meet participants' needs, if the cost is considered reasonable, if the plan allows participants to see the providers needed, and if participant had health coverage all of the last 12 months. The SCA also assesses if services are organized in an easy and accessible way for families of cyshcn. For participants who are 13 to 21 years of age, the SCA contains components to assess preparation for youth transitions including: if doctors or other health care providers talked about the changing health needs when the participant becomes an adult, if a plan for addressing changing needs has been developed, if doctors or other health care providers have discussed having the participant eventually see a doctor who treats adults, and if the participant has received vocational or career training to help prepare for a job.

SHCN Family Partnership
Family Partners will contact newly enrolled SHCN program participants to inform them of the Family Partnership Program and to increase awareness of the importance of a medical home for children with and without special health care needs. Family Partners will continue to share medical home information through their listservs, as well as at resource fairs, conferences, regional and statewide events, including the Parent-Caregiver Retreat. Family Partnership newsletters will keep families informed of statewide activities, as well as important information regarding supports available for families. The addition of a full-time Family Partnership Manager has strengthened the capacity of the Family Partnership Program to work closely with the Title V MCH core team and align efforts to implement medical home strategies. The Family Partnership Manager will continue leading the Family Partners in evaluating current activities and identifying future priorities related to medical home.

Family Partners will continue to be involved in a variety of initiatives. The Southeast Family Partner will continue to serve as the AMCHP Family Delegate for Missouri and will participate in family engagement activities within SHCN and Title V MCH programs. The Northeast Family Partner will continue to serve on the advisory committee for the Heartland Genetics Service Network and work with the St. Louis Resource and Respite Coalition.

SHCN plans to continue to utilize Title V MCH funds to support the printing and dissemination of Missouri Family to Family Information Center Life Course materials and resource folders for families of cyshcn.

Family advocacy is critical in building coordinated and comprehensive systems. The Early Childhood Comprehensive Systems Health Integration P-3 grant (ECCS HIP-3) partners with Title V MCH to maintain and support the Missouri Parent Advisory Council (PAC). Over the life of the grant, seven regional PACs will be established and supported and will feed into a larger statewide PAC. The PACs will inform early childhood policy and procedure at local, regional, and state levels. Historically, the PAC also developed opportunities for parent and family involvement in their communities and across the state. The expanded regional model of the PAC will ensure that it is more inclusive and representative of all Missouri families with diverse needs and backgrounds.

Dental Home
The Office of Dental Health (ODH) will continue to implement the Preventive Services Program (PSP) in Schools for the Severely Disabled under its ongoing agreement with DESE. The PSP provides an oral health screening by a dental professional, two applications of fluoride varnish for protection against tooth decay, and a referral to a local dental provider. The referral is designed to ensure identified needs are addressed and to link children to a dental home. Dental visits are recommended for all children at least once or twice annually and are especially important for children with special needs, as they may have behavioral, dietary, or physical complications that affect dental health.

Ordinarily, the PSP educates children about good oral hygiene at an educationally appropriate level. For the Schools for the Severely Disabled, the oral health education is directed toward school caregivers and parents of students that have physical and/or intellectual disabilities. Part of this education is an emphasis on connecting children to a Dental Home, regardless of whether a dental issue is identified at the time of the screening. Children also receive toothbrushes and toothpaste, which may be left at school or taken home. The target each year is to reach all 34 schools and serve approximately 300 students. The ODH's Oral Health Consultants will be traveling to the Schools for the Severely Disabled in order to screen and apply varnish as allowed. Consultants will also be available to advise on any dental issues students have. Oral health supplies, education, literature, and fluoride varnish will be available to any child who does not receive a dental screening. The ODH created an online screening survey form for the consultants to complete when they screen students. With those survey forms, the ODH will be able to determine which school has a higher participation rate and can look to that school nurse for advice on ways to increase participation at other schools with lower participation rates. The survey forms will also be used to create a one-page fact sheet/report that will be shared with DESE.

The ODH is working with the Missouri Coalition for Oral Health, which is coordinating collaborative efforts with Missouri's Developmental Disabilities Council, DMH and the University of Missouri Kansas City Dental School to educate dental professionals, thereby increasing access to care for cyshcn.

The Elk's Mobile Dental Program provides specialized dental services to individuals with Intellectual and Developmental Disabilities (I/DD). The program operates in 17 locations around the state, including in many rural areas where access to a dental home for individuals with I/DD is limited. Furthermore, the Elk's team is specially trained and equipped to serve individuals with I/DD, which increases compliance with regular and urgent dental treatment over time. The mobile unit is wheelchair accessible and sets up in a central location to reduce the burden and disruption of transporting individuals with I/DD. General Revenue has historically supported the Elk's Mobile Dental Program and pays for about 950 patient visits and 9,000 procedures. The FY24 proposed state budget includes increased funding for the Elks program. In addition to General Revenue, the Elk's Benevolent Trust, a non-profit organization, also provides financial support for the program. The Trust provides supplemental funding so adults and children with disabilities can receive dental care. It is important to note that the Elk's Mobile Dental Program also accepts Medicaid, which helps supplement the funding. Due to the shortage of dental professionals that are willing to accept Medicaid ~~as a form of payment~~ and/or the reluctance of many dental teams to treat individuals with certain I/DDs, the program is the dental home for some individuals.

Early Childhood Professionals
The Office of Childhood (OOC) Quality Initiatives Section within DESE provides inclusion referral services, technical assistance, and training throughout the state to help families and caregivers of cshcn.

Inclusion Specialists provide a variety of services for cshcn. The specialists:

- Assist families with locating appropriate child care that will successfully support the individual needs of their

child.
    - This includes providing the families with a list of licensed or regulated child care facilities who have the ability to work with their child. This facilitates easy decision-making without the time and frustration of an extensive search.
    - When the list does not produce a facility that can accommodate a specific need, the specialists reach out to the program to discuss the requirements of the child in need of care. Inclusion Specialists make site visits to the program to strategize on how the facility can make minor adaptations to successfully include the child.
    - They offer follow up technical assistance until the facility is fully equipped to meet the needs of the child.
- Provide training to caregivers to develop the necessary knowledge and skills to appropriately meet the needs of the child in care.
- Connect families with other community resources as appropriate.
- Provide general classroom, as well as child specific, observations. After the observations, the specialists are able to provide technical assistance to child care providers regarding the needs of the group or child. They help develop strategies and offer training as needed to further the knowledge and skills of the caregivers.

The Quality Initiatives Section will continue to provide inclusion services to support children with special needs, which includes children with a perceived developmental disability and/or delay, health/mental health, or behavior issue. The Inclusion Specialists will continue to assist families in locating appropriate care by providing resources and assistance so that families are educated to make decisions in their best interests. They will continue to offer technical assistance to child care programs so children with special needs can maintain placement as they grow and develop, thereby reducing preschool expulsion. Inclusion Specialists will continue offering training to child care providers as new caregivers enter the workforce and as the needs within their programs change as new children are enrolled.

While providing inclusion services to families and children, specialists have identified that many of the children with behavior concerns have also experienced some form of trauma. Developing the child care workforce to better identify the signs of trauma in children will help providers better meet the needs of the children in their care. Inclusion Specialists have begun to deliver evidence-based training to child care providers and families in order to educate them on the effects of trauma in early childhood and to identify how children's behaviors may be affected by trauma. The training further addresses the stress placed on children in the foster care system and ways caregivers can support children as they transition between homes.

In FY21, the Inclusion Services (IS) project listed above was expanded to include the addition of another Inclusion Specialist and a Social-Emotional Learning (SEL) project. The IS project provides an element of prevention in the training delivered to teachers, and in the knowledge teachers gain from on-site consultation that can be carried over to future challenges. However, the primary focus of the IS Project is intervention. Inclusion Specialists are asked to help a family or a provider respond appropriately to a challenge occurring at a specific point in time. The intervention focuses on helping the teacher work with a particular child or situation. A more comprehensive and proactive program is needed to most effectively prevent preschool expulsions and the short and long-term dangers they present. The SEL Project provides this support. A few of the main components of the program are:

- Four, daylong initial training sessions (one day a week for four weeks). The training focuses on understanding how children develop socially and emotionally, and how teachers can facilitate this development in real, practical ways. It is based on the research-based Pyramid and Conscious Discipline models.
- With family permission, the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) is administered to all children enrolled in classrooms participating in the project to identify children at greater risk of social-emotional delay. This could involve coordination with the Missouri Milestones Matter (MMM) project discussed

in the Child Health domain.
- Completion of classroom action plans to address environment, relationships, and social emotional teaching strategies. Three specific pro-social skills will be identified and taught to children. The action plan outlines individualized, specific steps to be taken.
- Completion of individual plans for children identified as being at-risk.
- A minimum of four on-site observation/consultation visits from a Project Specialist over a nine-month period to facilitate implementation of plans, and support teachers through challenges that arise. Progress towards goals will be made in between visits with sessions focusing on coaching specific strategies, observation of specific children, etc.
- Two half-day follow-up meetings on Saturday to network and problem-solve with other participants.
- Administration of the ASQ:SE at the conclusion of the project to all children who were screened at the beginning of the project and are still enrolled.
- If all training/meeting components are completed, each participant receives 32 approved training clock hours.
- Participants receive a comprehensive training manual and hands-on materials related to curriculum implementation.
- Program administrators attend a half-day session so they can support teachers' learning.

The Child Care Health Consultation (CCHC) Program will provide consultation and training for child care providers at regulated and unregulated child care facilities on topics around health and safety, which include topics relevant to young children with special health care needs such as: autism spectrum disorder, asthma, food allergies, seizure disorders, Tourette's syndrome, traumatic brain injury, diabetes, and inclusion. The CCHC Program will continue to: 1) provide consultations for child care providers to assist in the development of individualized health care plans (IHPs) with input from other health specialists and parents/guardians, and 2) assist with referrals to outside resources such as MO HealthNet for Kids, immunizations, developmental screening, and WIC. The CCHC Program will also continue to provide developmentally appropriate health promotion presentations for children in child care on topics including: safe interactions with children with food allergies, bullying, positive behavior support, self-esteem, celebrating differences, and empathy. CCHC Program services will continue to provide evidence-based and educational materials regarding the physical and emotional care of cshcn, optimize the physical, social, and emotional health of young children with special health care needs in the child care setting, and promote participation in community-based organizations. CCHC Program services will continue to be required to be inclusive of adults and children of all abilities, and family participation and engagement will be encouraged during all program services.

School Health

The School Health Program (SHP) considers school nurses as a component of a medical home; assuring students have insurance, and children with a potential for a life threatening event (such as a seizure, asthma flare, anaphylaxis event, alteration in blood sugar level), or a special health care procedure (such as gastric feeding, catheterization, or dressing change) have written procedures and emergency action plans in place. These plans are developed in collaboration with the parent/guardian and approved by a medical provider. The SHP will continue to promote the School Nurse Chronic Health Assessment Tool (SN-CHAT) to engage school nurses and parents in developing emergency action plans and IHPs.

The state school nurse consultant will continue to serve on the faculty for the Autism ECHO (Extension for Community Healthcare Outcomes). This learning opportunity shares autism specialist knowledge in a virtual learning network with a panel of interdisciplinary providers. Participants learn about best practices and evidence-based care for children with autism and developmental behavioral concerns, including detecting mental health concerns, diagnosing and treating common mental health disorders, making appropriate referrals, and supporting kids and teens in their treatment for mental health disorders. The ECHO meets every other week during the school year and targets school

nurses and support staff.

The SHP will continue to provide consultation, training, resources, and support to school nurses on health-related topics. The SHP prepares an annual summary report from data collected by school nurses in public, charter, private, and parochial schools. This data includes the nurse to student ratio, the number of students with special health care needs and/or chronic health conditions, and an assessment of student insurance status. This report is shared with stakeholders to inform them about the needs of students and school nurses. School nurses will continue to receive print materials, video presentations, and virtual conferences about MO HealthNet and other community health resources, including FQHCs to facilitate their role in supporting families to access health care and other health care services and strengthen their role in the medical home model. The SHP will continue to conduct an annual workshop for new health office staff. This three-day workshop provides training on hearing and vision screening, managing children with chronic health conditions in the school setting, guidance for writing emergency management and 504 plans, being a part of the Individual Education Plan (IEP) team, and developing IHPs for students. The SHP also provides guidance and consultation to all school nurses, referencing the "*Manual for School Health Guidelines,*" which includes a matrix of health care procedures permissible in the school setting. The SHP will continue efforts to ensure that sessions offered at the annual School Nurse Leader Collaborative, Spring School Nurse Association Conference, and the Coordinated School Health Coalition Conference are: applicable to school health services, support nursing best practice and actively promote the school nurse role in care coordination. A new online program, "*just in time resources", Show Me School Health*, is being launched in October 2023. This will be a website that houses information about specialized health care procedures in the school setting that a school nurse will need to be familiar with and have the ability to write an individualized health care action plan for, as well as a training and delegation plan. Tasks could be ambulation, transfer, diapering, tracheostomy suctioning, tube feeding, stoma care, catheter care, diabetes management, nebulizer treatments, oxygen and more. We will expand our training to developing 504 plans for students needing an accommodation in the school setting and the role of the school nurse on an IEP team. This program will also offer "simulation labs" for school nurses in rural settings.

The SHP will continue to partner with school board and principals' associations as well as the Missouri's Family and Community Trust and the MO HealthNet Division to promote access to care via Medicaid enrollment and awareness of FQHCs. The SHP will continue to support professional development opportunities for school health services staff by way of trainings, workshops, webinars and regional conferences to address Medicaid enrollment, Medicaid managed care, and management of cyshcn and chronic conditions.

The Missouri School Boards' Association (MSBA) leads an initiative to routinely include special services representatives and nurses on schools' emergency planning teams and for schools to consider the nature of disabilities and medical conditions presented by students and staff when creating, reviewing, and implementing emergency response plans. The SHP will continue to engage and partner with MSBA on the emergency planning process for students with special needs. The SHP will encourage the utilization of MSBA's Emergency Planning for Students with Special Needs Task Force resources to inform and support districts in improving their emergency planning process by considering the unique needs of each person within the school community.

Newborn Screening

Since April of 2017, information about the importance of a medical home for children with and without special health care needs has been included in the Newborn Screening booklet and will continue to be distributed to new and expectant parents. The Newborn Screening booklet is distributed upon request to birthing hospitals, pediatric hospitals and clinics, neonatal intensive care units, LPHAs, WIC clinics, businesses, health care providers at high schools, home birthing centers, prenatal classes, and obstetrician and gynecological clinics. On average, approximately 4,000 booklets are requested by these entities per month. In addition, the Newborn Screening Program will continue to distribute an electronic parent survey. The survey will continue to include questions about the

medical home in order to provide insight into parents' definitions of their child's medical home. The survey will be provided to parents whose child was diagnosed with a disorder identified as a result of a high risk presumptive positive newborn blood spot screen, parents whose child's blood spot screen was low risk and required a repeat screen, and a random sampling of parents whose child's screen was normal.

The Missouri Newborn Hearing Screening Program (MNHSP) will continue to collaborate with the Family Partnership Program to engage families in the Missouri Early Hearing Detection and Intervention (EHDI) system. Family Partners who are parents of children who are deaf or hard-of-hearing will contact parents of newborns who failed the newborn hearing screening to provide parent-to-parent support, review resources, and encourage appropriate follow-up with the medical home. Family Partners will continue to emphasize the role of the medical home in management of the unique needs of an infant with hearing loss through distribution of the "EHDI Parent Resource Toolkit for Western Missouri." Additionally, the MNHSP will recruit a pediatrician to the program's advisory standing committee to assist with incorporating medical home approaches in MNHSP activities.

Child Lead Poisoning Prevention

Childhood Lead Poisoning Prevention Program (CLPPP) staff will continue to work with LPHAs and Mo HealthNet lead case managers to coordinate clinical and environmental services for families of children with elevated blood lead (EBL) levels in order to strengthen the role of primary care providers within the public health domain. Supporting public health relationships involving professionals with a variety of clinical and environmental expertise results in a rapid decline in EBL, therefore preventing further undesirable health effects. These supportive activities will include:

- Leading education to health care providers, LPHAs, WIC programs, and many community activities;
- Documenting case managers, physicians, and other clinicians names and phone numbers in the records of children with EBL;
- Including Family Partners and representatives of various clinical and environmental disciplines when designing and planning new program strategies;
- Strategies to share and document pertinent case management information and actions across the disciplines and with family/caregiver input to result in coordination of care and more effective, efficient care; and
- Working with Family Partners to review program materials and planned activities.

The CLPPP will partner with other Title V MCH programs, health care providers, and DESE to establish well-coordinated efforts to provide early evaluation and referrals for services as well as ongoing monitoring and services for children with lead poisoning. Schools should have an early and ongoing role in the appropriate and timely follow-up of children with a history of EBL. Schools can request, collect, and record EBL information for all children in their district. Therefore, increasing timely referrals to DESE allows children with a history of EBL to access a variety of expanded and ongoing evaluation, monitoring, and intervention services such as school nurses, Parents as Teachers, First Steps Early Intervention Programs, Head Start Programs, and other special services to develop IEPs. DESE program staff can provide lead awareness education for all families/children in their districts, from birth to high school graduation, regarding the potential adverse effects of lead on the developing infant and child. They also share information on services available to families and children to decrease the potential ongoing exposure and detrimental effects of lead. They can work with children's medical providers to assure that initial and ongoing health, developmental, behavioral, and cognitive assessments/evaluations are performed. They can perform or refer for various types of child health and developmental evaluations and intervention services needed due to lead exposures that occur prior to and during their school years.

CLPPP staff will partner with LPHAs and Head Start programs to ensure blood lead testing is offered to vulnerable populations. Early identification of blood lead levels is critical to ensuring children are accessing services. The CLPPP staff will partner with LPHAs to provide point of care testing devices in high-risk counties to increase

identification of children at risk for lead poisoning and thus reduce the effects that can lead to special health care needs.

Local Public Health Agencies (LPHA)
The MCH Services Program will continue contracts with the LPHAs to support a leadership role for LPHAs at the local level to:

- Build community-based systems and expand the resources those systems can use to respond to priority MCH issues;
- Provide and assure mothers and children (in particular those with low income or limited access to health services access to quality MCH services;
- Reduce health disparities for women, infants, and children, including those with special health care needs;
- Promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for low income, at-risk pregnant women; and
- Promote the health of children by providing preventive and primary care services for low-income children.

LPHAs efforts to fulfill the purpose of the MCH Services contract will include activities and services that address the needs of cyshcn. One LPHA, Tri-County Health Department has selected to work on the priority health issue of children with and without special health care needs to ensure coordinated, comprehensive, and on-going health care services for children, provide education about special health care needs, and promote the medical home approach. In coordination with the WIC Program, the Tri-County Health Department assesses the medical home status of children ages 0-5 years. The health department has implemented an electronic health record to maintain accessible, comprehensive, and complete health records that can be shared with other providers. They plan to train providers and those in the community on the medical home approach and increase the number of children and families that have a "care notebook." This will assist families and caregivers in maintaining a record of their child's care, services, and providers, which can be taken to all medical appointments, therapies, conferences, and vacations to have a shared responsibility— ensuring the child receives the right care, at the right time, and in the right place. The MCH Services Program has worked with the Tri-County Health Department to research and develop a "Care Notebook", currently in the piloting phase with three different families through the Health Department. The goal is to gain insight from those with lived experience to guide completion of the final version.

State Agencies and Partners
The overall goal of the Missouri Disability and Health Collaborative is to support individuals with intellectual disabilities to be included and have access to the full range of evidence-based physical activity and nutrition programs provided through public health programs. Through the Missouri Disability and Health Collaborative, the DHSS-Bureau of Community Health and Wellness will continue to contract with University of Missouri Kansas City Institute for Human Development (UMKC-IHD) to assist with reviewing and adapting existing nutrition and physical activity strategies to assure inclusivity of people of all abilities. Missouri has developed several strategies to increase access to healthy foods and safe places to be physically active. However, few of these strategies have been designed to be accessible to people with intellectual disabilities or with the specific health needs of people with intellectual disabilities in mind.

In addition to the programs at DHSS, there are several other initiatives that contribute to Missourians receiving coordinated, comprehensive, and ongoing health care services. In October 2011, the Centers for Medicare and Medicaid Services (CMS) approved Missouri's State Plan Amendment (SPA) establishing Medicaid reimbursement for health homes, making Missouri the first state in the nation to have an approved SPA for health home services. This first SPA established Community Mental Health Center (CMHC) Healthcare Homes serving individuals with serious mental illness. A companion SPA establishing Primary Care Health Homes (PCHH) in Missouri was

approved in December 2011. Both SPAs were effective January 1, 2012. MO HealthNet, DMH, and the community mental health systems collaborated to establish ‘health homes’ throughout the state’s 29 CMHCs. Missouri’s CMHC Healthcare Home Program was selected to receive the American Psychiatric Association’s 2015 Gold Achievement Award in the category of community-based programs. The PCHH initiative provides intensive care coordination and care management as well as addresses social determinants of health for medically complex individuals. One aspect of PCHH includes the implementation and evaluation of the Patient Centered Medical Home (PCMH) model. PCHH emphasizes the integration of primary and behavioral health care in order to improve health outcomes. In addition, MO HealthNet employs Registered Nurse Case Managers in the Evidence-Based Decision Support Unit. The unit established a pilot case management project made up of a multidisciplinary team that includes clinicians. The purpose of the pilot is to build infrastructure to support participants. Participants are selected for the pilot utilizing an algorithm that determines participants with high needs and expenditures. The initiative builds a collaborative resource network to identify available resources. Care plans are developed for each of the participants in the case management program. Missouri’s pediatric hospitals also provide services that support comprehensive, coordinated, and ongoing healthcare. The Journey’s Program at the University of Missouri Children’s Hospital helps coordinate care provided by a child’s health care professionals, community, and family to meet the physical, emotional, and spiritual needs of the child and family as they cope with complex medical conditions. Children’s Mercy Hospital in Kansas City and St. Louis Children’s Hospital provide similar services, such as Family Centered Care Coordinators, The Beacon Program and Clinic, and the Pediatric Advanced Care Team.

Other Title V MCH Activities Related to cyshcn

SHCN coordinates programs and initiatives focused on developing, promoting, and supporting community-based systems that enable the best possible health and greatest degree of independence for Missourians with special health care needs. SHCN accomplishes its mission in collaboration with families, health care providers, and other community, state, and national partners. SHCN values family partnerships in decision-making and satisfaction with the services they receive. SHCN programs and initiatives include the ABI Program, CYSHCN Program, HCY Program, Family Partnership Initiative, and MFAW Program. Bureau programs and initiatives that serve cyshcn include the CYSHCN Program, the HCY Program, and the Family Partnership Initiative. In addition to these programs and initiatives, SHCN provides funding to Missouri Assistive Technology for the Kids Assistive Technology (KAT) project, which improves access and reduces barriers for cyshcn. SHCN also facilitates the Missouri Brain Injury Advisory Council and administers the Federal Traumatic Brain Injury State Partnership Grant.

The CYSHCN Program provides statewide assistance for individuals from birth to age 21 who have or are at increased risk for a medical condition that may hinder their normal physical growth and development and who generally require more medical services than other children and youth. The program focuses on early identification and service coordination for individuals who meet medical eligibility guidelines. As payer of last resort, the CYSHCN Program provides limited funding for medically necessary diagnostic and treatment services for individuals whose families also meet financial eligibility guidelines. To be eligible for the CYSHCN Program, participants must: be a Missouri resident, be between birth to 21, have an eligible special health care need condition (such as cerebral palsy, cystic fibrosis, cleft lip and palate, hearing disorders, hemophilia, paraplegia, quadriplegia, seizures, spina bifida, and traumatic brain injury), and meet financial eligibility guidelines for funded services (family income at or below 185% of the Federal Poverty Guidelines). The CYSHCN Program provides two primary services: Service Coordination and Funded Services. Service coordination is provided to all participants, regardless of financial status, including: outreach/identification and referral/application, eligibility determination, assessment of needs, resource identification, referral and access, family support, service plan development and implementation, monitoring, and evaluation, and transition/closure. SHCN maintains contracts with multiple LPHAs to provide service coordination for the CYSHCN Program. CYSHCN Service Coordinators complete comprehensive individual assessments during annual home visits to identify each participant’s/family’s unique needs and assist the family with

resource identification and referral to ensure their needs are met. In addition to service coordination, limited funding (up to $25,000 annually per participant) is available for medically necessary diagnostic and treatment services for participants whose families meet financial eligibility guidelines. Funded services may include but are not limited to: doctor visits, emergency care, inpatient hospitalization, outpatient surgery, prescription medication, diagnostic testing, orthodontia and prosthodontia (cleft lip/palate only), therapy (physical, occupational, speech, and respiratory), durable medical equipment, orthotics, hearing aids, specialized formula, and incontinence supplies. Service Coordinators assist participants/families with resource identification and referral. All third party liability is exhausted prior to accessing CYSHCN program funds. Direct care diagnostic and treatment services are supported through state funds. Service coordination is supported through state funds, Medicaid, and the Title V MCH Block Grant.

SHCN administers the HCY Program through a cooperative agreement with MO HealthNet. To be eligible for the HCY Program, participants must be a Missouri resident, be between birth and 21 years, need medically necessary services, and be enrolled in the MO HealthNet fee for service system (not the MO HealthNet Managed Care Plans). The HCY Program provides service coordination that involves: evaluation and needs assessment, identifying and accessing service providers, service plan development and implementation, coordination of services through resource identification and referral, family support, assisting in establishing a medical home, transition planning, and prior authorization of medically necessary services (private duty nursing, advanced personal care, personal care aide, skilled nursing visits, authorized registered nurse visits, and administrative case management). SHCN Nurse Service Coordinators monitor services through assessments, regular home visits, medical records, and care plan review. The HCY Program is primarily supported through Medicaid funds with secondary support through state and Title V MCH Block Grant funding.

The SHCN Family Partnership enhances the lives of individuals and families impacted by special heath care needs by providing resources and information to empower families to live a good life. The Family Partnership hosts events to benefit families through development of leadership skills, networking among peers, and staying current with trends and issues regarding special health care needs. Each Family Partner is a parent of a child or youth with special health care needs and is well equipped to assist families in exploring options and solutions. The SHCN Family Partnership is funded primarily through the Title V MCH Block Grant and secondarily through the HRSA Universal Newborn Hearing Screening and Intervention Program Grant. Additional information about the SHCN Family Partnership can be found in the Family Partnership section of the grant application.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - Number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			20	100
Annual Indicator	0		48	90
Numerator				
Denominator				
Data Source	MO DHSS MCH Program training attendance sheets		MO DHSS Internal Survey	MO DHSS MCH Training Log
Data Source Year	2019		2021	2022
Provisional or Final ?	Provisional		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	150.0	175.0	200.0

State Action Plan Table

State Action Plan Table (Missouri) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Address Social Determinants of Health Inequities.

SPM

SPM 3 - Number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Objectives

Increase the number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings from 0% to 65%.

Strategies

Ensure culturally and linguistically appropriate resources, education, and care are available for all women of childbearing age, mothers, children, and adolescents, including children and youth with special health care needs, and their families.

Promote breastfeeding in a culturally appropriate manner.

Educate DHSS Title V partners on the medical home approach and definition of children and youth with special health care needs.

Encourage and employ person-centered approaches to Title V programming.

Operationalize core MCH values, establish a standard level of training on the MCH Leadership Competencies, and create a plan to implement training to all Title V funded partners.

Build program and policy evaluation capacity.

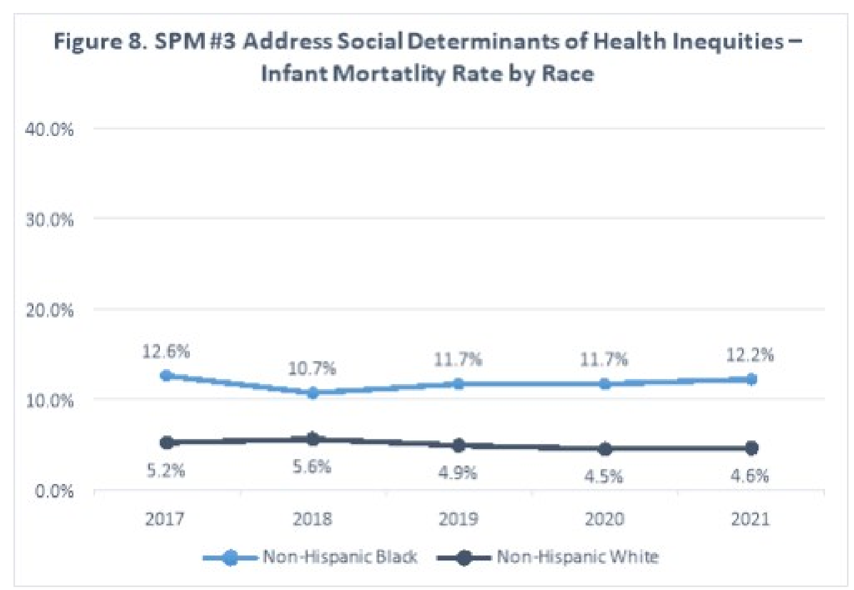
Cross-Cutting/Systems Builiding - Annual Report

SPM #3 Address Social Determinants of Health Inequities

Please note that additional examples of how SDoH were addressed may be found throughout the annual report narratives for the other National and State Performance Measures by population domain.

Existing economic and health disparities indicate a continuing need for prioritizing efforts to address the social determinants of health (SDoH). Economic stability is one of the primary SDoH. Missouri's poverty rate has declined each year from 14.8% in 2015 to 12.7% in 2021[1], which suggests increasing economic stability for some Missourians. However, additional examination indicates that poverty is consistently higher among Non-Hispanic Blacks and Hispanics compared to Non-Hispanic Whites. In 2021, the poverty rate for Non-Hispanic White Missourians (10.6%) was lower than that of both Non-Hispanic Blacks (22.9%) and Hispanics (18.9%).[2] Geographic disparities in poverty also exist with a 13.0% poverty rate for urban counties in 2021 compared to an 11.0% poverty rate for the rural counties in the same year.

Health care access and quality is also a primary domain of SDoH. Racial disparities in both infant and maternal mortality indicate a need to explore improvements in health care access and quality as part of efforts to address the SDoH. Missouri Vital Statistics data denote the Missouri infant mortality rate for 2021 was 5.7 per 1,000 live births. Though there was a reduction in Missouri's overall infant mortality rate from 2017 to 2021, the racial disparity between Non-Hispanic Black women and Non-Hispanic White women persisted (Figure 8). Additionally, the 2016-2020 maternal mortality rate for Non-Hispanic Black women (80.6) was considerably higher than that of Non-Hispanic White women (30.6).



To gain buy-in and build internal awareness and understanding across MCH programs and the Department of Health and Senior Services overall, Title V MCH has identified workforce development training on MCH core fundamentals, SDoH, trauma-response programs and services, and cultural competence. This workforce development training plan has allowed Title V MCH Block Grant-funded program staff to gain a better understanding of the impact of SDoH and how to effectively integrate strategies to address the root causes of health inequities into policies and program services and activities. The training plan was launched in FFY22 and 90 out of 100 Title V MCH program staff completed a series of three training videos from the Association of Maternal and Child Health Programs. The videos

provided baseline knowledge on core MCH issues as well background information about the history of the Title V MCH Block Grant. Beginning in FFY24 the training plan will be extended to external contractors.

Other Title V MCH Activities Related to the Cross-Cutting & Systems Building Domain

The Bureau of Special Health Care Needs (SHCN) Service Coordinators and Family Partners continually focus on the SDoH for families of individuals with special health care needs served by SHCN. SHCN employs Family Partners to provide the unique perspective of parents of children and youth with special health care needs (CSHCN). Interpreters are utilized for conversations and forms are translated into various languages. The Service Coordination Assessment (SCA) is a comprehensive assessment that assesses, identifies, and addresses concerns beyond the scope of services provided through SHCN programs. Examples of topics covered in the SCA include: insurance coverage, military service, mobility, transportation, dietary concerns, emotional status, social/environmental (such as social inactivity and barriers keeping the participant from getting out into the community or participating in activities they enjoy, as well as home environment safety and stability of living conditions), cognitive concerns, educational/vocational, family functioning (such as risk factors and family support), and cultural belief system. Both SHCN Service Coordinators and Family Partners frequently connect families with resources for food, housing, utility services, social supports, transportation, and recreational/leisure opportunities. SHCN emphasizes improving the quality of life for participants and families beyond the direct care services provided through SHCN programs. Additional information regarding SHCN is included in the CSHCN Domain of the application and report.

DHSS leveraged funding from the Centers for Disease Control and Prevention (CDC) State Physical Activity and Nutrition (SPAN) grant to provide a free virtual lactation consultant preparation course that prioritized participants serving communities with low breastfeeding rates and/or health care disparities among women of color. Every effort was made to encourage women of color to become peer counselors or International Board Certified Lactation Consultants (IBCLCs) in regions where disparities in care exist. The SPAN grant also funded Uzazi Village in Kansas City to support candidates in its lactation internship program, which prioritizes candidates who choose to serve in communities of color. This program helps candidates who wish to become IBCLCs to finish their required training and mentorship hours and prepare for the credentialing exam.

The School Health Program (SHP) implemented the School Nurse Chronic Health Assessment Tool (SN CHAT). The SN CHAT helps school nurses gather information about students who have chronic health conditions. School nurses can use this tool to guide conversations in person or via phone with a student’s parents/guardians or caregivers; learn about the health needs of an individual student; determine if they should create an individualized healthcare plan (IHP) and/or emergency action plan for a student; and consider many of the SDoH in developing a coordinated plan of care. SHP piloted the SN CHAT in the 2020-2021 school year, and is promoting the resource broadly as a useful tool for school districts to improve the quality of student health information and plan to appropriately address student health and education needs. The SHP surveyed school nurses from seven school districts to determine if the SN CHAT tool was useful. The surveyed schools increased their overall participation in Emergency Action Plans by 50% from the previous year and increased staff teaching about the individual child’s condition by 70% from the previous year.

The Child Care Health Consultation (CCHC) Program consultants continued to assess for referral needs at every training, consultation, and health promotion. To improve health care access, they referred children, providers, and parents to resources, including MO HealthNet, developmental screening, and WIC. CCHC Program services also increased the child care provider’s awareness of services available within their communities. The CCHC Program continued to provide services at regulated and unregulated child care facilities that serve families eligible for the Child Care Subsidy Program. CCHC Program services, including CPR/First Aid certifications and renewals, were provided at little to no cost to the child care provider. This was for the optimal health and safety of children and their

families and to ensure that all child care providers and children in child care learned about health and safety topics that address SDoH inequities. CCHC Program services also provided consultation and training for child care providers on implementing individualized care plans, and implementing policies and procedures that promote inclusivity and family partnerships. The CCHC Program Manager continued to assist CCHC Program trainers in the distribution and development of resources that address SDoH and racial justice. By providing these resources, more children and families received education about resources available to them and had access to health care. The CCHC program encouraged family participation in all program services, and services continued to be required to be inclusive of adults and children of all abilities. The capacity for LPHAs to deliver CCHC Program services was severely impacted by the COVID-19 pandemic.

The TEL-LINK Program referred 223 callers to MO HealthNet services to increase insurance coverage. The program continued to provide targeted outreach campaigns through online search engines to the underserved population through effective marketing strategies. The campaign reached over 175,000 Missourians resulting in 7,491 individuals taking action to find out more.

The Newborn Health program continued to partner with a wide-variety of community health providers to distribute the *Pregnancy and Beyond* booklet, which contains information about financial resources, including MO HealthNet for pregnant women and children.

The DHSS Newborn Screening Program collaborated with midwives across the state to ensure uninsured and low income clients had access to affordable blood spot screening. The Missouri State Public Health Laboratory maintains agreements with approximately 40 midwives primarily caring for clients who otherwise would decline blood spot screening due to cost. The midwives purchased blood spot collection cards at a discounted rate and passed those savings on to qualifying clients. The midwives reported an increase in compliance and fewer refusals due to the more affordable cost. On September 9, 2022, DHSS staff attended the Missouri Sickle Cell Disease State Action Planning Initiative meeting at Washington University in St. Louis. The goal of this initiative was to convene collaborators with a vested interest in improving health outcomes for individuals with sickle cell disease. The meeting served as a kick-off and vision-casting event to initiate a yearlong process to develop a comprehensive and cohesive State Action Plan for sickle cell disease and trait. The group envisioned the Action Plan to be a roadmap that will transform healthcare delivery including access and cost effectiveness of care for Missourians with sickle cell disease. At the meeting, workgroups were established and will meet regularly for a year with the goal of developing a written Action Plan by August 2023.

The MCH funded Home Visiting programs’ contracted home visitors assessed all home visiting clients for insurance status at initial enrollment and periodically throughout enrollment. As need for health care coverage was identified, home visitors assisted clients/families in the Medicaid enrollment process and to the Affordable Care Act marketplace by linking clients to their nearest Federally Qualified Health Center (FQHC) to speak with a trained navigator in order to obtain eligibility and enrollment assistance. Annual data on insurance coverage through Medicaid, private, or other insurance was collected on children and primary caregivers enrolled in home visiting. In FY22, 53.9% (387/717) of primary caregivers with medical insurance coverage maintained it continuously for 6 months. Insurance coverage is vital to assuring children access adequate preventive health care including well child care. In FY22, 92% (692/752) of children enrolled in home visiting received the last recommended well-child visit based on the America Academy of Pediatrics (AAP) schedule.

The Safe Cribs Program has worked to increase access to crib resources and education to areas of the state that are considered underserved.

As a member of the Medicaid Advisory Council, the SHP continued to collaborate and partner with the MO HealthNet, Managed Care plans, Department of Social Services (DSS), FQHCs, state agencies and programs, as well as funding organizations to provide information, tools, and resources to school nurses related to Medicaid and access to health care. These materials equip school nurses with information about health care plans and services to aid them when assisting parents and families to obtain adequate health insurance coverage and access health care services and health plan benefits. The SHP uses data shared by DSS to review the reported number of children enrolled in MO HealthNet annually for trends and comparison to the trending number of students reported as uninsured from school nurse reporting. With the passage of legislation to expand Missouri Medicaid eligibility to healthy adults, the SHP worked with school nurses to provide information and resources to support them in assisting families with MO HealthNet enrollment. The SHP supports school nurses in assessing student insurance status and assisting families with MO HealthNet applications and accessing benefits through a variety of training opportunities including virtual seminars attended by over 100 school nurses, email blasts and presentations at school nurse conferences.

The SHP leveraged funding from another grant to release a contract to provide school health services to small rural schools without a formal health services program. In the 2022-2023 school year, there were 60 schools without a formal school health program. This program is currently serving 64 school districts with a student population of 20,597 school age children in rural settings. These schools received onsite and virtual supervision and support by registered professional school nurses. The schools also received the equipment necessary to offer sensory screenings.

The SHP and the MCH Director participated in the *Show-Me School-Based Health Alliance* as a partner on the steering committee. This Missouri affiliate of the National School-Based Health Alliance works with partner organizations and community stakeholders to increase the number and expand the service offerings of school based clinics. Missouri has seen the number of school based health centers rise from five in 2017 to 106 (not including satellite clinics) in 2022. The Alliance also works to enhance access to health care services for all students since a barrier to care is that students may have to miss school for medical appointments and parents miss work to take students to those appointments.

The SHP collaborates with school health staff in local education agencies (public, private, parochial, and Charter schools) to collect annual reporting data utilizing an online database. This system has been in place for over a decade and the information is used to identify trends, facilitate planning of state resources, and ensure up-to-date communication with lead school nurses. The SHP uses the data to monitor staffing of school health services and to identify school districts without designated school health services staff. The program then offers additional support and technical assistance to assure a minimum level of health services are available. The database also collects district-level data for students with health insurance. The SHP reviews this data to identify needs of school nurses. The program also uses this information as an indicator for reporting to state and local leaders on the status of healthcare access in schools and communities. The SHP continued to engage school nurses to utilize the reporting system and investigate options to update the database to improve collection, access and data sharing.

The Early Childhood Comprehensive System (ECCS) received a five-year grant in August 2021, “ECCS Health Integration: Prenatal to 3 Program,” in the amount of $255,600 per year. This funding will support the ECCS Program in leading the first integration of health needs, resources, and systems into the existing Statewide Early Care and Education (ECE) Strategic Plan and will build on current collaborative efforts to increase the impact for the prenatal to three population. A System Assets Gap Analysis was completed and confirmed a lack of integration of the Maternal Child Health and ECE systems at both the state and the local level.

The MCH Services Program supports local public health agency (LPHA) efforts to:

- increase the number of clients that receive a risk assessment or screening and referral for Medicaid eligibility;
- assure that all women of childbearing age receive preconception care services that enables them to enter pregnancy in optimal health;
- develop and promote strategies to increase the proportion of women receiving prenatal care beginning in the first trimester; and
- assure that women of childbearing age and children eligible for Medicaid maintain coverage during the "unwinding of the COVID-19 Public Health Emergency".

LPHAs continue to:
- screen clients for MO HealthNet or other insurance coverage;
- screen for an identified primary care provider;
- perform pregnancy testing, prenatal education, and OB/GYN referrals as indicated;
- provide prenatal case management and/or referral for pregnant women;
- assist pregnant women with MO HealthNet program eligibility and enrollment; and
- screen clients for an identified dental care provider and provide dental referrals as indicated.

The MCH Services Program and the MCH Director continued to facilitate collaboration between DHSS, DSS, and the LPHAs to provide MEDES (Missouri Eligibility Determination and Enrollment System) updates, maintain open and effective interagency communication, promote adequate health insurance coverage, and improve health care access for MCH populations.

In addition, the MCH Services Program continued to contract with 111 LPHAs to address priority MCH issues in their communities. The MCH Services Program worked with the LPHAs in year one of their five-year work plans to address their selected priority health issue. The LPHA work plans include evidence-based strategies to address their selected local priority health issue (PHI), which includes addressing SDoH, existing health inequities, and gaps/weaknesses in access to care.

- The Jackson County Health Department chose addressing SDoH inequities among preconception/prenatal/postpartum women of childbearing age as their PHI. The Jackson County Health Department leadership reported increased awareness of local initiatives that impact the public's health as a result of implementing a local policy tracking process. This policy tracking process tasks Community Engagement and Policy Division staff with monitoring and reporting local legislative updates to inform leadership on city and county initiatives. An increase in stakeholder and elected official knowledge in regards to public health policy has been achieved as a result of developing a quarterly policy newsletter that is shared with stakeholders and elected officials, sharing state and local legislative updates, community partnerships, and public health policy in the news.

Through the Inclusion Services (IS) project, the Inclusion Specialists provided referrals to appropriate services, including services provided by local public school districts, as part of child-specific action plans. Specialists helped child care providers in identifying SDoH such as housing, food access, poverty, and/or exposure to violence as some possible reasons behind children's behaviors. Because child care providers increased their knowledge and skill set on how to better work with and maintain care for children with special needs, there has been a reduction in preschool expulsions. At the 6-week follow-up, an average 16.5% of children/families were referred for additional services with an average of 7.5% receiving additional services. When a child scored close to the cut-off on the Ages and Stages Questionnaire: Social-Emotional (ASQ-SE), the teacher and family received activities to support the child's overall growth and development. The Inclusion Specialist problem-solved with the teacher on how to address any potential

concerns. When a child scored “at-risk” or above the cut-off on the ASQ-SE, a referral for further evaluation was made to First Steps or the local school district depending on the child’s age.

The Office of Dental Health (ODH) continued to promote the importance of oral health for the entire MCH population through LPHAs, school districts and FQHCs. The ODH also continued to assess oral health screening results from schoolchildren in the state in order to promote services in those areas. The ODH leveraged other funding to educate the general public on the importance of water fluoridation, which is one of the most equitable public health intervention measures since everyone no matter their race, sex, age or gender can enjoy the benefits of community water fluoridation. The ODH also continued to develop posts for the DHSS social media site on the importance of oral health.

The CLPPP Program worked to connect case managers with language appropriate resources for their patients with elevated blood lead levels. The program utilized resources from across the nation to meet the needs of children and families impacted by lead poisoning. The program received several requests for information in Dari and Pashto and a link to translated information was provided.

The CLPPP staff are collecting data on disparities in lead poisoning to help guide programmatic decisions and identify areas of most need. Once identified, a strategic plan will be developed to address ongoing disparities across Missouri in an effort to reduce rates of lead poisoning for the most vulnerable Missourians.

The Missouri Newborn Hearing Screening Program (MNHSP) incorporated culturally and linguistically appropriate services into the program’s activities to assure that all babies born in Missouri receive a hearing screening and appropriate follow-up. The MNHSP empowered families with limited English proficiency by training all new and current MNHSP staff on use of phone interpretation services, updating imagery on the MNHSP brochures to reflect diverse populations, and creating bilingual parent literature in English and Spanish.

The Office on Women’s Health (OWH) incorporated cultural competence into multiple dimensions of their work. The OWH leveraged MCH funded staff to lead the rape prevention and education program. This program built capacity for cultural competence by contracting with the Missouri Coalition against Domestic and Sexual Violence (MOCADSV). MOCADSV developed a training for community health workers on health equity and violence prevention. By incorporating cultural competence into all of the work, the OWH had a larger impact on improving health for women in Missouri.

To address the SDoH inequities and continue building a comprehensive maternal-child public health system to address the priority needs of Missouri’s MCH population, the MCH Director:

- Used web-based platforms to engage in virtual meetings and continued to build relationships with statewide MCH stakeholders;
- Provided virtual and in-person presentations on the Life Course Perspective and facilitated a simulation of the Life Course Perspective for students enrolled in the MCH-focused MPH graduate program at St. Louis University;
- Initiated and engaged in discussions related to the SDoH, health literacy, health disparities, diversity, and inclusion;
- Promoted trauma-responsive and culturally competent MCH programs and services;
- Contributed to Department efforts to create a diverse and inclusive work environment and promoted incorporation of the principles of cultural competence and humility, diversity and inclusion into programs and initiatives;
- Promoted activities and initiatives to ensure access to care, including adequate insurance coverage, for MCH

populations and to promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities; and

- Practiced, promoted and supported efforts to recruit and retain a qualified, diverse and well-trained MCH workforce.

The Injury Prevention program continued to partner with the Safe Kids coalitions to implement evidence-based programs and identify gaps in current services. The Safe Kids coalitions addressed priorities including child passenger safety, bicycle safety, crib safety, TV and furniture tip-over, pedestrian safety, poisoning, farm safety, safe sleep, teen driver safety, medication, fire and water safety and other areas based on community needs. The coalitions offered a broad array of activities including: providing cribs, car seats and parental education, conducting car seat checks and certification training for child passenger safety technicians (CPST), promoting the National Safety Council's Defensive Driving Course (DDC), conducting media campaigns with prevention messages, and working with policymakers to address gaps in policies that could prevent injuries.

The Adolescent Health program (AHP) used some SDoH factors to determine the highest need areas of the state to direct federal funding for pregnancy prevention. The needs assessment for this is reran every 5-6 years depending on grant applications to determine if counties have increased or decreased needs.

The AHP continued its partnership with the Chafee Program and DSS to provide Making Proud Choices (MPC) Out of Home Edition to older youth who are aging out of foster care. These youth learn not only pregnancy prevention, but also adult preparation topics to prepare them for life after foster care. Over 160 foster youth participated in this program.

[1] U.S. Census Bureau, American Community Survey 1-Year Estimates Subject Tables.
[2] U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE).

Cross-Cutting/Systems Building - Application Year

SPM #3 Address Social Determinants of Health Inequities

The Centers for Disease Control and Prevention (CDC) defines Social Determinants of Health (SDoH) as “conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes.” SDoH include factors like socioeconomic status, education, neighborhood and physical environment, employment, social supports, and access to quality health care. From the Life Course Perspective, addressing SDoH is integral to improving health and reducing longstanding disparities in MCH. Many disparate health outcomes persist in MCH, including a higher risk of maternal mortality among Black women and a higher risk of infant mortality among Black infants. A deeper understanding of SDoH and the root causes of health inequities is imperative for promoting and improving the health of Missouri’s mothers, infants and children.

To gain buy-in and build internal awareness and understanding across MCH programs and the Department of Health and Senior Services (DHSS) overall, Title V MCH is implementing a core MCH training plan, including didactic and interactive experiences for leaders, team members and MCH program staff. To gain a better understanding of the impact of SDoH and how to effectively integrate strategies to address the root causes of health inequities into policies and program services and activities and to provide foundational skills, MCH leadership is working to identify workforce development training on MCH fundamentals, Life Course Perspective, SDoH, cultural competence and humility, and health literacy.

MCH leadership is reviewing existing resources, MCH Navigator trainings, MCH Leadership Competencies, and evidence-based training methods and content and developing a continuously evolving training plan to establish initial and ongoing training requirements for internal Title V MCH program staff and external contractors. The training plan will continue to be developed and implemented beyond the Title V MCH core team.

In alignment with the new DHSS *Culturally and Linguistically Appropriate Services Standards* Policy, the diverse populations served by Title V MCH will be considered at all stages of Title V MCH program and service delivery, and Title V MCH funded programs will consider the needs of their target population(s) and how programs will be inclusive of and non-stigmatizing towards program participants. All programs and services will be culturally and linguistically aware and appropriate, to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Special focus will be given to marginalized and underrepresented populations and communities. The Culturally and Linguistically Appropriate Services (CLAS) standards will be applied as general guidelines for all programs and services to provide a uniform framework for developing and monitoring CLAS that are broadly inclusive of diverse racial, ethnic, sexual, and other cultural and linguistic groups.

The person-centered approach ultimately sees human beings as having an innate tendency to develop towards their full potential. The key principles of person-centered care include: valuing people – treating them with dignity and respect by being aware of and supporting personal perspectives, values, beliefs and preferences; autonomy - providing choice and respect for choices made; life experience - understanding the importance of a person’s past, their present-day experience, and their hopes for the future; understanding relationships - collaborative relationships, social connectedness and opportunities to engage in meaningful activities; and environment - organization-wide commitment to individual and organizational learning underpinned by person-centered principles. Title V MCH funded programs and services will incorporate the key principles and apply the central themes believed to help achieve person-centered care: 1) congruence – being completely genuine; 2) empathy – striving to understand a person’s experience; and 3) unconditional positive regard – being non-judgmental and valuing.

Information regarding services provided to address the SDoH inequities for children and youth with special health care needs and their families can be found in the CSHCN Population Domain and Family Partnership section narratives.

If Missouri is awarded the CDC SPAN grant funding for FFY24-29, DHSS will provide a lactation consultant preparation course at a centrally located site, making it available to participants from areas of the state that currently have low breastfeeding rates and disparities. Every effort will be made to encourage women of color to become peer counselors or International Board Certified Lactation Consultants (IBCLCs) in regions where disparities in breastfeeding support exist. DHSS will provide a level 1 lactation training in 2023 and a level 2 lactation training in 2024. The combination of these two courses will provide the 90 hours of lactation specific education needed to sit for the IBCLC exam. The state breastfeeding coordinator and the Bureau of Community Health and Wellness (BCHW) also plan to implement a one-year mentorship program for under-resourced applicants planning to sit for the exam. Using funding from the SPAN grant, the program will provide a scholarship to pay for the IBCLC exam. The combined result of these efforts should significantly reduce barriers to achieving the IBCLC credential. In addition to IBCLC training, if Missouri is awarded the SPAN grant for the next funding cycle, funding will also be made available for doulas and other mid-level lactation providers to receive breastfeeding training and support specific to their scope of practice. Title V MCH resources will be leveraged to support ongoing and new activities associated with the CDC SPAN grant.

The Missouri Physical Activity and Nutrition (MPAN) Program will continue collaborating with the Healthy Weight Advisory Committee, a subgroup of the Missouri Council for Activity and Nutrition. The committee provides expertise and advice to advance and monitor collaborative, sustainable, evidence-based strategies for increasing the number of children at a healthy weight. MPAN will support the Advisory Committee in efforts to increase workforce capacity to deliver weight management treatments aligned with the newly available MO HealthNet benefit for children and adults.

The School Health Program (SHP) will continue to implement the School Nurse Chronic Health Assessment Tool (SN CHAT) and broadly promote the resource as a tool for school districts to improve the quality of student health information and plan to appropriately address student health and education needs.SN CHAT has two main components; the parent interview tool and an easy to use emergency action plan for the school nurse to use with school staff. This interview tool was developed so that school nurses will be efficient in asking pertinent questions in a collaborative approach with parent. It is developed to be used in a face-to-face conversation or by phone with the parent or guardian.

The SHP is contracting with the state Missouri Action Council and its regional affiliates to offer poverty simulations for every school district in every county in Missouri during the 2023-24 school year.

As administrator of the Early Childhood Comprehensive Systems (ECCS) Health Integration P-3 grant, the Office of Childhood (OOC) at the Department of Elementary and Secondary Education will work with a contractor to provide the Safe Environment for Every Kid (SEEK) training to pediatricians and family medicine physicians across the state. SEEK is an evidence-based model developed to support primary care health providers in identifying risk factors and helping prevent child maltreatment. SEEK offers a practical model to help address SDoH and enhance primary care, ultimately improving the health and well-being of children and families. The trainings will include strategies to address targeted SDoH that are also risk factors for child maltreatment, such as parental depression, major parental stress, substance use, intimate partner (domestic) violence, food insecurity, and harsh punishment. Additional training modules will address the medical and behavioral health teams in primary care settings. Modules will include relationship building, motivational interviewing, addressing barriers to engagement, and probing suicidality. The grant will also be used to provide maternal substance use and trauma-informed care training to home visitors and other early childhood care and education professionals.

Other Title V MCH Activities Related to the Cross-Cutting & Systems Building Domain

To continue building a comprehensive maternal-child public health system to address the priority needs of Missouri's MCH population, the MCH Director will continue to:

- Build relationships with statewide MCH stakeholders;
- Provide presentations on and facilitate a simulation of the Life Course Perspective to undergraduate and graduate students and internal and external partners and stakeholders;
- Initiate and engage in discussions related to the SDoH, health literacy, health disparities, diversity, and inclusion;
- Promote trauma-responsive and culturally competent MCH programs and services;
- Contribute to Department efforts to create a diverse and inclusive work environment and incorporate the principles of cultural competence and humility, diversity and inclusion into programs and initiatives;
- Promote activities and initiatives to ensure access to care, including adequate insurance coverage, for MCH populations and to promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities;
- Explore opportunities to expand Missouri's MCH data capacity and enhance public health surveillance/reporting systems; and
- Promote and support efforts to recruit and retain a qualified, diverse and well-trained MCH workforce.

The Child Care Health Consultation (CCHC) Program will continue to provide consultation and training for child care providers and health promotion for children in child care at both regulated and unregulated child care facilities, including those that serve families eligible for the Child Care Subsidy Program. CCHC Program services will continue to be inclusive of adults and children of all abilities. Services will address a variety of health and safety topics that affect SDoH, and will be provided at little to no cost to the child care provider and the children in their care to ensure that everyone has access to program services to improve their health and promote safe environments. LPHA staff that provide CCHC Program services will continue to assess for referral needs for health care access, including MO HealthNet for Kids, immunizations, developmental screening, and WIC. CCHC Program services will also continue to assist child care providers in the identification and utilization of community resources and organizations that address health disparities. The CCHC Program will also continue to facilitate CPR/First Aid training at little to no cost for child care providers. The CCHC Program Specialist will continue to assist LPHA staff providing CCHC Program Services in developing resources for child care providers and families and health promotion for children in child care. The resources will address SDoH inequities and social justice, and provide resources for employee and community-based assistance. The CCHC Program will continue to encourage family participation in all services, and continue to provide consultation and training for child care providers on developing and implementing procedures, and providing trainings that promote inclusivity and optimal family partnerships for the health and safety of children in child care.

The TEL-LINK Program will refer callers to MO HealthNet to improve health and reduce health disparities by increasing insurance coverage among the MCH population. The program will continue to provide outreach to the underserved population through effective marketing strategies. The ParentLink MCH WarmLine and MCH Navigators will continue to assist parents, caregivers, and families with enrollment in eligible MO HealthNet coverage plans, WIC, Supplemental Nutritional Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Missouri Child Care Subsidy Program, Child and Adult Care Food Program (CACFP), MO Low Income Home Energy Assistance Program, and other financial and social support services, as needed.

The Newborn Health program will continue to partner with a wide-variety of community health providers to distribute

the *Pregnancy and Beyond* booklet, which contains information about financial resources for pregnant women and children, including MO HealthNet.

The Title V MCH funded Home Visiting programs' contracted home visitors will assess all home visiting clients for insurance status at initial enrollment and periodically throughout enrollment. As need for health care coverage is identified, home visitors will assist clients/families in the Medicaid enrollment process and accessing the Affordable Care Act marketplace by linking clients to their nearest FQHC to speak with a trained navigator in order to obtain eligibility and enrollment assistance. Annual data on insurance coverage through Medicaid, private, or other insurance will be collected on children and primary caregivers enrolled in-home visiting. Insurance coverage is vital to assuring children can access adequate and equitable preventive health care including well child care. Annual performance measure data will be collected on the percentage of children enrolled in home visiting who receive the last recommended well-child visit based on the America Academy of Pediatrics (AAP) schedule. Data will be analyzed for practices indicating unrecognized racial and/or cultural bias that could result in unintentional healthcare inequity.

The SHP, as a member of the Medicaid Advisory Council, will continue to collaborate and partner with the MO HealthNet Managed Care plans, Department of Social Services (DSS), FQHCs, state agencies and programs, and funding organizations to provide information, tools, and resources to school nurses. These materials will equip school nurses with information about health care plans and services to aid them when assisting parents and families obtain adequate health insurance coverage, and access health care services and health plan benefits. The outreach materials and patient education is available in multiple languages and is reviewed by health literacy professionals to assure the messages are relevant to targeted audiences and communities. The SHP will use data shared by DSS to review the reported number of children enrolled in MO HealthNet annually for trends and comparison to the number of students reported as uninsured from school nurse reporting. With the passage of legislation to expand Missouri Medicaid eligibility to healthy adults, the SHP will work with school nurses to provide information and resources to support them in assisting families with MO HealthNet enrollment. The SHP will support school nurses in assessing student insurance status, assisting families with MO HealthNet applications, and accessing benefits through a variety of training opportunities.

The SHP and the MCH Director will continue to participate in the *Show-Me School-Based Health Alliance* as a partner on the steering committee. This Missouri affiliate of the National School-Based Health Alliance will work with partner organizations and community stakeholders to increase the number of school-based clinics and expand the service offerings. Missouri has seen the number of school based health centers rise from five in 2017 to 106 (not including satellite clinics). The Alliance will also work to enhance access to health care services for all students; students missing school for medical appointments and parents missing work to take students to appointments are barriers to seeking care.

The SHP will continue to collaborate with school health staff in local education agencies (public, private, parochial, and charter schools) to collect annual reporting utilizing an online database. This system has been in place for over a decade and the information is used to identify trends, facilitate planning of state resources, and ensure up-to-date communication with lead nurses in Missouri schools. The SHP uses the data to monitor staffing of school health services and to identify school districts without designated school health services staff. The Program is then able to offer additional support and technical assistance to assure a minimum level of health services are available. The database also collects district-level data for students with health insurance, and the SHP reviews this data to identify resource and information needs of school nurses. The program also uses this information as an indicator for reporting to state and local leaders on the status of healthcare access in schools and communities. The SHP will continue to engage school nurses to utilize the reporting system and investigate options to update the database to improve collection, access, and data sharing.

The MCH Services Program will support LPHA efforts to:

- Increase the number of clients that receive a risk assessment or screening and referral for Medicaid eligibility;
- Assure that all women of childbearing age receive preconception care services that will enable them to enter pregnancy in optimal health; and
- Develop and promote strategies to increase the proportion of women receiving prenatal care beginning in the first trimester.

LPHAs will continue to:

- Screen clients for MO HealthNet or other insurance coverage;
- Screen for an identified primary care provider;
- Perform pregnancy testing, prenatal education, and OB/GYN referrals as indicated;
- Provide prenatal case management and/or referral for pregnant women;
- Assist pregnant women with MO HealthNet Program eligibility and enrollment; and
- Screen clients for an identified dental care provider and provide dental referrals as indicated.

The MCH Services Program and the MCH Director will continue to facilitate collaboration between DHSS, DSS, and the LPHAs to provide Missouri Eligibility Determination and Enrollment System (MEDES) updates, maintain open and effective interagency communication, promote adequate health insurance coverage, and improve health care access for the MCH population.

In addition, the MCH Services Program will continue to contract with 111 LPHAs to address priority MCH issues in their community. The MCH Services Program worked with the LPHAs in FFY2021 to conduct a focused, local assessment of MCH priority needs, identifying at least one priority health issue aligned with the FFY 2021-2025 Title V MCH priorities, and developed a five-year, FFY 2022-2026, work plan to address the selected priority health issue(s). The LPHA work plans include evidence-based strategies to address their selected local priority health issues, including addressing SDoH, existing health inequities, and gaps/weaknesses in access to care.

- The Jackson County Health Department has chosen Addressing SDoH inequities among women of childbearing age as their selected priority health issue. The LPHA created and adopted a Policy Action Plan to impact racial disparities and inequities. The health department provides evidence-based trainings, curriculums and practices on racial disparities and inequities to internal and external providers and partners. In an effort to communicate regularly and effectively with regional decision-makers, the health department's Community Engagement & Policy Division sends quarterly newsletters to municipal, county, and state policymakers, University Health leadership, and other community stakeholders, including an overview of the department's activities during the previous quarter, new policy or issue briefs, relevant public health policy or legislative updates, and relevant news stories. Policy newsletters were sent in January 2023 and April 2023 to 189 regional stakeholders. In addition, the health department provides regularly scheduled public health orientation, to include an overview of the health department's capabilities, programs and services, and centering equity in all activities, to newly elected Jackson County Legislators and University Health Administrators and Board Members.

The Safe Cribs for Missouri Program will continue to ensure culturally and linguistically appropriate resources and educational materials are available to participating agencies for promoting Sudden Infant Death Syndrome (SIDS) prevention and safe sleep environments during initial and follow-up educational sessions provided with crib placements.

The Office on Women's Health (OWH) will promote diversity and inclusion across all of its programs. The maternal mortality team and Pregnancy Associated Review (PAMR) Board will review all maternal deaths for contributing SDoH and bias and/or discrimination. Data will be used to identify issues and support recommendations to end bias and discrimination and promote trauma-responsive and culturally competent care and services. In the women's health programs, the OWH will ensure materials developed and distributed include evidence-based information to address gaps/weaknesses in access to care and health disparities. The violence prevention team will work across topic areas to promote diversity among community health workers. By addressing health disparities and the SDoH, the OWH will prevent violence and reduce maternal mortality.

Newborn screening touches nearly every baby born in Missouri regardless of their socioeconomic status and/or cultural background. The Newborn Blood Spot Screening Program will continue to strive to understand the parent's experience with newborn screening by implementing an improved survey process. The parent survey will include questions that assess for various barriers to seeking needed repeat screens or additional testing. The survey will ask for voluntary demographic information to ensure data is gathered from diverse participants. Determining areas of the newborn screening population where access or information is lacking will help improve outreach strategies and enhance capacity to provide more meaningful education to parents. The newborn screening team will continue to seek out and participate in opportunities to further understanding of ways to provide more culturally and linguistically inclusive services to the broadly diverse population affected by newborn blood spot screening.

The Missouri Newborn Hearing Screening Program (MNHSP) will increase the incorporation of CLAS into the program's mission to assure all babies born in Missouri receive a hearing screening and appropriate follow-up to increase the likelihood that children with hearing loss achieve communication skills. The MNHSP and its collaborating partners, the Family Partnership Program and the Missouri State University MOHear Project, will work to reflect commitment to diversity and inclusion. The MNHSP will recruit at least two more parents of children who are deaf or hard-of-hearing (DHH) or adults who are DHH to the program's advisory committee, a standing committee of the state Genetics Advisory Committee. Additionally, the MNHSP will recruit a pediatrician to the standing committee to assist with incorporating medical home approaches in MNHSP activities.

The Childhood Lead Poisoning Prevention Program (CLPPP) will focus on available data analytics to identify gaps in care and disparities in blood lead testing across the state. Once identified, outreach strategies will be implemented and resources distributed to address disparities on a priority basis. CLPPP will also work with national partners to develop and distribute culturally and linguistically diverse resources related to lead poisoning prevention. CLPPP plans to conduct a health literacy review on several documents and provide translated copies of documents on the website to address linguistically diverse populations. Three documents will be reviewed for health literacy and translated into other languages based on identified needs.

The Office of Dental Health (ODH) will continue to promote diversity and inclusion across all programs. Based on responses received from the LPHAs regarding the primary languages of their most frequent clientele, the ODH had several pieces of oral health literature translated into seven different languages. These pieces of oral health literature are available for the LPHAs to download and print. As funding allows, the ODH will print a few of the highly requested items and make them available for ordering.

The Adolescent Health Program (AHP) is undergoing a strategic planning process and plans to organize future Council for Adolescent and School Health (CASH) activities using SDoH categories. The categories will be used to plan future professional development opportunities and identify areas for growth and ways to organize future efforts for the AHP and CASH.

Through the Inclusion Services (IS) project, the Inclusion Specialists will continue to provide referrals to appropriate services, including services provided by local public school districts, as a part of child-specific action plans.

III.F. Public Input

The Department of Health and Senior Services (DHSS) utilizes various opportunities to seek input from stakeholders, community and family partners, and program participants in program decision-making. MCH assessment data, trends, priorities, performance measures, strategies, and outcomes are regularly presented to stakeholders and Title V MCH implementing partners. MCH leadership engages and solicits input from local public health agencies (LPHAs), community-based organizations, primary care and safety-net providers, and family partners to inform ongoing strategy development and implementation. Input is solicited through individual and group presentations, the DHSS website, webinars, stakeholder convenings, advisory groups, and participation in inter-agency committees and task forces.

Message to Partners for Public Input on Proposed Use of Funds

To solicit public input on the FY 2024 Title V MCH Block Grant application and proposed use of funds (PUF), the PUF document was posted on the DHSS website MCH Block Grant and Public Notice webpages, published in the LPHA weekly newsletter, the *Friday Facts*, and disseminated via email to a diverse group of MCH stakeholders. This included administrators from the 115 LPHAs, other LPHA team members, healthcare providers, hospitals, non-profit and other community organizations, other government agencies, community members, and family partners.

The MCH Director sent the following email message to over 900 MCH partners statewide.

> Dear MCH Stakeholder,
>
> Each year, the Missouri Department of Health and Senior Services (DHSS) receives funds from the Health Resources and Services Administration (HRSA)/Maternal Child Health Bureau (MCHB), in the form of the Title V Maternal and Child Health (MCH) Services Block Grant, to be used to promote and improve the health and well-being of Missouri's pregnant women, mothers, infants, children, adolescents, children and youth with special health care needs (CYSHCN), and their families. The block grant requires DHSS, as the state MCH agency, to solicit public comments from consumers and partners across the state regarding the application and proposed use of funds for the next federal fiscal year (FFY). As a valued partner of Missouri's Title V MCH Block Grant Program, we value your input and appreciate the diversity of perspective and scope of experience your partnership contributes.
>
> We invite you to review the attached FFY 2024 Proposed Use of Funds (PUF) document and send us any comments or questions you have for the Department's consideration. In addition to the proposed breakdown and distribution of funds for FFY 2024, the document also provides a general overview of the types of services supported through the block grant, and includes the FFY 2021 – 2025 MCH priorities and overarching principles. The FFY 2024 Proposed Use of Funds may also be accessed at https://health.mo.gov/information/publicnotices/publiccomment.php.
>
> Please send your feedback on the proposed use of funds **no later than July 19, 2023** to MCH@health.mo.gov or reply to this email.
>
> Please feel free to share this message and the PUF with any Missouri citizens, as well as other stakeholders and partners serving the MCH population. I encourage you to contact me to share any information, suggestions, questions, or concerns and/or discuss opportunities for collaboration.
>
> Thank you for participating in this important work, sharing your expertise and serving Missouri's MCH

populations.

Responses, summarized below, were received from a total of 12 partners and stakeholders.

- “I was wondering how this works in relation to our current MCH grant/contract plans? Thanks.” (LPHA team member experienced with the MCH Services contract)
- “I would like to see education on clean drinking water from public health and MCH perspective. Not the standard drinking water messaging by regulators. Not education overwhelmed by fluoride, or particular industry practices, or any subjects that may cause some of the public to put up guards or negative responses by industry groups or policy makers. But solid education on importance of clean drinking water to public health. Also would like to see continued work with reducing lead. Otherwise I think the proposal looks good, for what it’s worth. Thank you MCH Program for your work! We are glad to be partners in public health with you.” (LPHA administrator)
- “I would love to see the return of state-wide chronic disease prevention programming. We try to do our best on social media, etc but I feel some actual programming would be very beneficial. Please let me know if you have any questions or concerns. Thank you for all you do! I appreciate you and your team!” (A LPHA team member experienced with the MCH Services contract)
- “We have reviewed this and are pleased to see oral health included as a priority. The specification for funds to be used for direct care services, enabling services and public health service & systems is also impressive. We have no additional comments at this time. Thank you for the opportunity to review. (*Missouri Coalition for Oral Health)*
- “We are pleased to pass along Health Forward Foundation’s comments regarding the proposed use of funds for the Title V Maternal and Child Health block grants for FY 2024. We have offered our comments in consultation with one of our community leaders to help provide perspective from those working directly with birthing people and children who are most likely to be positively impacted by these block grant funds. We also stand ready to provide additional comments and resources on these community investments, should you have the need. Please feel free to reach out directly to Health Forward Foundation’s President and CEO or myself *(Policy Impact Strategist)* should you have any additional questions or other needs related to these comments. Thank you so much and we look forward to continued partnership in this space.”

  “Health Forward Foundation (HFF) respectfully submits comments on the proposed use of Title V Maternal and Child Health (MCH) block grant funds. Our comments are rooted in Health Forward’s purpose, values of trust, equity/inclusion/antiracism, partnership, learning and stewardship and reflect our policy priorities and goals. Our comments also align with DHSS’ vision for optimal health and safety for all Missourians, in all communities, for life, as well as the 10 MCH Essential Services. Our comments emphasize our communities of focus – people of color and people in rural areas – whose health outcomes are impacted by structural racism, structural urbanism, and other systemic barriers.
  In sum, we recommend that block grant funding be focused on the following themes:
    1) Supporting improved data, including disaggregated data, for mortality reviews;
    2) Improve access through funding culturally-responsive pre-natal and post-partum care by community based organizations (CBOs);
    3) Increasing the diversity of people of color underrepresented in the Maternal and Child Health healthcare workforce;
    4) Ensuring housing and nutrition for birthing people is easier to access;
    5) Exploring payment and delivery models linked to quality of care, and;
    6) Enhancing clinical and home visits through community-based services like community health workers (CHWs) helps outcomes for both mother and child.

I am happy to speak with you to answer any questions or continue in thought partnership. Thank you for all that you do to keep Missouri birthing persons and their children healthy, safe, and thriving as they grow together."

Community Leader Insights (MCH leader insights as a community based perinatal support organization working to eliminate maternal and child health disparities for Black and Brown communities)

- "Another important aspect of CBOs in this space is that, oftentimes health care providers are not best positioned to help these communities as "[health care] providers are woefully ignorant about the communities they serve! Who is helping them [providers] become community literate?"
- "Many "Black and brown children live within systematically designed environments that are just more unsafe…old, unhealthy homes and poor food availability and poor educational opportunities," and are negatively impacting child and adolescent health."
- "Clinicians will need to implement more intrapregnancy visits that focus on contraception, mental health, and pre-pregnancy wellness," especially now that Missouri has expanded post-partum Medicaid coverage to 12 months."
- "Please view the DocuCourse "Pregnancy and Prejudice" here for greater insight."

- "I want to thank you for your outstanding example of leadership and modeling how to collaborate with partners. I would like to have a better understanding of what the Public Health and Service Systems - Coordination and Systems Development category means in terms of activities/services that are eligible." (Department of Mental Health partner)
- "Addressing National Priority Area "Improve pre-conception, prenatal and postpartum health care services for women of child bearing age – Well Woman Care (Women/Maternal Health)": Is there interest/intention for education, training, hiring of Medication Assisted Treatment providers within medical settings to address substance use needs/stabilization prior to referral to other treatment providers (particularly, Alcohol Use Disorder and Opioid/Stimulant Use Disorders) during all stages of maternal health? Recommend focus on education and training of screening, identification and treatment of postpartum depression, trauma and other social determinates of health to build infrastructure for the use of dyadic Evidence Based Practices (EBP) treatments such as Child Parent Psychotherapy and TF CBT) to promote early relational health of infants and mothers thus mitigating the impact of ACE scores and long term health outcomes."
- "Thank-you for sending over this information. MHD (MO HealthNet Division) has reviewed your proposal and does not have any questions or concerns at this time. If there are any projects you would like assistance on, please do not hesitate to reach out to us." (MO HealthNet partner)
- "Thank you for sharing." (MO HealthNet partner)
- "Nice work! Thank you for your partnership and support." (internal partner)
- "Looks wonderful to me!" (SHCN Family Partner)
- "Non-profit community based organizations are an important partner in making lasting sustainable improvements in health and wellness. There are 24 YMCA associations serving 70 communities in Missouri. Several YMCA evidence-based health initiatives directly address the priority areas of the Title V Maternal and Child Health Services Block Grant: maternal health, injury prevention, and reducing obesity among children and adolescents. YMCA's Diabetes Prevention Program helps those at high risk for gestational diabetes make lifestyle changes to reduce risk. Research shows our CDC approved curriculum can reduce the number of cases by 58%. Drowning is the #1 cause of preventable death for children ages 1-4. Per the CDC, drowning rates for black children are significantly higher in all age categories of children, adolescents, and young adults. Drowning is the leading cause of death for children with Autism Spectrum Disorder (ASD). Access to a pool, swimming lessons and standardized Safety Around Water curriculum have been proven to reduce the risk of drowning. Healthy Weight and Your Child is an evidence based intervention to address childhood obesity. Our curriculum has shown significant and sustained reductions in body mass index, waist

circumference, and sedentary activities, and an increase in self-esteem. WE can partner with local communities and the State to offer our programs and improve health outcomes at no-cost to Missourians."

Responses were sent by the MCH Director to each person/organization who provided comment on the PUF. DHSS highly values input from MCH stakeholders and fellow Missourians, and all input will be taken into consideration in ongoing Title V MHC Program discussion and planning.

Engagement/Input for Ongoing Title V MCH Block Grant Implementation

Ongoing opportunities for input regarding the Title V MCH Block Grant are also available throughout the year. Virtual and in-person Public Health System meetings involve DHSS senior management and LPHA administrators and include discussions focused on a variety of public health topics including MCH issues.

DHSS seeks input from those considered "MCH Stakeholders" at other meetings, such as: Maternal-Child Learning Action Network, MO HealthNet Maternal Health Coordination, Missouri Perinatal Quality Collaborative/Maternal Child Learning Action Network, ParentLink Advisory Board, Genetics Advisory Committee, Council for Adolescent and School Health (CASH), Missouri Injury and Violence Prevention Advisory Committee (MIVPAC), Pregnancy Associated Mortality Review (PAMR) Board, Women's Health Council, Early Childhood Comprehensive System Steering Committee, Parent Advisory Council, Safe Sleep Coalition, Missouri Brain Injury Advisory Council, Community Health Worker Advisory Committee, Missouri Bootheel Regional Consortium, Bootheel Babies and Families, Nurture KC, Missouri Child Psychiatry Access Project Steering Committee, and Missouri Association for Infant and Early Childhood Mental Health, to name a few. Collaborative calls with Healthy Start grantees allow an opportunity to share resources and discuss program updates and opportunities for collaboration.

DHSS recognizes the critical role of Title V MCH funds in addressing the ongoing needs of Missouri's MCH population. Input from the MCH stakeholders and public served an important role in the development of this application and ongoing development and implementation of the State Action Plan. DHSS collaborates with partners and stakeholders and continually seeks opportunities to obtain input from other sources, and stakeholder engagement is an ongoing priority. Responses received in response to the PUF provide the opportunity to engage with new stakeholders and inform the public of the Title V MCH Services Block Grant history, purpose, goals, funding methodology, and performance measurement and the Missouri MCH State Action Plan.

The DHSS Maternal Child Health Block Grant webpage lists Missouri's National and State Priority Areas, provides links to key Title V MCH resources, and has a direct link to email any questions and/or comments regarding the MCHBG. The FFY 2024 Application and FFY 2022 Annual Report will be added to this webpage once the final document is available and will remain available throughout the duration of the grant. A link is also currently on the webpage to direct the reader to the Title V Information System (TVIS) website.

III.G. Technical Assistance

As the Missouri Title V MCH Program continues to implement the FFY 2021-2025 State Action Plan and plan for the next five-year statewide MCH Needs Assessment, areas of needed technical assistance are identified. Several current and ongoing topics for possible technical assistance have been discussed among the Title V MCH Core Team. Should the team decide to pursue technical assistance on one or more of the following topic areas, a Technical Assistance Request Form will be completed.

- Innovative methodology to collect qualitative data, engage stakeholders, including families, individuals and family-led organizations, solicit meaningful programmatic input, implement a structured and inclusive priority-setting process, and accomplish collaborative program planning as part of conducting the Five-Year statewide MCH Needs Assessment process.
- Building program and policy evaluation capacity.
- Applying Return on Investment (RoI) and Economic Impact (EI) analyses to programs and initiatives receiving Title V MCH Block Grant funding to evaluate value and impact of current Title V funding allocations.
- Expanded statewide implementation of the medical home model for children with and without special health care needs.
- Strengthening state and local capacity to actively engage youth leaders and improve the health of adolescents.
- Integrating and elevating diversity, inclusion, cultural humility, and evidence-based continuous quality improvement into MCH strategic planning and programming and aligning efforts with requirements of other federal funders to avoid duplication of efforts and promote consistency.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - DHSS MOUs with DSS-DESE-DMH.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MO DHSS Strategic Map.pdf

Supporting Document #02 - DHSS Title V MCHBG Contract_DESE Office of Childhood_FFY 2023_Final.pdf

Supporting Document #03 - FFY 2023 MCH Services Contract Scope of Work.pdf

Supporting Document #04 - DHSS-related Acronyms.pdf

Supporting Document #05 - References-Resources-Data Sources - FINAL.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DCPH-DSDS-DESE OoC Org Charts.pdf

VII. Appendix

+

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Missouri

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 13,186,864	
A. Preventive and Primary Care for Children	$ 4,175,109	(31.6%)
B. Children with Special Health Care Needs	$ 4,022,725	(30.5%)
C. Title V Administrative Costs	$ 1,098,528	(8.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 9,296,362	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,987,230	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 9,987,230	
A. Your State's FY 1989 Maintenance of Effort Amount $ 9,987,230		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 23,174,094	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 23,174,094	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
No Other Federal Programs were provided by the State on Form 2 Line 9.	

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 13,088,625 (FY 22 Federal Award: $ 12,469,248)		$ 10,199,806	
A. Preventive and Primary Care for Children	$ 4,092,830	(31.3%)	$ 3,133,970	(30.7%)
B. Children with Special Health Care Needs	$ 4,113,625	(31.4%)	$ 3,098,518	(30.3%)
C. Title V Administrative Costs	$ 1,086,820	(8.3%)	$ 756,875	(7.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 9,293,275		$ 6,989,363	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,987,230		$ 9,987,230	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 9,987,230		$ 9,987,230	
A. Your State's FY 1989 Maintenance of Effort Amount $ 9,987,230				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 23,075,855		$ 20,187,036	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 0		$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 23,075,855		$ 20,187,036	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
No Other Federal Programs were provided by the State on Form 2 Line 9.		

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: Missouri is applying for $13,186,864, which is higher than what the state has historically received in previous years. This amount reflects the total funds necessary to implement the planned strategies and initiatives and to meet the needs of the Maternal and Child populations as illustrated in the program narratives.	
2.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: As of 6/30/2023, $10,199,806 of the total FY 22 award amount ($12,469,248) had been expended. Plans are in place to ensure the remaining FY 22 funds ($2,269,442) will be expended by the end of the two-year grant cycle ending September 30, 2023. (The majority of the remaining amount has already been allocated for planned expenditures between 7/1 - 9/30/2023). The FFR will include final expenditure data and the total amount expended at grant closeout.	
3.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: This is an estimated total expenditure amount for Preventive and Primary Care for Children based on the expectation that all remaining FY 22 funds will be expended by the end of the two-year grant cycle ending September 30, 2023. As of June 30, 2023, actual expenditures totaled $3,133,970. Of the remaining FY 22 funds to be expended, at least $606,805 of additional funding will be expended for Preventive and Primary Care for Children to meet the minimum of 30% ($3,740,775) of the Federal Allocation. The FFR will include final expenditure data and the total amount expended at grant closeout.	
4.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
This is an estimated total expenditure amount for Children with Special Health Care Needs based on the expectation that all remaining FY 22 funds will be expended by the end of the two-year grant cycle ending September 30, 2023. As of June 30, 2023, actual expenditures totaled $3,098,518. Of the remaining FY 22 funds to be expended, at least $642,257 of additional funding will be expended for Children with Special Health Care Needs to meet the minimum of 30% ($3,740,775) of the Federal Allocation. The FFR will include final expenditure data and the total amount expended at grant closeout.

5.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
This is an estimated total expenditure amount for Administrative Costs based on the expectation that all remaining FY 22 funds will be expended by the end of the the two-year grant cycle ending September 30, 2023. Administrative costs are anticipated to fall under the allowable 10% maximum. The FFR will include final expenditure data and the total amount expended at grant closeout.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Missouri

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 2,087,013	$ 1,730,078
2. Infants < 1 year	$ 1,797,033	$ 1,478,777
3. Children 1 through 21 Years	$ 4,175,109	$ 3,133,970
4. CSHCN	$ 4,022,725	$ 3,098,518
5. All Others	$ 6,456	$ 1,588
Federal Total of Individuals Served	$ 12,088,336	$ 9,442,931

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 2,328,754	$ 2,326,970
2. Infants < 1 year	$ 1,010,247	$ 921,703
3. Children 1 through 21 Years	$ 453,304	$ 404,809
4. CSHCN	$ 5,656,964	$ 5,844,886
5. All Others	$ 537,961	$ 488,862
Non-Federal Total of Individuals Served	$ 9,987,230	$ 9,987,230
Federal State MCH Block Grant Partnership Total	$ 22,075,566	$ 19,430,161

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through June 30, 2023 for Pregnant Women. With the expectation that all remaining FY 22 funds will be expended by the end of the two-year grant cycle ending September 30, 2023, the total expenditure amount through September 30, 2023 for Pregnant Women is expected to be higher.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: This is an estimated total expenditure amount through June 30. 2023 for Infants < 1 year. With the expectation that all remaining FY 22 funds will be expended by the end of the two-year grant cycle ending September 30, 2023, the total expenditure amount through September 30, 2023 for Infants < 1 year is expected to be higher.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: This is an estimated total expenditure amount through June 30, 2023 for Children 1 through 21 years. With the expectation that all remaining FY 22 funds will be expended by the end of the two-year grant cycle ending September 30, 2023, the total expenditure amount through September 30, 2023 for Children 1 through 21 years is expected to be higher.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through June 30, 2023 for CYSHCN. With the expectation that all remaining FY 22 funds will be expended by the end of the two-year grant cycle ending September 30, 2023, the total expenditure amount through September 30, 2023 for CYSHCN is expected to be higher.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Missouri

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 282,022	$ 280,317
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 44,300	$ 49,356
B. Preventive and Primary Care Services for Children	$ 80,315	$ 85,882
C. Services for CSHCN	$ 157,407	$ 145,079
2. Enabling Services	$ 5,202,096	$ 2,735,239
3. Public Health Services and Systems	$ 7,702,746	$ 7,184,250
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 180,317
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
CSHCN Direct Care Payments		$ 100,000
Direct Services Line 4 Expended Total		$ 280,317
Federal Total	$ 13,186,864	$ 10,199,806

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 2,884,620	$ 2,861,550
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 2,296,334	$ 2,297,894
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 588,286	$ 563,656
2. Enabling Services	$ 434,682	$ 335,542
3. Public Health Services and Systems	$ 6,667,928	$ 6,790,138
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 2,284,244
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
CSHCN Direct Care Payments		$ 563,656
SIDS Payments		$ 13,650
Direct Services Line 4 Expended Total		$ 2,861,550
Non-Federal Total	$ 9,987,230	$ 9,987,230

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through June 30, 2023 for Direct Services. Based on the expectation that all remaining FY 22 funds will be expended by the end of the two-year grant cycle ending September 30, 2023, the total expenditure amount through September 30, 2023 for Direct Services is expected to be higher.	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through June 30, 2023 for Enabling Services. Based on the expectation that all remaining FY 22 funds will be expended by the end of the two-year grant cycle ending September 30, 2023, the total expenditure amount through September 30, 2023 for Enabling Services is expected to be higher.	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through June 30, 2023 for Public Health Services and Systems. Based on the expectation that all remaining FY 22 funds will be expended by the end of the two-year grant cycle ending September 30, 2023, the total expenditure amount through September 30, 2023 for Public Health Services and Systems is expected to be higher.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Missouri

Total Births by Occurrence: 69,390 **Data Source Year: 2022**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	68,265 (98.4%)	765	195	195 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Mucopolysaccharidosis Type II (MPS II)	Primary Congenital Hypothyroidism
Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences
Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency
X-Linked Adrenoleukodystrophy				

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Krabbe disease	68,265 (98.4%)	3	1	1 (100.0%)
Fabry disease	68,265 (98.4%)	46	11	11 (100.0%)
Gaucher disease	68,265 (98.4%)	5	0	0 (0%)
Arginemia	68,265 (98.4%)	0	0	0 (0%)
Citrullinemia type II	68,265 (98.4%)	0	0	0 (0%)
Defects of biopterin cofactor biosynthesis	68,265 (98.4%)	0	0	0 (0%)
Defects of biopterin cofactor regeneration	68,265 (98.4%)	0	0	0 (0%)
Hyperphenylalaninemia	68,265 (98.4%)	3	3	3 (100.0%)
Hypermethioninemia	68,265 (98.4%)	0	0	0 (0%)
Tyrosinemia type II	68,265 (98.4%)	0	0	0 (0%)
Tyrosinemia type III	68,265 (98.4%)	0	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	68,265 (98.4%)	0	0	0 (0%)
Carnitine palmitoyl transferase deficiency I	68,265 (98.4%)	0	0	0 (0%)
Carnitine palmitoyl transferase deficiency II	68,265 (98.4%)	0	0	0 (0%)
Dienoyl-CoA reductase deficiency	68,265 (98.4%)	0	0	0 (0%)

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Glutaric acidemia type II	68,265 (98.4%)	0	0	0 (0%)
Medium-chain ketoacyl-CoA thiolase deficiency	68,265 (98.4%)	0	0	0 (0%)
Medium/Short chain L-3-hydroxy axyl-CoA dehydrogenase deficiency	68,265 (98.4%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	68,265 (98.4%)	8	8	8 (100.0%)
2-Methyl-3-hydroxybutyric aciduria	68,265 (98.4%)	0	0	0 (0%)
2-Methylbutyryl-CoA dehydrogenase deficiency	68,265 (98.4%)	0	0	0 (0%)
2-Methylbutyrylglycinuria	68,265 (98.4%)	0	0	0 (0%)
3-Methylglutaconic aciduria	68,265 (98.4%)	0	0	0 (0%)
Isobutyryl-CoA dehydrogenase deficiency	68,265 (98.4%)	0	0	0 (0%)
Malonic acidemia	68,265 (98.4%)	0	0	0 (0%)
Various other hemoglobinopathies	68,265 (98.4%)	3	3	3 (100.0%)
T-cell related lymphocyte deficiencies	68,265 (98.4%)	3	3	3 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Missouri does not conduct long-term follow-up at this time. Once the infant is confirmed and put on treatment the case is closed.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: To avoid duplicative counts, if a secondary condition was confirmed positive, the presumptive positive was counted in the secondary condition presumptive positive count and subtracted from the core condition presumptive positive count. Additional conditions screened for by MO are also reflected separately from the core condition presumptive positive count.	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: MO does passive surveillance for CCHD and data for confirmed cases is not known.	
3.	**Field Name:**	**Krabbe disease - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: To avoid duplicative counts, if a secondary condition was confirmed positive, the presumptive positive was counted in the secondary condition presumptive positive count and subtracted from the core condition presumptive positive count. Additional conditions screened for by MO are also reflected separately from the core condition presumptive positive count.	
4.	**Field Name:**	**Fabry disease - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: To avoid duplicative counts, if a secondary condition was confirmed positive, the presumptive positive was counted in the secondary condition presumptive positive count and subtracted from the core condition presumptive positive count. Additional conditions screened for by MO are also reflected separately from the core condition presumptive positive count.	
5.	**Field Name:**	**Gaucher disease - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2022**

Column Name: **Other Newborn**

Field Note:

To avoid duplicative counts, if a secondary condition was confirmed positive, the presumptive positive was counted in the secondary condition presumptive positive count and subtracted from the core condition presumptive positive count. Additional conditions screened for by MO are also reflected separately from the core condition presumptive positive count.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Missouri

Annual Report Year 2022

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	**(A) Title V Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private / Other %**	**(E) None %**	**(F) Unknown %**
1. Pregnant Women	2,983	38.7	0.0	59.7	0.0	1.6
2. Infants < 1 Year of Age	15,614	38.7	0.0	59.7	0.0	1.6
3. Children 1 through 21 Years of Age	54,249	29.0	0.0	64.0	7.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,770	38.0	0.0	55.0	7.0	0.0
4. Others	2,722	10.0	0.0	80.0	10.0	0.0
Total	75,568					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	69,453	No	69,319	52.7	36,531	2,983
2. Infants < 1 Year of Age	70,183	Yes	70,183	97.3	68,288	15,614
3. Children 1 through 21 Years of Age	1,634,610	Yes	1,634,610	12.8	209,230	54,249
3a. Children with Special Health Care Needs 0 through 21 years of age^	347,410	Yes	347,410	17.9	62,186	1,770
4. Others	4,465,198	Yes	4,465,198	0.5	22,326	2,722

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**

Field Note:
Fiscal Year: 2022
Expectant moms downloading the Count the Kicks App, FFY 2022: 781
Mothers receiving home visiting services through Building Blocks, FFY 2022: 281
Mothers served by Healthy Families Missouri Home Visiting Program, FFY 2022: 26
Prenatal care services through Local Public Health Agencies, FFY 2022: 1895
Total: 2983

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**

Field Note:
Fiscal Year: 2022
Infants receiving home visiting services through Building Blocks FFY 2022: 79
Infants served by Healthy Families Missouri Home Visiting Program FFY 2022: 19
Portable cribs and Safe Sleep education delivered through Local Public Health Agencies (LPHAs) to low income families FFY 2022: 180
Infants receiving services through Local Public Health Agencies, FFY 2022: 15,336
Total FFY 2022: 15,614

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**

Field Note:
Fiscal Year: 2022
Child Regulation (Child Care Services) FFY 2022: 145
Teen Outreach Program, FFY 2022: 102
EAP, FFY 2022: 1,926
AAP: FFY 2022: 1,372
SAFE-Exams, FFY 2022: 3,237
CARE (Physical Abuse) Exams, FFY 2022: 1,437
Oral Health (PSP): FFY 2022: 42,901
Children with Special Health Care Needs, FFY 2022: 1,770
Students w SHCN under SHS Contracts FFY 2022: 2,422
Sexual Risk Avoidance Education FFY 2022: 407
Other Teen Pregnancy Prevention Education (through PREP), FFY 2022: 300
Total FFY 2022: 54,249

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**

Field Note:
Fiscal Year: 2022
Children and Youth with Special Health Care Needs Program SFY 2022: 584
Healthy Children and Youth Program SFY 2022: 1,186
Total SFY 2022: 1,770

5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**

Field Note:
Fiscal Year: 2022
Child Care Referrals for families of CYSHCN FFY 2022: 174
Teachers trained on inclusion services FFY 2022: 1,904
Number of Child Passenger Safety (CPS) technicians trained through CPS training FFY 2022: 254
Trained in Home Visiting programs FFY 2022: 108
Health Care Providers, foster parents training on Current Adolescent Health Issues FFY 2022: 245
Total SFY 2022: 2,722

6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2022**

Field Note:
Fiscal Year: 2022
Pregnant Women FFY 2022: 2,983
Infants < 1 Year Age FFY 2022: 15,614
Children 01 through 21 Years of Age FFY 2022: 54,249
Children with Special Health Care Needs (Subtotal Children of 0-21 Years of Age) FFY 2022: 1,770
Others FFY 2022: 2,722
Total FFY 2022: 77,338

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**

Field Note:
Pregnancy and Beyond Books distributed FFY 2022: 24,589
MIECHV Home Visiting Program FFY 2022: 289
Prenatal care services through LPHAS FFY 2022: 1,895
Oral Health FFY 2022: 9,726
Numerator: Total FFY 2022: 36,499
Denominator: MODHSS Vital Statics File - Provisional Live Births, 2022: 69,319

2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2022**

Field Note:
MODHSS Vital Statics File - Provisional Live Births for 2022

3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**

Field Note:
Numerator: Newborn Hearing Screenings FFY 2022: 69,692
Denominator: Data Source: National Vital Statistics System – MO Occurrent Live Births, 2021: 70,183

4.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

Field Note:
Children obesity prevention program FFY 2022: 109
Safe Kids FFY 2022: 68,757
Safe Ride Cards Distribution FFY 2022: 14,615
Referrals triage & reviewed (Child under 4 yrs) FFY 2022: 4,688
Child Regulation (Child Care Services) FFY 2022: 145
School Health Participants FFY 2022: 16,650
Oral Health (PSP) FFY 2022: 42,901
CSHCN Served FFY 2022: 61,091
Numerator: Total FFY 2022: 208,956
Denominator: US Census Bureau Population Estimates, 2021: 1,634,610

5.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

Field Note:
Direct Services: (CYSHCN) Children & Youth with Special Health Care Needs Program FFY 2022: 1,770
Indirect Services: FFY 2022: 61,091
Brain Injury (Outreach with the Traumatic Brain Injury Grant) FFY 2022: 9,815
Bureau of Special Health Care Needs (Community outreach, and printed materials) FFY 2022: 6,979
(CYSHCN) (Community Outreach and printed materials) FFY 2022: 13,973
Healthy Children and Youth FFY 2022: 123
Special Health Services Web Inquiries FFY 2022: 30,201
Numerator: Total Services: SFY 2022: 62,261
Denominator: Data Source: National Survey of Children's Health CSHCN Prevalence Estimates 0-17 (2020-2021) multiplied by US Census Bureau Population Estimates 0-21, 2021: 347,410

6.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**

Field Note:
Distribution of 10 Ways to Be a Better Dad FFY 2022: 12,441
Number of on Site Technical Assistance Visits FFY 2022: 316
Community Outreach Contacts FFY 2022: 9,367
Obesity Prevention Program FFY 2022: 2
MIECHV Trained in Home Visiting Programs FFY 2022: 488
Total FFY 2022: 22,614
Denominator: Data Source: US Census Bureau Population Estimates, 2021

Data Alerts: None

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Missouri

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	69,317	49,946	9,286	5,237	153	1,736	243	2,254	462
Title V Served	26,813	15,497	6,096	3,099	69	395	177	1,213	267
Eligible for Title XIX	26,813	15,497	6,096	3,099	69	395	177	1,213	267
2. Total Infants in State	68,954	49,729	9,197	5,213	153	1,734	234	2,243	451
Title V Served	26,584	15,786	6,219	2,579	88	373	134	1,187	218
Eligible for Title XIX	26,584	15,786	6,219	2,579	88	373	134	1,187	218

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: total deliveries for reporting year - birth and fetal death files	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: primary payer listed as Medicaid, reporting year - birth file	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: primary payer listed as Medicaid, reporting year - birth file	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: total infants - population MICA	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: primary payer listed as Medicaid, year prior to reporting year - birth file	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: primary payer listed as Medicaid, year prior to reporting year - birth file	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Missouri

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 835-5465	(800) 835-5465
2. State MCH Toll-Free "Hotline" Name	TEL-Link	TEL-Link
3. Name of Contact Person for State MCH "Hotline"	Megan Hammann	Megan Hammann
4. Contact Person's Telephone Number	(573) 526-0213	(573) 526-0213
5. Number of Calls Received on the State MCH "Hotline"		2,571

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	Oral Health/Special Health Services/Vaccines for Children Program/Genetics and Healthy Childhood/WIC and Nutrition Services	Oral Health/Special Health Services/Vaccines for Children Program/Genetics and Healthy Childhood/WIC and Nutrition Services
2. Number of Calls on Other Toll-Free "Hotlines"		18,409
3. State Title V Program Website Address	https://health.mo.gov/living/families/mch-block-grant/	https://health.mo.gov/living/families/mch-block-grant/
4. Number of Hits to the State Title V Program Website		1,976
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Missouri

1. Title V Maternal and Child Health (MCH) Director	
Name	Martha J. Smith, MSN, RN
Title	Missouri MCH Director & Interim CYSHCN Director
Address 1	P.O. Box 570
Address 2	930 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102
Telephone	(573) 751-6435
Extension	
Email	Martha.Smith@health.mo.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Martha J. Smith, MSN, RN
Title	Missouri MCH Director & Interim CYSHCN Director
Address 1	P.O. Box 570
Address 2	930 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102
Telephone	(573) 751-6435
Extension	
Email	Martha.Smith@health.mo.gov

3. State Family Leader (Optional)	
Name	Sheree Pursley
Title	Family Partner
Address 1	P.O. Box 570
Address 2	912 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102
Telephone	(800) 451-0669
Extension	
Email	Sheree.Pursley@health.mo.gov

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

 Created on 8/11/2023 at 12:33 PM

Form 9
List of MCH Priority Needs

State: Missouri

Application Year 2024

No.	Priority Need
1.	Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.
2.	Promote safe sleep practices among newborns to reduce sleep-related infant deaths.
3.	Reduce obesity among children and adolescents.
4.	Reduce intentional and unintentional injuries among children and adolescents.
5.	Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.
6.	Enhance access to oral health care services for children.
7.	Promote Protective Factors for Youth and Families.
8.	Address Social Determinants of Health Inequities.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.	Continued
2.	Promote safe sleep practices among newborns to reduce sleep-related infant deaths.	New
3.	Reduce obesity among children and adolescents.	New
4.	Reduce intentional and unintentional injuries among children and adolescents.	Continued
5.	Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.	Continued
6.	Enhance access to oral health care services for children.	New
7.	Promote Protective Factors for Youth and Families.	New
8.	Address Social Determinants of Health Inequities.	New

Form 10
National Outcome Measures (NOMs)

State: Missouri

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	77.7 %	0.2 %	52,400	67,428
2020	75.7 %	0.2 %	50,668	66,941
2019	75.6 %	0.2 %	52,721	69,768
2018	75.4 %	0.2 %	52,361	69,446
2017	76.6 %	0.2 %	52,597	68,679
2016	77.6 %	0.2 %	54,806	70,617
2015	77.2 %	0.2 %	55,511	71,931
2014	76.7 %	0.2 %	55,543	72,390
2013	75.3 %	0.2 %	54,031	71,734
2012	76.0 %	0.2 %	54,074	71,154
2011	76.5 %	0.2 %	55,134	72,054
2010	77.2 %	0.2 %	56,322	72,988

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	89.4	3.7	592	66,236
2019	83.2	3.5	574	68,989
2018	80.1	3.4	560	69,920
2017	75.4	3.3	527	69,896
2016	70.2	3.1	502	71,513
2015	61.2	3.4	329	53,734
2014	65.9	3.0	473	71,741
2013	67.6	3.1	485	71,716
2012	74.5	3.2	537	72,112
2011	66.8	3.0	487	72,950
2010	73.1	3.2	538	73,592
2009	71.1	3.1	540	75,937
2008	59.2	2.8	461	77,822

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	25.2	2.7	90	357,168
2016_2020	23.5	2.5	85	362,420
2015_2019	19.8	2.3	73	368,196
2014_2018	21.3	2.4	79	371,429

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	8.9 %	0.1 %	6,168	69,400
2020	8.7 %	0.1 %	6,020	69,236
2019	8.8 %	0.1 %	6,356	72,072
2018	8.7 %	0.1 %	6,389	73,211
2017	8.7 %	0.1 %	6,336	72,968
2016	8.7 %	0.1 %	6,473	74,622
2015	8.3 %	0.1 %	6,248	74,992
2014	8.2 %	0.1 %	6,163	75,282
2013	8.0 %	0.1 %	6,033	75,182
2012	7.7 %	0.1 %	5,809	75,142
2011	7.9 %	0.1 %	5,995	75,814
2010	8.2 %	0.1 %	6,286	76,459
2009	8.1 %	0.1 %	6,393	78,865

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	11.3 %	0.1 %	7,821	69,362
2020	11.0 %	0.1 %	7,599	69,207
2019	10.9 %	0.1 %	7,832	72,032
2018	10.7 %	0.1 %	7,849	73,198
2017	10.6 %	0.1 %	7,702	72,948
2016	10.2 %	0.1 %	7,584	74,586
2015	10.0 %	0.1 %	7,504	74,962
2014	9.8 %	0.1 %	7,346	75,269
2013	9.6 %	0.1 %	7,195	74,902
2012	9.9 %	0.1 %	7,423	75,073
2011	9.6 %	0.1 %	7,269	75,588
2010	10.0 %	0.1 %	7,655	76,402
2009	9.9 %	0.1 %	7,803	78,681

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	29.1 %	0.2 %	20,170	69,362
2020	28.3 %	0.2 %	19,595	69,207
2019	27.3 %	0.2 %	19,690	72,032
2018	26.4 %	0.2 %	19,325	73,198
2017	26.0 %	0.2 %	18,986	72,948
2016	25.1 %	0.2 %	18,713	74,586
2015	24.2 %	0.2 %	18,163	74,962
2014	24.4 %	0.2 %	18,340	75,269
2013	24.2 %	0.2 %	18,129	74,902
2012	25.3 %	0.2 %	19,020	75,073
2011	25.9 %	0.2 %	19,550	75,588
2010	27.2 %	0.2 %	20,759	76,402
2009	26.6 %	0.2 %	20,938	78,681

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.2	0.3	430	69,515
2019	5.8	0.3	422	72,324
2018	5.9	0.3	430	73,467
2017	6.0	0.3	439	73,244
2016	6.6	0.3	495	74,934
2015	6.6	0.3	497	75,285
2014	5.6	0.3	422	75,558
2013	6.3	0.3	473	75,497
2012	6.4	0.3	483	75,659
2011	6.1	0.3	465	76,318
2010	6.1	0.3	470	76,978
2009	6.4	0.3	506	79,127

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	5.9	0.3	408	69,285
2019	6.1	0.3	443	72,127
2018	6.3	0.3	465	73,269
2017	6.3	0.3	457	73,034
2016	6.6	0.3	492	74,705
2015	6.5	0.3	487	75,061
2014	6.1	0.3	461	75,360
2013	6.5	0.3	491	75,296
2012	6.6	0.3	498	75,446
2011	6.3	0.3	482	76,117
2010	6.6	0.3	505	76,759
2009	7.1	0.3	558	78,905

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.7	0.2	257	69,285
2019	3.9	0.2	283	72,127
2018	3.8	0.2	279	73,269
2017	3.8	0.2	279	73,034
2016	4.2	0.2	317	74,705
2015	4.2	0.2	319	75,061
2014	3.8	0.2	283	75,360
2013	4.4	0.2	330	75,296
2012	4.2	0.2	319	75,446
2011	4.0	0.2	307	76,117
2010	4.1	0.2	316	76,759
2009	4.5	0.2	357	78,905

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	2.2	0.2	151	69,285
2019	2.2	0.2	160	72,127
2018	2.5	0.2	186	73,269
2017	2.4	0.2	178	73,034
2016	2.3	0.2	175	74,705
2015	2.2	0.2	168	75,061
2014	2.4	0.2	178	75,360
2013	2.2	0.2	162	75,296
2012	2.4	0.2	180	75,446
2011	2.3	0.2	175	76,117
2010	2.5	0.2	189	76,759
2009	2.5	0.2	201	78,905

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	163.1	15.4	113	69,285
2019	177.5	15.7	128	72,127
2018	225.2	17.6	165	73,269
2017	179.4	15.7	131	73,034
2016	223.5	17.3	167	74,705
2015	206.5	16.6	155	75,061
2014	209.7	16.7	158	75,360
2013	248.4	18.2	187	75,296
2012	200.1	16.3	151	75,446
2011	202.3	16.3	154	76,117
2010	218.9	16.9	168	76,759
2009	223.1	16.8	176	78,905

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	108.2	12.5	75	69,285
2019	95.7	11.5	69	72,127
2018	94.2	11.3	69	73,269
2017	124.6	13.1	91	73,034
2016	105.7	11.9	79	74,705
2015	95.9	11.3	72	75,061
2014	112.8	12.2	85	75,360
2013	94.3	11.2	71	75,296
2012	110.0	12.1	83	75,446
2011	85.4	10.6	65	76,117
2010	96.4	11.2	74	76,759
2009	109.0	11.8	86	78,905

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	7.1 %	1.0 %	4,570	64,114
2020	6.2 %	0.9 %	4,007	64,679
2019	5.8 %	0.7 %	3,837	66,556
2018	5.5 %	0.9 %	3,743	67,515
2017	5.8 %	0.8 %	3,938	67,929
2016	5.1 %	0.8 %	3,545	69,899
2015	6.5 %	0.8 %	4,528	69,911
2014	6.5 %	0.8 %	4,612	70,717
2013	8.4 %	0.9 %	5,958	70,904
2012	8.5 %	1.1 %	5,955	70,491
2011	5.4 %	0.7 %	3,883	71,474
2010	5.2 %	0.7 %	3,717	71,870
2009	4.8 %	0.7 %	3,573	74,298
2007	4.5 %	0.7 %	3,460	76,679

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.7	0.3	443	66,560
2019	5.3	0.3	370	69,603
2018	5.3	0.3	376	70,534
2017	5.1	0.3	357	70,263
2016	5.9	0.3	422	71,724
2015	5.1	0.3	276	54,065
2014	4.4	0.3	318	72,540
2013	4.2	0.2	304	72,289
2012	3.5	0.2	251	72,668
2011	3.1	0.2	227	73,592
2010	2.8	0.2	212	74,422
2009	2.0	0.2	150	76,501
2008	1.7	0.2	131	78,195

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	12.5 %	1.2 %	162,365	1,295,133
2019_2020	11.3 %	1.3 %	144,593	1,281,061
2018_2019	13.6 %	1.4 %	174,536	1,287,345
2017_2018	12.4 %	1.5 %	161,455	1,301,281
2016_2017	11.2 %	1.3 %	145,427	1,293,510
2016	11.7 %	1.4 %	151,883	1,296,123

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	23.1	1.9	155	671,387
2020	20.4	1.7	138	675,065
2019	19.7	1.7	133	675,493
2018	20.2	1.7	137	678,402
2017	21.6	1.8	147	682,079
2016	21.2	1.8	145	684,438
2015	21.7	1.8	149	687,559
2014	19.6	1.7	135	689,889
2013	19.3	1.7	134	694,290
2012	22.0	1.8	153	696,365
2011	20.9	1.7	146	698,014
2010	17.7	1.6	125	704,581
2009	24.5	1.9	172	700,639

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	51.5	2.5	412	800,527
2020	47.4	2.5	369	778,428
2019	43.2	2.4	337	780,786
2018	45.2	2.4	354	783,327
2017	47.7	2.5	374	783,928
2016	41.7	2.3	327	785,023
2015	41.6	2.3	327	786,368
2014	35.4	2.1	279	787,156
2013	37.2	2.2	294	790,407
2012	39.0	2.2	311	798,190
2011	42.1	2.3	341	810,723
2010	42.5	2.3	349	820,711
2009	42.7	2.3	353	826,046

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	17.2	1.2	202	1,177,266
2018_2020	16.7	1.2	195	1,169,485
2017_2019	18.5	1.3	217	1,174,314
2016_2018	19.2	1.3	227	1,180,579
2015_2017	19.6	1.3	232	1,186,213
2014_2016	17.8	1.2	211	1,188,480
2013_2015	17.6	1.2	210	1,190,800
2012_2014	17.4	1.2	208	1,197,220
2011_2013	19.8	1.3	241	1,215,589
2010_2012	20.5	1.3	254	1,241,119
2009_2011	21.4	1.3	271	1,266,664
2008_2010	22.7	1.3	291	1,284,102
2007_2009	26.6	1.4	343	1,290,664

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	12.5	1.0	147	1,177,266
2018_2020	14.5	1.1	169	1,169,485
2017_2019	16.3	1.2	192	1,174,314
2016_2018	17.2	1.2	203	1,180,579
2015_2017	14.9	1.1	177	1,186,213
2014_2016	12.8	1.0	152	1,188,480
2013_2015	10.7	1.0	127	1,190,800
2012_2014	9.7	0.9	116	1,197,220
2011_2013	9.5	0.9	115	1,215,589
2010_2012	9.2	0.9	114	1,241,119
2009_2011	8.3	0.8	105	1,266,664
2008_2010	9.1	0.8	117	1,284,102
2007_2009	9.1	0.8	117	1,290,664

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	20.4 %	1.3 %	278,712	1,367,041
2019_2020	21.1 %	1.4 %	288,780	1,368,395
2018_2019	21.9 %	1.5 %	301,956	1,375,829
2017_2018	21.2 %	1.7 %	293,652	1,382,534
2016_2017	21.5 %	1.6 %	298,327	1,385,801
2016	22.8 %	1.7 %	316,087	1,386,660

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	14.7 %	2.3 %	41,057	278,712
2019_2020	19.7 %	2.9 %	56,805	288,780
2018_2019	15.6 %	2.7 %	47,149	301,956
2017_2018	16.4 %	3.3 %	48,147	293,652
2016_2017	19.2 %	3.2 %	57,406	298,327
2016	19.2 %	3.3 %	60,757	316,087

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	1.7 %	0.4 %	19,414	1,156,922
2019_2020	2.1 %	0.5 %	23,725	1,143,480
2018_2019	2.0 %	0.5 %	23,159	1,140,048
2017_2018	2.2 %	0.6 %	25,127	1,136,126
2016_2017	2.7 %	0.6 %	30,948	1,131,436
2016	3.0 %	0.8 %	34,462	1,158,499

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	8.9 %	0.9 %	102,218	1,147,623
2019_2020	8.4 %	0.9 %	95,578	1,134,465
2018_2019	10.7 %	1.3 %	121,359	1,131,234
2017_2018	11.0 %	1.5 %	125,283	1,134,509
2016_2017	9.8 %	1.2 %	111,315	1,130,732
2016	10.3 %	1.3 %	118,512	1,149,872

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	44.5 %	4.3 %	68,554	153,923
2019_2020	48.7 %	4.6 %	74,063	151,975
2018_2019	53.6 %	5.1 %	91,376	170,506
2017_2018	51.9 % ϟ	6.2 % ϟ	87,101 ϟ	167,958 ϟ
2016_2017	57.2 % ϟ	6.0 % ϟ	80,743 ϟ	141,196 ϟ
2016	64.0 % ϟ	6.3 % ϟ	91,752 ϟ	143,344 ϟ

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	91.9 %	1.0 %	1,247,920	1,357,397
2019_2020	90.6 %	1.2 %	1,229,690	1,357,216
2018_2019	88.5 %	1.3 %	1,214,704	1,371,977
2017_2018	89.8 %	1.3 %	1,239,942	1,380,789
2016_2017	91.0 %	1.2 %	1,257,974	1,382,631
2016	90.8 %	1.4 %	1,252,871	1,380,320

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	12.7 %	0.2 %	2,905	22,856
2018	13.0 %	0.2 %	4,710	36,127
2016	12.3 %	0.2 %	5,335	43,404
2014	13.0 %	0.2 %	5,696	43,895
2012	13.5 %	0.2 %	6,913	51,368
2010	14.4 %	0.2 %	7,306	50,575
2008	14.6 %	0.2 %	6,684	45,662

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	16.9 %	1.8 %	43,588	258,675
2019	18.4 %	1.7 %	46,328	251,708
2017	16.6 %	1.4 %	42,368	254,814
2015	13.1 %	1.6 %	33,506	256,658
2013	14.9 %	1.3 %	37,631	253,277
2009	14.3 %	1.0 %	37,677	263,540
2007	11.9 %	1.4 %	31,402	264,619
2005	13.8 %	1.2 %	36,083	260,788

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	18.9 %	2.1 %	107,889	569,876
2019_2020	19.6 %	2.2 %	109,081	557,921
2018_2019	16.3 %	2.0 %	93,473	572,420
2017_2018	12.5 %	1.8 %	73,841	588,818
2016_2017	12.7 %	1.7 %	72,138	568,815
2016	14.0 %	2.2 %	78,884	562,399

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	5.7 %	0.4 %	78,647	1,381,585
2019	6.4 %	0.4 %	87,028	1,369,358
2018	4.7 %	0.3 %	64,442	1,373,732
2017	4.5 %	0.3 %	62,542	1,385,654
2016	4.7 %	0.3 %	65,048	1,389,424
2015	5.8 %	0.3 %	80,405	1,387,462
2014	6.8 %	0.4 %	94,070	1,392,278
2013	7.3 %	0.5 %	101,597	1,398,774
2012	7.2 %	0.4 %	100,248	1,400,984
2011	6.7 %	0.4 %	94,012	1,410,826
2010	6.3 %	0.4 %	89,775	1,417,025
2009	7.1 %	0.4 %	102,160	1,431,242

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	70.6 %	3.4 %	51,000	73,000
2017	70.0 %	3.2 %	50,000	72,000
2016	58.3 %	4.4 %	44,000	75,000
2015	68.4 %	4.0 %	52,000	76,000
2014	67.3 %	3.8 %	52,000	77,000
2013	57.8 %	4.7 %	44,000	76,000
2012	68.8 %	4.3 %	52,000	76,000
2011	60.1 %	4.5 %	46,000	76,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	58.1 %	1.5 %	752,152	1,294,861
2020_2021	58.3 %	1.7 %	755,094	1,295,187
2019_2020	59.7 %	1.6 %	765,203	1,281,747
2018_2019	57.0 %	1.9 %	734,540	1,288,893
2017_2018	50.8 %	1.9 %	663,536	1,306,209
2016_2017	53.9 %	1.7 %	704,687	1,307,883
2015_2016	59.4 %	2.2 %	781,158	1,315,081
2014_2015	54.1 %	1.9 %	712,828	1,318,342
2013_2014	54.0 %	1.9 %	712,235	1,320,284
2012_2013	51.6 %	2.2 %	683,156	1,324,118
2011_2012	44.9 %	2.6 %	600,028	1,336,935
2010_2011	48.1 %	2.8 %	643,683	1,338,218
2009_2010	38.4 %	2.7 %	464,148	1,208,718

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	76.2 %	2.9 %	301,921	396,177
2020	69.9 %	3.1 %	275,289	393,934
2019	69.0 %	3.5 %	270,385	391,684
2018	61.6 %	3.3 %	240,545	390,439
2017	57.8 %	3.3 %	226,431	391,861
2016	51.6 %	3.4 %	202,093	391,848
2015	51.8 %	3.6 %	204,078	394,099

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	89.6 %	2.1 %	355,101	396,177
2020	84.2 %	2.5 %	331,860	393,934
2019	82.4 %	2.8 %	322,624	391,684
2018	80.6 %	2.9 %	314,818	390,439
2017	80.1 %	2.8 %	313,877	391,861
2016	83.9 %	2.4 %	328,587	391,848
2015	85.7 %	2.5 %	337,703	394,099
2014	86.1 %	2.3 %	342,835	398,320
2013	81.5 %	2.8 %	325,358	399,029
2012	88.0 %	2.5 %	352,124	399,970
2011	79.6 %	2.7 %	319,043	400,748
2010	66.0 %	3.0 %	265,563	402,428
2009	60.2 %	2.9 %	244,974	407,293

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	90.4 %	2.0 %	358,275	396,177
2020	85.3 %	2.4 %	336,135	393,934
2019	84.8 %	2.6 %	331,974	391,684
2018	78.3 %	2.9 %	305,793	390,439
2017	74.3 %	2.9 %	291,109	391,861
2016	66.2 %	3.2 %	259,219	391,848
2015	69.7 %	3.3 %	274,832	394,099
2014	63.3 %	3.3 %	252,165	398,320
2013	60.7 %	3.6 %	242,178	399,029
2012	58.3 %	3.9 %	233,048	399,970
2011	54.6 %	3.3 %	218,744	400,748
2010	49.2 %	3.0 %	197,927	402,428
2009	45.5 %	3.0 %	185,153	407,293

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	17.1	0.3	3,312	194,146
2020	18.8	0.3	3,556	189,387
2019	20.3	0.3	3,851	189,903
2018	21.6	0.3	4,109	190,464
2017	22.5	0.3	4,301	191,316
2016	23.4	0.4	4,505	192,808
2015	25.1	0.4	4,838	192,583
2014	27.2	0.4	5,232	192,076
2013	30.0	0.4	5,814	193,780
2012	32.2	0.4	6,317	196,167
2011	34.6	0.4	6,944	200,937
2010	37.3	0.4	7,669	205,841
2009	40.6	0.4	8,499	209,478

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	11.9 %	1.3 %	7,605	63,878
2020	13.3 %	1.3 %	8,617	64,586
2019	14.6 %	1.2 %	9,700	66,257
2018	13.7 %	1.3 %	9,213	67,191
2017	13.9 %	1.2 %	9,371	67,202
2016	14.0 %	1.3 %	9,774	69,686
2015	14.0 %	1.2 %	9,834	70,137
2014	12.6 %	1.1 %	8,948	70,939
2013	12.5 %	1.1 %	8,862	70,850
2012	15.0 %	1.4 %	10,559	70,436

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	3.0 %	0.7 %	40,961	1,364,110
2019_2020	2.3 %	0.5 %	31,290	1,363,872
2018_2019	3.3 %	0.7 %	44,823	1,371,360
2017_2018	2.6 %	0.7 %	35,722	1,381,458
2016_2017	2.8 %	0.7 %	38,213	1,376,406
2016	3.7 %	0.9 %	50,741	1,367,870

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Missouri

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	2019	2020	2021	2022
Annual Objective			70.1	70.5	71
Annual Indicator		72.9	72.6	72.5	72.4
Numerator		757,602	754,373	755,016	751,551
Denominator		1,038,992	1,039,355	1,041,255	1,038,345
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	66.4	68.1	70.1	70.5	71
Annual Indicator	72.9	72.6	72.5	72.5	
Numerator	769,769	769,579	755,016	755,016	
Denominator	1,055,678	1,060,305	1,041,255	1,041,255	
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	
Data Source Year	2018	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	71.5	72.0	72.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2019 data	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2019 data used as proxy for 2020	

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			85.2	86.4
Annual Indicator	84.0	83.1	84.8	82.9
Numerator	55,547	54,118	53,369	51,856
Denominator	66,118	65,137	62,925	62,533
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			85.2	86.4
Annual Indicator	83.1	84.8	84.8	
Numerator	54,118	53,369	53,369	
Denominator	65,137	62,925	62,925	
Data Source	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	87.6	88.8	90.0

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	2020	2021	2022
Annual Objective			41.9	43.9
Annual Indicator	39.9	40.3	37.1	36.6
Numerator	25,485	25,609	23,096	22,467
Denominator	63,920	63,599	62,314	61,451
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

State Provided Data				
	2019	2020	2021	2022
Annual Objective			41.9	43.9
Annual Indicator	40.3	37.1	37.1	
Numerator	25,609	23,096	23,096	
Denominator	63,599	62,314	62,314	
Data Source	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	46.0	48.0	50.0

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	2020	2021	2022
Annual Objective			49	49.2
Annual Indicator	48.7	55.0	54.6	58.9
Numerator	31,408	35,105	33,976	36,271
Denominator	64,465	63,808	62,273	61,579
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

State Provided Data				
	2019	2020	2021	2022
Annual Objective			49	49.2
Annual Indicator	55	54.6	54.6	
Numerator	35,105	33,976	33,976	
Denominator	63,808	62,273	62,273	
Data Source	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	49.5	49.7	50.0

Field Level Notes for Form 10 NPMs:

None

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2018	2019	2020	2021	2022
Annual Objective	278.4	275.2	275.1	275	274.9
Annual Indicator	281.6	284.0	271.9	278.6	304.6
Numerator	2,211	2,226	2,130	2,175	2,371
Denominator	785,023	783,928	783,327	780,786	778,428
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2016	2017	2018	2019	2020

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	278.4	275.2	275.1	275	274.9
Annual Indicator	250.2	254.1	275.9	275.9	
Numerator	1,960	1,984	2,148	2,148	
Denominator	783,327	780,786	778,428	778,428	
Data Source	MO PAS	MO PAS	MO PAS	MO PAS	
Data Source Year	2018	2019	2020	2020	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	274.8	274.8	274.7

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
2019 used as proxy for 2020

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2019	**2020**	**2021**	**2022**
Annual Objective			37.6	37.8
Annual Indicator	37.4	32.8	31.2	34.3
Numerator	174,971	156,884	145,507	154,430
Denominator	467,457	477,809	465,671	450,203
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			37.6	37.8
Annual Indicator	32.8	31.2	31.2	
Numerator	156,884	145,507	145,507	
Denominator	477,809	465,671	465,671	
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	
Data Source Year	2018_2019	2019_2020	2019_2020	
Provisional or Final ?	Final	Final	Final	

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	38.2	38.4	38.6

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2021**

   Column Name: **State Provided Data**

   Field Note:
   2020-2021 data not available.

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	2019	2020	2021	2022
Annual Objective	43.5	49	49.8	50.6	51.4
Annual Indicator	48.6	50.6	46.9	51.9	48.5
Numerator	144,848	148,654	141,727	149,881	135,203
Denominator	298,327	293,652	301,956	288,780	278,712
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	43.5	49	49.8	50.6	51.4
Annual Indicator	50.6	46.9	51.9	51.9	
Numerator	148,654	141,727	149,881	149,881	
Denominator	293,652	301,956	288,780	288,780	
Data Source	NSCH	NSCH	NSCH	NSCH	
Data Source Year	2017_2018	2018_2019	2019_2020	2019_2020	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	52.2	53.0	54.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
2020-2021 data not available.

Form 10
State Performance Measures (SPMs)

State: Missouri

SPM 1 - Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	71.5	71.7	71.9	72.1	72.3
Annual Indicator	70.9	74.2	72.5	72.5	69.8
Numerator	923,366	955,152	928,942	928,942	905,262
Denominator	1,302,509	1,288,116	1,280,625	1,280,625	1,296,180
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2019_2020	2020_2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	72.5	72.7	72.9

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note: Annual objectives based on percent of children, ages 01 to 17 years, who had a preventive dental visit in the last year.
Data Source: National Survey of Children's Health (NSCH)

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Note: Annual objectives based on percent of children, ages 01 to 17 years, who had a preventive dental visit in the last year.
Data Source: National Survey of Children's Health (NSCH)

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Note: Annual objectives based on percent of children, ages 01 to 17 years, who had a preventive dental visit in the last year.
Data Source: National Survey of Children's Health (NSCH)

4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note: Annual objectives based on percent of children, ages 01 to 17 years, who had a preventive dental visit in the last year.
Data Source: National Survey of Children's Health (NSCH)

5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
2020-2021 data not available

6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note: Annual objectives based on percent of children, ages 01 to 17 years, who had a preventive dental visit in the last year.
Data Source: National Survey of Children's Health (NSCH)

SPM 2 - Suicide and self-harm rate among youth ages 10 through 19

Measure Status:				Active
State Provided Data				
	2019	2020	2021	2022
Annual Objective			17.4	16.8
Annual Indicator	17.4		17.4	30.7
Numerator	1,200		1,200	274
Denominator	6,897		6,897	892
Data Source	YRBS		YRBS	YRBS
Data Source Year	2019		2019	2021
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	16.2	15.5	15.0

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2021**

   Column Name: **State Provided Data**

   Field Note:
   2021 data not yet available for release

2. **Field Name:** **2022**

   Column Name: **State Provided Data**

   Field Note:
   Data for this measure is not comparable to previous indicators. In previous YRBS surveys, there was not a question included to capture self-harm among youth ages 10 through 19. Past annual indicators are reflective of suicide ideology question only. The 2022 percentage of respondents that had seriously considered attempting suicide, based on 2021 YRBS survey results, is 20%. Going forward, annual indicators for this measure will be based on a combined rate of suicidality and self-harm as data is available.

SPM 3 - Number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Measure Status:	Active

State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			20	100
Annual Indicator	0		48	90
Numerator				
Denominator				
Data Source	MO DHSS MCH Program training attendance sheets		MO DHSS Internal Survey	MO DHSS MCH Training Log
Data Source Year	2019		2021	2022
Provisional or Final ?	Provisional		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	150.0	175.0	200.0

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Missouri

ESM 1.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).

Measure Status:	Active

State Provided Data

	2019	2020	2021	2022
Annual Objective			85.8	86.2
Annual Indicator	85.3	83.7	86.7	86.6
Numerator	604	1,001	1,204	1,573
Denominator	708	1,196	1,388	1,816
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	86.8	87.2	87.9

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			83.6	83.8
Annual Indicator	83.3	91.8	76.6	99.4
Numerator	234	202	108	166
Denominator	281	220	141	167
Data Source	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	84.0	84.6	85.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.2.1 - Percentage of high school students who reported distracted driving.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			45	44.2
Annual Indicator	45.8	45.8	45.8	38
Numerator	722	722	722	197
Denominator	1,576	1,576	1,576	518
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2019	2019	2019	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	43.5	42.5	41.5

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2020**

 Column Name: **State Provided Data**

 Field Note:
 2019 YRBSS data used as proxy for 2020 year

2. **Field Name:** **2022**

 Column Name: **State Provided Data**

 Field Note:
 YRBSS conducted on odd numbered years. 2022 data reflects final survey data from 2021.

ESM 8.1.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	100
Annual Indicator	33	33	352	486
Numerator				
Denominator				
Data Source	MO DHSS Go NAPSACC data	MO DHSS Go NAPSACC data	MOPHIRS Report - CLPHS Service Log	MO DESE CCHC program
Data Source Year	2019	2019	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	200.0	300.0	400.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2022**

   Column Name: **State Provided Data**

   Field Note:
   Note: Annual Indicator reflects logged training hours for 2022.

ESM 11.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			1,800	2,000
Annual Indicator	1,682	1,822	1,057	637
Numerator				
Denominator				
Data Source	MO DHSS Programs	MO DHSS Programs	MO DHSS Programs	MO DSS Programs
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	2,400.0	2,800.0	3,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Family Partnership will disseminate information on the importance of a medical home to families of children and youth with special health care needs. Family Partnership previously shared a newsletter focusing on medical home information with families enrolled in SHCN services.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Family Partnership will disseminate information on the importance of a medical home to families of children and youth with special health care needs. Family Partnership previously shared a newsletter focusing on medical home information with families enrolled in SHCN services.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Family Partnership will disseminate information on the importance of a medical home to families of children and youth with special health care needs. During FY22, Family Partnership was only able to share one approved newsletter focusing on medical home information with families enrolled in SHCN services.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Missouri

SPM 1 - Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of children, ages 1-17 years, who had a preventive dental visit in the last year.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Children, ages 1-17, who had a preventive dental visit in the last year. **Denominator:** All children ages 1 through 17 years.
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)
Significance:	Poor oral health in children is linked to difficulty speaking, eating, and learning. Poor oral health is linked to poor overall health for children and adults both. Preventive dental visits are recommended for pregnant women due to increased risk of periodontal disease during pregnancy. Poor oral health during pregnancy is dangerous for the mother and is linked to poor outcomes for infants. Preventive dental visits are recommended at least annually for infants and children. Preventive dental visits include a cleaning and examination for tooth decay and other issues with the teeth, gums, and jaw. Many dental visits also result in the application of fluoride varnish and/or dental sealants on molars to prevent dental caries. For both children and adults, dental visits are an important time for providing education about proper oral hygiene, prevention of dental injuries, and importance of good oral health for overall health.

SPM 2 - Suicide and self-harm rate among youth ages 10 through 19
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2025, reduce the suicide death rate among youths 10-19 years from 7.8% per 100,000 (CY 2019 Vital Statistics).</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of high school kids who seriously considered attempting suicide in the past year (YRBS)</td></tr>
<tr><td>Denominator:</td><td>Number of adolescents in grades 9 through 12 (YRBS)</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>YRBS</td></tr>
<tr><td>Significance:</td><td>According to 2022 Missouri Vital Statistics provisional data, suicide remains the tenth leading cause of death for all ages among Missouri residents and the third leading cause of death among adolescents 10-19 years old. In 2022, there were 59 deaths due to suicide among adolescents ages 10 to 19 years, or 7.5 deaths per 100,000. Suicide and suicidal ideation is often indicative of mental health problems and stressful or traumatic life events. In 2021, 20.4% of high school students reported they had thought seriously about committing suicide in the past year. While females are more likely to report attempting suicide, males are more likely to succeed in committing suicide. The suicide mortality rate for males is 2-4 times that of females in adolescent age group (Miranda-Mendizabal, et al. 2019).</td></tr>
</table>

SPM 3 - Number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** The number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings. **Denominator:**
Data Sources and Data Issues:	MO DHSS MCH Program training attendance sheets
Significance:	Increasing staff awareness through training, and providing opportunities to deepen their practical knowledge of applying an equity lens to their work, will be valuable infrastructure-building activities that have the potential to impact MCH work across the state. The state Title V program will promote training resources on health equity, and racial justice concepts to staff members. Partners who had better understand principles related to health equity, social determinants of health, the life course model, and other relevant frameworks, would be better able to incorporate these principles into their programs and the community.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Missouri

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Missouri

ESM 1.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the percent of women who reported a routine checkup within past 2 years (BRFSS).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women, ages 18 through 44, who had a preventive medical visit within past 2 years **Denominator:** Number of women, ages 18 through 44
Data Sources and Data Issues:	BRFSS
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women’s health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes.

ESM 5.1 - At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the percent of safe crib program clients who were placing their baby in a safe sleep environment.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** At the time of follow-up, number of mothers reporting that they most often place their baby in a safe sleep environment **Denominator:** Number of Safe crib program clients participated in follow-up visit
Data Sources and Data Issues:	MO DHSS Safe Cribs Program
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. http://pediatrics.aappublications.org/content/128/5/1030

ESM 7.2.1 - Percentage of high school students who reported distracted driving.
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Decrease the high school students who reported distracted driving
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey) **Denominator:** Number of adolescents in grades ages 9 through 12
Data Sources and Data Issues:	YRBS
Significance:	Motor-vehicle crashes are a leading cause of death and nonfatal injury among Missouri adolescents, resulting in approximately 100 deaths and 54,000 nonfatal injuries resulting either hospitalization or an ER visit in 2022. Risk for motor-vehicle crashes and resulting injuries and deaths varies, depending on such behaviors as seat belt use or impaired or distracted driving. Improved understanding of adolescents' transportation risk behaviors can guide prevention efforts. According to the Missouri 2021 Youth Risk Behavior Survey 42.3% of high school students did not always wear a seat belt, 15% rode with a drinking driver, 4.3% of students had driven a car after drinking alcohol and 42.5% had texted or e-mailed while driving during the 30 days before the survey. Traffic safety and public health professionals can use these findings to reduce transportation risk behaviors by selecting, implementing, and contextualizing the most appropriate and effective strategies for specific populations and for the environment.

ESM 8.1.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.
Definition:	**Unit Type:** Count **Unit Number:** 5,000 **Numerator:** Number of programs/training's on promoting healthy eating and active lifestyle campaigns among children. **Denominator:**
Data Sources and Data Issues:	MO DESE CCHC data
Significance:	Increasing awareness and knowledge about the importance of proper nutrition and the consequences of poor nutritional habits is a first step for good health practices. Developing skills for reading food labels and preparing healthy snacks and meals are important for improving nutritional behaviors. Creating social support networks to encourage adoption of healthy nutritional habits can be accomplished through community cooking classes, dinner clubs, and offering healthy party snacks. Child Care Wellness contracts will support LPHAs in providing training and technical assistance to child care providers in improving child care physical activity and nutrition policies and practices. LPHAs will report child care provider activities and progress directly to the Child Care Health Consultation (CCHC) program for tracking.

ESM 11.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of family members, healthcare providers, and community professionals educated on the medical home approach
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of family members, healthcare providers, and community professionals who receive education on the medical home approach **Denominator:**
Data Sources and Data Issues:	MO DHSS program data
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. https://medicalhomeinfo.aap.org/Pages/default.aspx

Form 11
Other State Data

State: Missouri

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Missouri

Annual Report Year 2022

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	2		
2) Vital Records Death	Yes	Yes	Daily	2	Yes	
3) Medicaid	Yes	Yes	Daily	2	Yes	
4) WIC	Yes	Yes	Annually	2	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	1	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	1	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	3	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	24	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None