Maternal and Child Health Services Title V Block Grant

Missouri

FY 2026 Application/ FY 2024 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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Sarah Willson
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July 24, 2025

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 2026 Application and FFY 2024 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 December 31, 2026) 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.

Please note the following:

- The attached "DHSS-Related Acronyms" document includes a comprehensive list of standardized acronyms used throughout Missouri's application and report narratives. Please refer to the attached list, as only acronyms are used throughout the narratives to represent terms included in the "DHSS-Related Acronyms" attachment.
- The term "provider" is broadly used throughout the narratives to refer to a wide range of individuals or organizations offering a variety of services to support individuals and families throughout their health journey, promoting overall well-being and quality of life.

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

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 2 of the 2026 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: December 31, 2026.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Missouri's Title V MCH Services Block Grant is managed by the Department of Health and Senior Services (DHSS) and is organizationally situated in the Division of Community and Public Health (DCPH). Martha Smith, MSN, RN, is the State Director for Maternal and Child Health (MCH), and Andrea Tray, MPH, is the Children and Youth with Special Health Care Needs (CYSHCN) Director. The Title V MCH Services Block Grant application is submitted by DHSS as the designated state agency for the allocation and administration of these block grant funds and oversight of all Title V funded programming. State MCH Leadership and Title V MCH programming are positioned throughout multiple DHSS divisions and organizational units. DCPH serves as the umbrella entity to facilitate access to numerous MCH-targeted programs, and DCPH programs provide a majority of DHSS services for the MCH population. The capacity of Missouri's Title V MCH programming is broad, encompassing programs and staff within DHSS, the Office of Childhood at DESE, LPHAs, and numerous private and community partners. Through these programs, initiatives, and partnerships, a statewide system is supported to assure comprehensive, coordinated, and family-centered MCH services, including services for cyshcn.

DHSS used the conceptual framework provided by HRSA/MCHB and the MCH Evidence Center to guide the needs assessment process and inform understanding of MCH population needs across the state. The Office of Epidemiology (OOE) initiated the statewide Missouri Five-Year Needs Assessment in the fall of 2023. The needs assessment timeline included development and execution of a contract for conducting the listening sessions, qualitative and quantitative data collection and analysis (Spring 2024 – Fall 2024), and stakeholder input (Winter 2024 – Spring 2025). The final state priorities were determined after review of all needs assessment components and coordination with DHSS leadership.

Summary of MCH Needs Assessment Findings

Missouri's 2025 MCH Needs Assessment identified ongoing and emerging challenges impacting the state's MCH population. The findings were informed by listening sessions, quantitative data analysis, a public survey, and stakeholder input. Together, these components provided a comprehensive picture of MCH population needs and priorities to guide statewide MCH strategic planning for the next five years. Some specific issues identified include:

- Access to Care: Barriers such as cost, provider shortages, lack of transportation, and insurance gaps were highlighted across the state. Many residents struggle to access primary, dental, behavioral, and specialty care.
- Mental Health: Limited mental health services are available, especially in rural areas. Stigma, lack of providers, and affordability remain major barriers.
- CYSHCN Needs: Families face fragmented systems, high costs, limited rural access, and insufficient funding for needed therapies and services.
- Community and Population-Level Factors Influencing MCH Outcomes: Issues beyond public health and health care, including transportation and housing, were highlighted as contributing to poor health.

MCH Priorities and Five-Year State Action Plan

Based on the Five-Year Needs Assessment completed in the spring of 2025, MCH Leadership and OOE identified the following FY 2026-2030 state priorities and developed strategies and action plans to address these needs:

1. Access to patient-centered, coordinated, and comprehensive postpartum care.
2. Preventive oral health care services during pregnancy.
3. Safe infant sleep practices and environments to promote safe infant sleep and reduce sleep-related infant deaths.
4. Access to holistic oral health care services for children.
5. A stable and supportive relationship with a caring non-parental adult to enhance adolescent psychological well-being and empower youth with the tools and training to reach their full potential.
6. Smooth and successful transition from child-centered to adult-oriented health care, promoting continuity of care, improving health outcomes, and empowering youth to manage their own health.
7. Access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children with and without special health care needs.
8. Strengths-based services and supports to promote healthy family relationships and functioning, enhance resilience, foster social connections, develop knowledge of parenting and child development, and support children's social and emotional development.

Core values to be applied across all priorities, performance measures, and strategies were identified: person-centered, strengths-based approach; family and youth partnership and engagement; success through enhanced skills, knowledge, and capabilities; excellence; collaboration; access; integrity; and accountability.

Seven National Performance Measures (NPMs) and one State Performance Measure (SPM) were chosen to align with the priority needs and are discussed below by population domain. The two new Universal NPMs, postpartum visit and medical home, are included in the Women/Maternal and CYSHCN and Child Health domains, respectively. Evidence-based or -informed strategies will be implemented to address each priority, and the effectiveness of those strategies in making progress toward targeted objectives will be monitored by tracking the identified performance measures.

Women/Maternal Health

Priority: Access to patient-centered, coordinated, and comprehensive postpartum care

NPMs: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth

B) Percent of women who attended a postpartum checkup and received recommended care components

Recognizing postpartum care is critical to identification and treatment of any pregnancy-related complications, including postpartum depression and anxiety, yet significant gaps in access to postpartum care were highlighted through the needs assessment process, access to postpartum care will be prioritized. The postpartum visit provides an opportunity to monitor recovery from delivery, manage chronic conditions such as hypertension or diabetes, and address issues like pain, breastfeeding challenges, or signs of postpartum depression. This visit also provides an opportunity for maternal care providers to connect new mothers with local support resources and assure appropriate referrals to address comprehensive health care needs, ensuring physical, emotional, and mental well-being after childbirth and beyond. In Missouri, where access to maternal health care varies by region, especially in rural areas, timely postpartum care is essential to prevent complications and support a healthy transition into motherhood.

Priority: Preventive oral health care services during pregnancy

NPM: Percent of pregnant women who receive preventive dental care during pregnancy

Oral health, ranked as a top priority through the needs assessment process, is a critical component of a person's overall health and well-being, and poor oral health during pregnancy has been linked to an increased risk of preterm

birth and low birth weight.

Perinatal/Infant Health

Priority: Safe infant sleep practices and environments to promote safe infant sleep and 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
D) Percent of infants room-sharing with an adult

Sleep-related infant death due to suffocation continues to be a leading cause of infant mortality in Missouri, with persistent racial disparities. Title V funding is the sole source of funding support for the Safe Cribs for Missouri Program, which provides safe sleep education and free portable cribs to eligible families. DHSS works closely with home visiting programs, LPHAs, and community partners to provide cribs, safe sleep education, trainings, and resources to reduce the risk of infant injury or death due to unsafe sleep environments. Quality improvement initiatives to promote safe infant sleep practices and environments will be prioritized.

Child Health

Priority: Access to holistic oral health care services for children

NPM: Percent of children ages 1 through 17 who had a preventive dental visit in the past year

To address the identified priority need for access to oral health care, holistic oral health care for children, focused on the overall well-being of the child, not just their teeth, will be prioritized. By addressing nutrition, hygiene habits, safety, emotional health, and early prevention, holistic care encourages positive behaviors, reduces the risk of chronic issues, supports healthy growth and development, and helps build a strong foundation for lifelong oral and general health.

Adolescent Health

Priority: A stable and supportive relationship with a caring non-parental adult to enhance adolescent psychological well-being and empower youth with the tools and training to reach their full potential

NPM: Percent of Adolescents, ages 12 through 17, who have one or more adults outside the home whom they can rely on for advice or guidance

Adolescent health plays a critical role in shaping a young person's future, influencing their physical, emotional, and social development, and having even one caring non-parental adult can make a significant difference. These trusted adults provide guidance, support, and a safe space for adolescents to express themselves, which can boost their sense of self and belonging. Their presence is especially valuable when teens face challenges or lack consistent support at home. Needs assessment findings showed adolescents in Missouri continue to be at risk of poor mental health and injury-related deaths, including suicide. Supportive adult relationships will be prioritized to promote adolescent self-esteem, resilience, mental well-being, and healthy decision-making.

Priority: Smooth and successful transition from child-centered to adult-oriented health care, promoting continuity of care, improving health outcomes, and empowering youth to manage their own health

NPM: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care.

As young people age, their physical, emotional, and social needs evolve, and the transition from child-centered to adult-oriented healthcare is a critical step in promoting adolescent and adult health. To lay the foundation for improved health outcomes, DHSS will collaborate with partners to prioritize coordinated transition, foster health literacy, and empower youth to take responsibility for their own well-being.

CYSHCN

Priority: Access to family-centered, coordinated, comprehensive, and community-based health care services and supports 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 receive family-centered, coordinated, comprehensive, and community-based health care services and supports (reported in Child Health and CYSHCN domains)

A medical home provides continuous, comprehensive, and coordinated care that supports a child's physical, emotional, and developmental needs and ensures timely preventive services, effective management of chronic conditions, and seamless access to specialty care and support services, as needed. Access to health care, including primary, behavioral health, and specialty care providers, was a top priority identified through the needs assessment process. DHSS programs promote health insurance coverage and educate on the medical home approach to improve the likelihood all children will have a medical home and services to address their needs. The Bureau of SHCN provides targeted education to enrolling families on the importance of a medical home.

Cross-Cutting/Systems Building

Priority: Strengths-based services and supports to promote healthy family relationships and functioning, enhance resilience, foster social connections, and support children's social and emotional development.

SPM: Percent of children and parents participating in a family skills development and strengthening program who report improvement on program evaluation metrics.

Family skills development and strengthening programs focus on identifying and building upon existing strengths, capacities, and resources within a family, empowering them to overcome challenges. To address the broader priority to support the overall health and well-being of families and children across the life course, strengths-based approaches will be leveraged to foster healthy family relationships and functioning.

DHSS celebrates successes in system development and partnership and is committed to ongoing support of systems to deliver comprehensive, coordinated, and family-centered services and ensure MCH populations, including cyshcn, attain their full health potential. Title V resources are allocated and program activities are implemented to specifically address the identified priorities, along with planning for and responding to ongoing MCH needs and emerging issues and hazards. 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 a broad spectrum of programming to address priority needs and community and population-level factors influencing MCH outcomes, and efforts are grounded in collaboration with a range of state and local partners. Service coordination through the CYSHCN and HCY programs help families develop and obtain high-quality supports and services to meet their needs. Early childhood programs are offered to ensure children have the opportunity to grow up healthy, safe, and ready to learn and able to become productive members of society. Family- and community-centered partnerships, feedback, and collaboration are valued and centered in MCH efforts. SHCN Family Partners, who are parents of individuals with special health care needs and have firsthand experience, provide peer-to-peer support for families to

navigate options and solutions focused on the unique needs of individuals with complex medical conditions, from birth to age 21. The Bureau of SHCN utilizes input and guidance from the Family Partners and the families served to enhance the quality of services and support for cyshcn. Title V funded FTEs are leveraged to develop meaningful partnerships with schools, child care providers, state departments and associations, local organizations, and community groups to promote systems of care that benefit the MCH population and overcome issues preventing access to care.

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

Federal Title V funds provide backbone funding for approximately 118 key staff positions across DHSS and the Office of Childhood at DESE (not including senior leadership and budget/financial, procurement and information technology support staff). This includes the Chief Medical Officer and staff who serve children and youth with special health care needs (cyshcn), including four SHCN Family Partners; epidemiological staff who analyze data to identify priority health needs of the maternal/child population; staff who focus on women's, infant's, children's, and/or adolescent's health; and staff working on special MCH initiatives. Staff also provide technical assistance to community partners and the 115 LPHAs. Contract funding to LPHAs to help build community-based systems and expand the resources those systems can use to respond to priority MCH issues comprises almost thirty percent of Title V funds. The bulk of remaining contract funds are allocated for home visiting, service coordination for cyshcn, early childhood, oral health promotion, community health and wellness initiatives, and MCH navigator and support services. The majority of state match supports newborn screening testing by the State Public Health Lab, newborn screening follow-up, direct care for cyshcn, and maternal mortality prevention. State funds also support women's health services for incarcerated women and the Sexual Assault Forensic Examination – Child Abuse Resource and Education program. Title V funds allow Missouri to coordinate public health services provided to the MCH population by working across multiple state programs, engaging community partners and families, and collaborating with stakeholders throughout the state to address ongoing and emerging issues impacting MCH.

Over the past few years, Title V funds have been leveraged to expand the MCH Coordinator position to 1.0 FTE and establish the CYSHCN Director position as 1.0 FTE, increasing capacity to provide statewide leadership for priorities related to cyshcn, medical home, and family partnership. Title V funds support the MCH Learning Community, launched in 2023 to promote cross-collaboration, relationship building, knowledge-sharing, and problem-solving, and quarterly publication of the MCH Newsletter. DHSS leveraged Title V funding to secure state funding to support the Maternal Mortality Prevention Plan (MMPP), launched in state FY 2024, and the Statewide Fetal and Infant Mortality (FIMR) Network, launched in state FY 2025. Title V funds support two FTE for the FIMR Coordinator and FIMR Epidemiologist positions, necessary to implement the statewide FIMR Network, and support FTEs to lead and implement the MMPP. To help build a strong public health workforce, inclusive of the MCH workforce, the MCH Director also serves as the State Lead for Public Health Nursing, providing leadership, expertise, and advocacy related to public health nursing practice, standards, and issues, along with specialized MCH nursing leadership and expertise. Title V funds support the MCH Director's and other programs' participation in Department strategic planning and service on state-level MCH and public health boards. The MCH Director is supported to serve as the Region VII Director on the Board of Directors for the Association of Maternal and Child Health Programs. With the support of organizational leadership, the MCH Director leverages Title V funding to serve as a thought leader and architect for the future of Missouri's MCH system and outcomes.

Note: Reporting of federal and state Title V expenditures by individual MCH populations and service level of the MCH Pyramid to demonstrate how federal Title V funds support gap-filling services and complement state funds in providing a range of MCH services is included in Forms 3a and 3b.

III.A.3. MCH Success Story

Collaboration is the key to effectively supporting families of children and youth with special health care needs (cyshcn). The SHCN Family Partnership Program is dedicated to enhancing the lives of cyshcn and their families by providing resources, information, and connections that empower families to live a good life, experiencing improved health, economic security, and meaningful social connections.

Through the MCH Services Program, SHCN Family Partnership collaborated with the Tri-County Health Department to support completion of “Your Child’s Care Notebook”. The Care Notebook is a comprehensive resource designed to help families organize and share important health information with their care teams. It equips caregivers with essential tools to ensure anyone providing care to cyshcn can respond effectively. Drawing from their lived experiences as parents of cyshcn, the SHCN Family Partners helped shape the content of the notebook to address the specific needs of cyshcn and their families. While tailored to support cyshcn, the notebook is a versatile resource that can help coordinate care for and benefit children of all ages, both with and without special health care needs. This collaboration led to joint presentations on medical home approach and the Care Notebook at the Disability Awareness Convention, hosted by the Arya Foundation, the Family Partnership Parent and Caregiver Retreat, and the Missouri Coordinated School Health conference. Additional presentations are scheduled at several future convenings. Printed copies of the Care Notebook were distributed to attendees, providing them with a practical resource they could use immediately. During the Retreat, a family member stated, “It was important for me to learn that I have a medical home, as I thought I had a hospice home.,” highlighting the value of accessible, accurate information for families navigating complex care needs. The Care Notebook is available electronically, as both a fillable form and non-fillable form, expanding its reach to anyone seeking to organize health information and share it with their care team.

Building on this collaborative foundation, SHCN worked with LifeCourse Nexus Training and Technical Assistance Center at the University of Missouri Kansas City to develop the “Resource Guide For Missouri Families of Children From Birth to Age 12.” The guide was designed to strengthen support networks by providing families with detailed descriptions, links, and phone numbers of various statewide resources. The SHCN Family Partnership Manager presented a “spotlight session’” on the Resource Guide at the Charting the LifeCourse Showcase. Organized by the “Three Buckets of Support” - Discovery and Navigation, Connecting and Networking, and Goods and Services - this guide is a valuable tool for all families, especially those of cyshcn. It highlights the supports available through SHCN Family Partnership and Missouri Family to Family, both of which provide free statewide services led by parents or family members of individuals with special health care needs or disabilities.

The success of this initiative underscores the tangible impact and pivotal role of the Title V MCH Block Grant in addressing critical needs and promoting the well-being of children. These efforts, funded by Title V at state and local levels, exemplify the transformative impact of collaborative synergy and strategic resource allocation in advancing MCH. Through these collaborative efforts, Family Partners helped create valuable resources, gained valuable insight into the power of building connections and networking with other organizations and agencies, and provided resources to families that offer support and reassurance they are not alone on their journey.

Note: Additional information is included in the CSHCN domain narratives.

III.B. Overview of the State

III.B.1. State Description

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 2022 U.S. Census state population estimate was 6,168,181 residents.[2] From 2013 to 2023, the state's population increased by 2.7%, including a 3.4% increase for males and a 2% increase for females.[2,3] Missouri was ranked 29th among the 50 states and the District of Columbia for population density (90.26 people per square mile in 2022.[4])

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 are 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 (979,595) and Jackson (723,244) counties. The greatest population density is in St. Louis City, with 4,401 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 is Texas County, with an area of 1,177 square miles and a population density of 22 persons per square mile. In total, 48 of Missouri's counties have a population density below 25 persons per square mile.[5]

Age

The estimated median age of Missourians for 2023 was 38.9 years old.[6] For 2023, nearly 22.5% of the state's population (1,386,571) was less than 18 years old, and 17.5% of the population (1,079,129) was age 65 or older.[6] Missouri's MCH population including women of childbearing age (15-44), infants, children, and adolescents (under 1-19) was 2,741,543.[6] This accounted for 44.4% of the state's roughly 6.17 million population. Among this MCH population, 1,193,673 were women of childbearing age (15-44 years) and 1,547,870 infants, children, and adolescents (ages 0-19 years).[6] There was an estimated 328,340 children with special health care needs for the 2022-2023 time period.[7] In 2023, there were 67,065 Missouri resident live births, of which 13.8% were African American and 78.6% were White.[8] Hispanic births in Missouri increased by 20% from 2021 to 2023 (4,593 and 5,512 respectively).[8]

Racial/Ethnic Background and Language

Based on population estimates from 2023, Missouri residents are predominantly White (84.6%) with a

significant African American (12.8%) population and smaller Asian (2.9%) and American Indian/Alaskan Native (2%) resident populations.[2] For 2022, the top three jurisdictions for proportion of population that is Black or African American alone or in combination are St. Louis City (46%), Pemiscot County (28.3%), and St. Louis County (26.1%).[9] The Hispanic or Latino population comprises 5.2% of Missouri's population.[2] Population growth for Hispanics in Missouri was 42% from 2013[10] to 2023,[2] compared to 21.9% for Hispanics or Latinos nationally in the same time span.[10,11]

The U.S. Census Bureau, via the American Community Survey (ACS), provides 5-year estimate data, suggesting the various racial/ethnic backgrounds in Missouri. The 2023 5-year estimate of native-born United States citizens comprising the Missouri population was 5,898,279 (95.6%).[12] Furthermore, 2023 ACS 5-year estimates indicate 4.4% of the Missouri population was foreign born with an estimated population size of 269,902.[12] Of the residents that were not born in the United States, 37.2% were from Asia, 31.9% from Latin America, 16.6% came from Europe, 10.7% came from Africa, and 3.7% from other regions of the world.[12] Furthermore, 6.6% of Missourians five years and older spoke a language other than English at home.[12] Of the group that spoke a language other than English at home, 2.2% persons spoke English less than 'very well'.[12] An estimated 165,840 (2.9%) of Missourians 5 years and older spoke Spanish at home instead of English.[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 variation in racial/ethnic background of the state population.

Addressing factors related to racial/ethnic background that led to adverse maternal-child health outcomes represents an ongoing challenge for public health in the state. Examining data from 2023, the infant mortality rate (age <1 year) for African American babies (13.2 per 1,000) was more than double that of White babies (4.3 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 2023 ACS 5-year estimates indicate 91.6% of Missourians over the age of 25 are high school graduates or higher.[14] This was higher than the national average of 89.4%.[15] However, the percentage of Missourians in this age group that have a bachelor's degree or higher (31.9%), was less than the U.S. average (35%).[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 was $68,920, which was $9,618 less than the national median household income of $78,538.[17,18]

Missouri's unemployment rate increased from 3.6% in December 2024 to 4% in May 2025 (preliminary).[19] Data from the Department of Labor and Industrial Relations showed the total number of unemployment claims for Missouri in the 2024 Fiscal Year was 117,000, a decrease from 168,671 in Fiscal Year 2023 and a significant decrease from 253,236 in Fiscal Year 2022.[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 had 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 health care infrastructure and workforce.

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 2023 (12.6%) was lower compared to the estimated percent (13.7%) for 2019.[23,24] Furthermore, Missouri's estimated 2022 poverty rate for children under 18 years old was 16%, which was higher than the state overall rate. [23] Approximately 756,528 Missourians were living below poverty, with 216,943 children under 18.[23]

Food insecurity is an important issue that can affect children and families. According to Feeding America, 15.4% of Missourians were food insecure in 2023, which was higher than the national rate of 14.3%.[25] Additionally, the child food insecurity rate for Missouri was 18.1%, representing nearly a quarter of a million children.[25] There was a significant disparity in food insecurity rates by race, with White non-Hispanic Missourians having a food insecurity rate of 13.0% compared to 33.0% for Black and 21.0% for Latino Missourians.[25]

Homelessness

The 2024 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 2024. Overall, 7,312 Missourians, 2,150 families with children, and 501 unaccompanied youth were reported to experience homelessness on any given night in 2024.[28]

Environment

Lead mining and smelting have been an important part of Missouri's history since the early 1700s. Missouri has been the dominant lead-producing state in the nation since 1907. 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'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. On August 28, 2023, Missouri regulations for lead testing in children changed (701.340-701.342), making testing guidelines simplified for providers and families. All parents of a child under four years will be provided education and a child's blood lead level tested annually. All children receiving Medicaid benefits must also have lead testing at 12 and 24 months of age.

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, the 2021 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 2024, Missouri had the seventh-largest highway system in the nation.[30] The transportation infrastructure has three key measures: airports, railroads, and waterway mileage. The Missouri highway system is comprised of nearly 34,000 miles of highways and more than 10,000 bridges.[30] Additionally, county roads and city streets add 98,000 miles and just over 14,000 additional bridges. [30] 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 42.8% increase in the rate of vehicle fatalities from 2013 to 2023.[13] In 2023, 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.[33] Between 2018 and 2023, 6,166 people were killed in motor vehicle accidents in Missouri, a rate of 16.7 deaths per 100,000 residents.[32] In 2020, for the first time since 2007, the motor vehicle fatalities total (1,031) was over 1,000.[32] Missouri saw an increase in total motor vehicle deaths from 2021 to 2022 but a decrease from 2022 to 2023.[32] The decrease in Missouri motor vehicle deaths from 1,111 in 2022 to 1,041 in 2023 was a 6.7% decrease.[32] This marked the fourth straight year of motor vehicle fatalities totaling over 1,000.[32]

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 (87.0%) in 2023 was below the national average of 91.9% for the same year.[33] 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.[34]

Health Infrastructure

Five predominant schools 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 5,105 osteopathic and 28,559 allopathic physicians.[35,36] Of these physicians, there are 1,072 obstetrician/ gynecologists and 20 specializing in obstetric/gynecologic surgery.[35,36] Additionally, there are 2,488 physicians certified in pediatrics and 467 specialized pediatricians (e.g., pediatric pulmonology, pediatric emergency medicine, pediatric cardiology, etc.).[35,36]

As of July 7th, 2025, there are 163 hospital facilities in Missouri spread across 69 counties/jurisdictions.[37] The majority of hospitals are located in urban counties. There are also 44 hospitals with psychiatric beds.[38] There were 802 licensed pediatric beds and 886 licensed NICU beds.[39,40] 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 and five veterans centers.[41] Missouri also has another four outpatient clinics associated with the out-of-state VA Medical Centers in Fayetteville, Arkansas and Leavenworth, Kansas. [41] There are 340 Rural Health Clinics (RHC), which must be located in a non-urban area and in a federally designated or certified shortage area, and 28 FQHCs; 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.[42] From 2014 to 2023, 19 Missouri hospitals closed, and the closures were located in Health Professional Shortage Areas (HPSA). [42] Of the 19 closures,12 hospitals were located in rural counties and left 50 rural counties without a hospital.

[42] 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 2024 America's Health Rankings Annual Report published by the United Health Foundation, were its high prevalence of high school completion, high childhood immunization rate, and low average number of health-based drinking water violations. Nearly 90% of students graduated from high school (ranked 7th), and Missouri ranked 13th for low rates of severe housing problems. [43] Some of the most challenging issues facing Missouri are low prevalence of adults meeting physical activity guidelines (23.7%; ranked 45th), high homicide rate (11.8 per 100,000; ranked 45th), and high prevalence of cigarette smoking (15.3%; ranked 42nd).[43] Mental health providers increased 51%, from 180.7 per 100,000 in 2018 to 273.3 per 100,000 in 2024.[43] Nationally in 2024, Missouri saw a slight increase in overall rank to 39th from 40th in 2023.[43] However, Missouri nationally ranked 36th for low birthweight, declined from 34th, and maintained 35th for low birthweight racial disparity compared to 2023.[43]

Health Insurance Coverage

Overall, Current Population Survey estimates indicate a decrease in percentage of uninsured Missourians from 9.3% in 2019 to 9.2% in 2023.[44,45] Missouri's estimated uninsured percentage for 2023 is higher than the 8.6% national estimate for the same year.[46] Missouri's estimated percent of children under the age of 19 without health insurance increased from 2019 (5.6%) to 2023 (6.1%) but remained higher than the national level (5.4%).[44,45,46] An estimated 13.1% of Missouri women (ages 19-44) were without public or private health insurance in 2023, compared to 14.1% in 2019.[47,48] The estimated percentage for 2023 was higher than the national level for the same year (11.7%).[49]

Statewide-Managed Care

The MO HealthNet managed care system started in 1995 when DSS first contracted with managed care plans 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 MO HealthNet 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 fitting into one of the following eligibility categories must enroll in a managed care health plan:

- 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 children and youth with special health care needs) may also opt out of the Managed Care Program and choose the FFS Program.

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 2024, that amounts to approximately $21,597 for a single individual and $36,777 for a household of three. Medicaid eligibility was previously set in state statute, but the amendment added Medicaid Expansion to Missouri's constitution, effective July 1, 2021. 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 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. 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. Nearly 312,000 individuals were enrolled via Medicaid expansion by early 2023, peaking at a little more than 350,000 and then dropping during the "unwinding" of the continuous coverage rule. By late June 2024, the number of people enrolled had dropped to under 300,000, with noted drops especially in children, custodial parents, and the disabled. As of February 2025, total net enrollment in Missouri's Medicaid program has remained relatively steady at about 1.27 million since May 2024.

Department of Health and Senior Services (DHSS) Priorities

State MCH Leadership is located within DHSS. Effective February 16, 2025, Sarah Willson was appointed as the Director of DHSS and is responsible for the management of the Department and the administration of its programs and services. Willson served as Vice President of Clinical and Regulatory Affairs for MHA since 2016, providing clinical and regulatory guidance to over 140 hospitals across the state and serving as a key expert in licensing, compliance, and survey processes for various health care settings. She also collaborated with lawmakers to develop health care legislation at both the state and federal levels.

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 DHSS Strategic Map 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

Public Health Accreditation Board (PHAB) Accreditation

In furthering the commitment to improving public health infrastructure and championing performance improvement and innovation, DHSS achieved PHAB reaccreditation in December 2024. This national public health accreditation

program assesses a health department's capacity to carry out the 10 Essential Public Health Services and the Foundational Capabilities as well as serving as a marker for health departments to commit to promoting public trust and demonstrating an ongoing commitment to quality and performance improvement. DHSS' achievement in meeting PHAB standards outlined in Version 2022 for reaccreditation assures increased capacity to respond to public health emergencies, encourages the use of fair and impartial health care and services as a lens to identify health priorities, builds the health department's capacity to better serve communities, and assures stakeholders the health department is delivering Foundational Capabilities.

In October 2024, DHSS held its required site visit with the PHAB Assigned Accreditation Specialist and three volunteer site visitors. These site visitors are retired or active public health professionals from peer jurisdictions tasked with the review of accreditation materials submitted by agencies to identify areas of opportunity or necessary clarifications. After discussion at the site visit, the panelists prepare a report listing how completely the applying agency met requirements for each measure on a scale of "not demonstrated, slightly demonstrated, largely demonstrated, and fully demonstrated". After the site visit, DHSS' final report included only one "slightly demonstrated" measure and zero "not demonstrated" measures.

To ensure ongoing readiness for reaccreditation, DHSS has committed resources to ensure maintenance and accountability, including implementing a State Health Improvement Plan (SHIP) Accountability Plan, creating a department-wide Lean Six Sigma team dedicated to completing quality improvement projects and fostering a culture of continuous improvement, and measuring progress for department-wide plans such as the Strategic Plan, Workforce Development Plan, and SHIP, all also required by PHAB, in the department's performance management system, AchieveIt. Specifically, the SHIP Accountability Plan identifies co-leads from various divisions of the department to work with stakeholders to collect data on the progress made towards the goals outlined in the SHIP and input the data into AchieveIt to create public dashboards and annual progress reports.

DHSS also recognizes the crucial role of public health accreditation as a systems-building strategy for LPHAs. While the state-level agency works to maintain its reaccredited status under the PHAB standards and measures, DHSS is utilizing grant funding to support LPHAs on their accreditation journeys as well. Achieving initial accreditation can be a major commitment for LPHAs, demanding expertise, staff time, and funding. To eliminate these barriers, DHSS offers multi-faceted support to LPHAs. Local agency administrators are free to pursue accreditation under the accrediting body of their choice, either PHAB at the national level or the Missouri-specific Missouri Institute for Community Health (MICH) standards.

DHSS established a contract with the Missouri Center for Public Health Excellence (MOCPHE) to provide a wide range of technical assistance activities to LPHAs pursuing accreditation. MOCPHE offers accreditation learning communities, cohorts, special events and training opportunities, and hands-on assistance for LPHAs in pursuit of initial accreditation or reaccreditation. DHSS is also contracting directly with PHAB to provide access to their readiness assessment for all LPHAs at no cost. This assessment and the accompanying training provide a deep dive into an agency's current status to understand which PHAB program is right for the agency at the time of completion. Those not quite ready to pursue full accreditation are steered towards the Pathways Program and given resources on next steps. Those ready for accreditation are encouraged to engage with MOCPHE and peer networks and granted access to advanced training materials to set them up for success.

Through cost reimbursement contracts, DHSS is providing funding to LPHAs pursuing accreditation to support any activity necessary for accreditation. LPHAs may contract with entities for more advanced assistance, hire new staff, train existing staff, pay for staff time dedicated to accreditation activities, and/or purchase necessary supplies and

software to meet requirements. Lastly, DHSS secured state general revenue funding to provide incentive payment options to LPHAs to encourage and reward public health service delivery. LPHAs may claim incentive payments for participation in accreditation-related training sessions, completion of the PHAB readiness assessment, or by providing evidence of current accreditation under PHAB or MICH.

Missouri Foundational Public Health Services (FPHS)
Two key elements of DHSS' efforts to transform and elevate the public health system across the State of Missouri are the ongoing project to adopt the Missouri FPHS model and support LPHAs as they work towards achieving public health accreditation. These vital projects are reflected in goals included in the first priority issue in the SHIP, titled "Public Health Systems Building".

DHSS is pursuing a multi-year, statewide project to understand the cost of fully implementing the FPHS model across the public health system. A capacity assessment in 2020 highlighted a gap in the public health workforce and supporting funding that negatively impacts the public health system's ability to deliver the services necessary to adopt the FPHS model. To address this gap, DHSS is partnering with the University of Missouri to conduct a cost gap analysis utilizing data from all 115 LPHAs in the state of Missouri. Every LPHA thus far has successfully reported two years of data utilizing a costing assessment tool to report precise dollar amounts necessary for each jurisdiction to adequately deliver services based around the FPHS model. Using the findings from the costing assessment that will be completed in 2026, DHSS will prepare a request for enhanced state funding to build up and sustain the public health system. DHSS will also support local jurisdictions as they request additional local funding to enhance support and ensure additional sustainability measures.

A key component of this costing project is the development and adoption of an accountability plan to assure transparency and reporting around the use of additional funds and their impact on the citizens of Missouri. A set of proven performance measures, reporting requirements for LPHAs, and accountability reports to stakeholders at the federal, state, and local levels will ensure transparency around the project and build a foundation for potential future increases in funding.

Rural Maternal Health
Access to health care stands as another significant barrier for rural Missouri women. Of the 161 licensed hospitals in Missouri, 67 (42%), including five behavioral health hospitals, are located in rural counties. Of those 67 hospitals, 62 are hospitals with medical/surgical beds, five are behavioral health hospitals, and 31 are Critical Access Hospitals (CAHs), which have 25 beds or less and provide a limited scope of service. The additional four CAHs are located in non-rural counties. 41 rural counties and 1 urban county (36% of the 115 counties) do not have a hospital, with an average distance to a hospital for these counties of 29.4 miles. Additionally, 111 out of 114 counties are Primary Medical HPSAs, with some areas experiencing unmet needs in over 75% of health care services. 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, the Interagency Maternal Health Consortium, convened by DHSS, engages key stakeholders to strategize potential solutions and approaches to address the barriers and challenges.

Missouri's MCH Leadership is involved with many DHSS initiatives and priorities. 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 MCH team members participate in the PAMR Board

meetings and discussion to reduce maternal mortality. The MCH team also works with LPHAs, the majority of which are located in rural communities, to ensure access to health care 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.

- §192.025 (1951) DHSS is designated as the official agency of the state to receive federal funds for health purposes.
- §191.323 (1985) gives DHSS the power and duty to prevent and treat genetic disease and birth defects.
- §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.
- §192.070 (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.
- §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.
- §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).
- §192.601 (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).
- §192.067 (2019) authorizes DHSS to receive information from patient medical records for the purpose of abstracting data (i.e., PAMR).
- §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-delivery.
- §163.048 (2023) 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.

- §191.1720 (2023) establishes the "Missouri Save Adolescents from Experimentation (SAFE) Act", prohibiting health care providers from performing sex change surgeries or prescribing hormones or drugs for the purposes of sex change to Missouri children under the age of 18.
- §208.662 (2023) provides extended postpartum coverage for eligible mothers to receive medical assistance benefits during the pregnancy and during the twelve-month period that begins on the last day of the woman's pregnancy and ends on the last day of the month in which such twelve-month period ends.
- §701.340-701.342 (2023) requires all children under 72 months of age be screened for lead risk factors using the *Healthy Child and Youth (HCY) Lead Risk Assessment Guide*. If a parent/guardian answers yes or no response to any question, the child should receive a blood lead test. All parents of a child under age 4 shall be provided lead education annually, and every child under age 4 shall be offered a blood lead test annually. All children receiving Medicaid benefits must have lead testing at 12 and 24 months of age.

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

67 bills were Truly Agreed To and Finally Passed (TAFP) during the 2025 regular session of the Missouri Legislature. 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, 2025 Regular Session.

Child Care and Early Education

- SB 150: Temporary licensing for child care facilities
- HB 2: Child care subsidies are paid prospectively and based on enrollment
- HB 5: Funding for a child care cost-share program

Health and Mental Health

- SB 79 – Modifies provisions related to health care
  - Audiovisual and audio-only technologies for telehealth
  - MO HealthNet coverage for cochlear implants and hearing-related devices
  - Prenatal testing for syphilis, hepatitis B & C, and HIV
  - Coverage for a 6-month supply of generic birth control
- HB 225: Specialty hospital exemptions relating to forensic examinations of victims of sexual assault

Child Welfare

- SB 43 – Protection of Vulnerable Persons
  - Champions for Children Tax Credit
  - Admissibility of hearsay evidence for children up to 18-years-old
  - Statewide council on Sex Trafficking & Sexual Exploitation of Children
  - Endangering the welfare of a child for exposure to fentanyl and carfentanil
- SB 121: Newborn safety incubators
- SBs 43 & 121: Diaper bank tax credit

- HB 11: Funding for legal support for informal kinship caregivers
- HB 594: Sales tax exemption on diapers and feminine products
- HBs 737 & 81: Non-disclosure acts void in child sexual abuse cases
- HBs 737 & 486 – Protection of Children
    - Benefits for children in foster care, including a program to provide a comprehensive system of service delivery, education, and residential care for youth with severe behavioral challenges
    - Increases legal age for marriage from 16 to 18
    - Adds abducted or missing African American youth in the system to the Amber Alert System and makes it unlawful to discriminate against any person because of a protected classification

Schools

- SB 68 – Elementary & Secondary Education
    - Cardiac Emergency Response Plans
    - Requires schools to have a policy to prohibit cell phones in the classroom
    - Extends Young Child with a Developmental Delay diagnosis through first grade
    - Prohibits Zero-Tolerance Policies
    - Recovery High Schools
    - “Get the Lead Out of School Drinking Water Act” modifications
    - Establishes the "Stop the Bleed Act", "bleeding control kit", and traumatic blood loss protocol for schools
    - Allows magnet, charter, public, and private schools to establish recovery high schools
- HB 495: Committee on School Safety

Minimum Wage

- HBs 567,758, & 958: Modifies scheduled adjustment of minimum wage based on increases or decreases of the Consumer Price Index and repeals paid sick leave requirements

Constitutional Amendments - Upon voter approval

- HJR 73: Reproductive Health Care – repeal the Right to Reproductive Freedom Initiative

SFY 2026 Budget Wins

On June 30, Governor Mike Kehoe signed the 13 bills passed by the legislature that comprise Missouri’s SFY 2026 budget, approving $50.8 billion in spending, with $15.4 billion in general revenue.

The SFY 2026 budget includes appropriation authority for a time of service adjustment plan for full-time state employees. This plan provides a 1% salary increase for every two years of continuous state service, up to a maximum of 10% after 20 years. Certain job classes and departments are excluded or receive a different adjustment, such as a one percent cost of living increase for employees in 24/7 facilities with an existing time of service pay plan.

Strengthening Education and Workforce Development Systems

- A $300 million increase for the foundation formula, the state’s basic aid program for public schools.
- $376.6 million to support the state’s full reimbursement of transportation costs to school districts, including $15 million in new funding.
- $50 million in general revenue funding to bolster the Empowerment Scholarship Account program.
- $33.4 million to ensure all teachers are paid at least the statutory minimum.

Infrastructure

- $91 million for rural road improvements.
- $7 million investment for fentanyl testing in wastewater systems at schools.

Early Childhood

- $10 million to offer grant funding opportunities to support partnerships between employers, community partners, and the child care industry to make more childcare slots available for Missouri families.
- $107 million to revamp the child care payment system so providers receive their money at the beginning of each month for the children enrolled in their center.

Health

- $5 million to help grow Missouri's health care workforce through Nursing Incentive Grants.
- $4 million increase for the Alternatives to Abortion Program.
- $3 million for a new center Children's Advocacy Center in southwest Missouri.
- $2 million increase for Pregnancy Resource Center Grants.
- $250,000 for Newborn Safety Incubators.

Note: For references, please refer to the References attachment.

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[*] Using the definition described in the Biennial Rural Health report (https://health.mo.gov/living/families/ruralhealth/pdf/biennial2022.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.

III.B.2. State Title V Program

III.B.2.a. 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. A Core Team provides MCH direction and carries out the daily and ongoing processes of Title V with a focus on the overarching MCH system, inclusive of all five population health domains.

The MCH Steering Committee is comprised of MCH Core Team members (listed in the Workforce Capacity section of the application), the MCH Family Leader, who serves as 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; sets a strategic direction for MCH programming; serves as the key decision-making body for program-wide activities; and identifies and provides support to state and local level efforts. The Steering Committee ensures MCH efforts address the purpose of the MCH Block Grant and its Vision and Mission statements.

A new Missouri MCH Alliance has been launched, facilitated by the University of Missouri Kansas City-Institute for Human Development (UMKC-IHD)and comprised of external partners, such as LPHA representatives, family/parent advocates, adolescents, and other state agency associates and representatives of the urban/rural and demographic composition of the state. Alliance membership includes professionals with expertise in MCH care and services, consumers with an interest in the health of mothers and children, and individuals with experiential insight who can speak to the specific needs of the MCH population in Missouri. The Alliance will serve as a MCH think tank, sharing

information and ideas, identifying new/emerging MCH needs, brainstorming solutions to priority MCH issues, and providing feedback on MCH plans, initiatives, and outcomes. These activities will provide ongoing support to MCH and Title V initiatives, inform strategies and measures for the MCH State Action Plan, and support ongoing needs assessment efforts.

Missouri's MCH Leadership and programs maintain active partnerships with local and state agencies including, but not limited to, 115 LPHAs, DSS, DESE, DMH, MHA, MFH, Missouri Chapter of the AAP, ACOG, Show-Me School-Based Health Alliance, Community Health Workers Association of Missouri, Children's Trust Fund, ParentLink, UMKC-IHD, and schools of nursing and public health. MCH team members participate on and lead various state committees and initiatives, such as the Perinatal Quality Collaborative/Maternal-Child Learning Action Network at MHA, Early Childhood Coordinated Systems (ECCS) Steering Committee, Missouri Injury and Violence Prevention Advisory Council, and the Advisory Board for the Center of Excellence in MCH Education, Science and Practice at Saint Louis University, to collaborate with stakeholders and strategically align goals and activities. The MCH Director, along with the MCH Leadership Team and DHSS leadership, are regularly called upon to serve as a convener, collaborator, and partner in addressing priority MCH issues, speaking and/or facilitating panel discussions at convenings, and serving as a resource to LPHAs and MCH partners across the state. Through partnerships with federal agencies, DHSS 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 require special considerations for the MCH population 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. MCH Leadership advocates 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 responsive social services, and removing barriers to trauma responsive and congruent care. MCH Leadership 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.

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 (OOC) at DESE, MCH Leadership 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 DHSS and the Office of Childhood is established through an interdepartmental contract with a detailed Scope of Work. The ECCS team works with communities to improve early childhood outcomes by providing opportunities for implementation of the OOC 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) and 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 Child Care Health Consultation, Child Care Inclusion Services, and MCH Services. ECCS links a wide range of organizations and services into one unified system to support families and communities in promoting optimal development of young children and ensuring families are aware of the resources available to them.

DHSS partners with UMKC-IHD to organize, convene, and facilitate a statewide Maternal Health Multisector Action Network and strengthen the comprehensive statewide system to respond to the needs of women and families affected by mental health and substance use.

Title V Framework

The Life Course Perspective is a conceptual framework for understanding and addressing disparities in MCH. 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 several core principles, eliminate health disparities, and create safe, stable, and nurturing relationships and environments for children and families in Missouri, the MCH FY 2026-2030 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.

DHSS 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. Title V 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 Title V 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.

The CYSHCN Director leads state efforts to improve the system of services for cyshcn. A crosswalk has been prepared to identify current efforts within the guiding principles of optimal health, quality of life and well-being, access to services, and financing of services. The CYSHCN Director will work with MCH programs and partners to align their work and priorities with these principles.

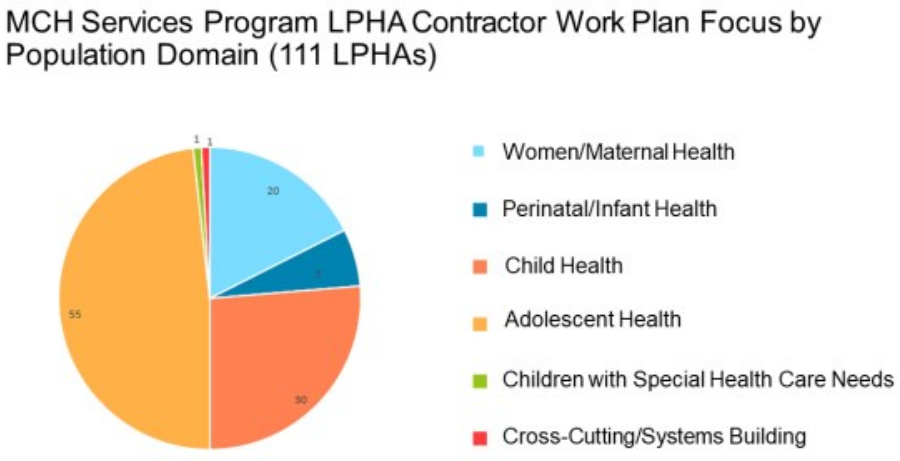
Core Public Health Functions

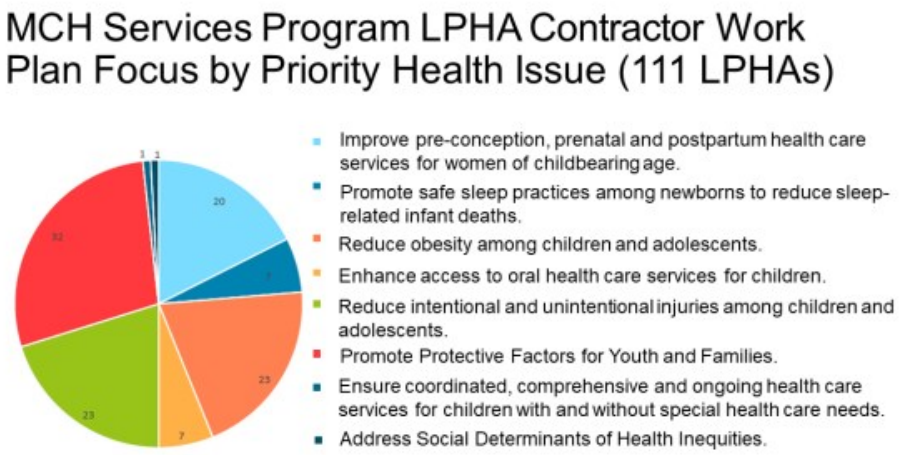
Assessment

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. MCH team members 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, and State Systems Development Initiative (SSDI), among other relevant sources. Additionally, the Evidence-based or –Informed Strategy Measures (ESMs) will measure the impact/outcome of specific strategies and help evaluate whether Title V funded program activities are meeting 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 112 LPHAs to address the needs of their local MCH population. Each LPHA submits a five-year work plan with four annual contract renewals. The MCH Services Contract priority health issues (PHI) are set to align with the Title V MCH Block Grant national and state priorities to realize 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 FY 2022-2026 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 FY 2022-FY 2026 MCH Services LPHA contractor work plans by population domain and PHI. *(Note: Although an additional LPHA was added to the contract in FY 2024, the 112th contract is an abbreviated contract and will not have an identified priority health issue and population domain to report on until FY2025. Therefore, only 111 LPHAs are included in the graphics below.)*



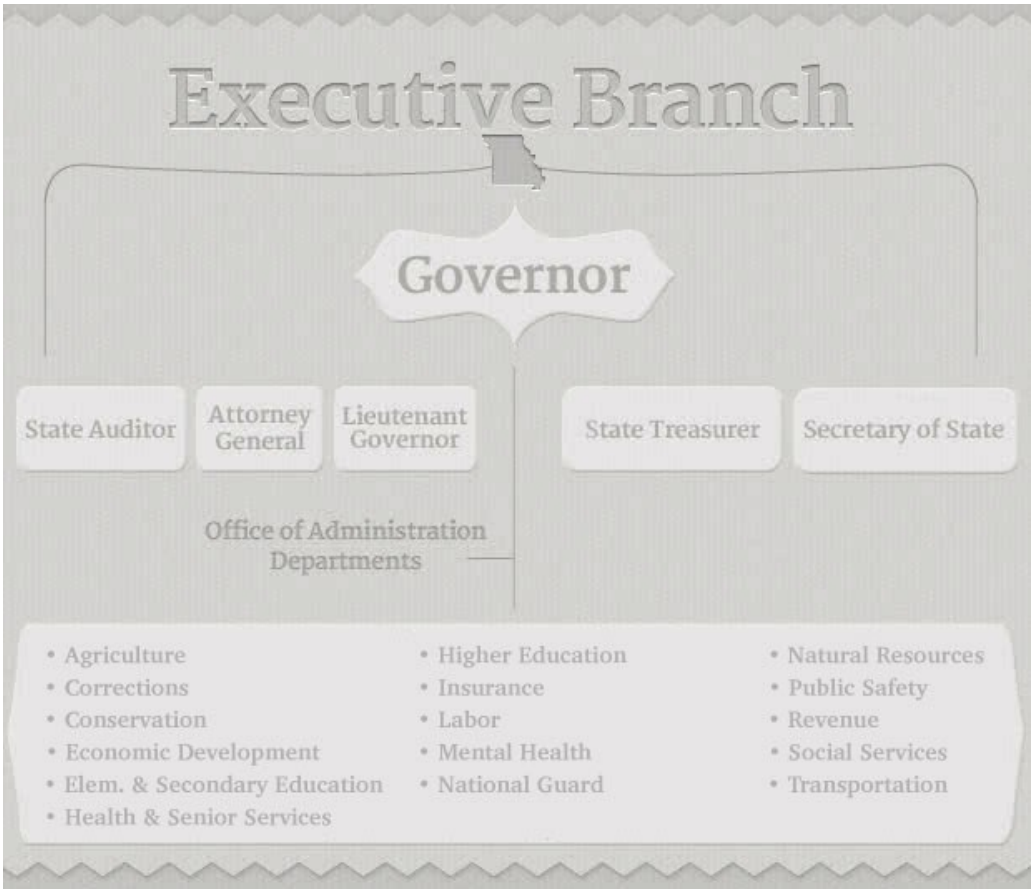


Assurance

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 congruent, 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 measurable improvements in outcomes and other indicators of quality in services or processes, which contribute to 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 FY 2026-2030 Title V State Action Plan was intentionally reimagined from the FY 2021-2025 State Action Plan to identify general strategies to achieve the identified objectives and overall vision. FY 2026-2027 will be ongoing planning years for 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. Internal MCH programs and external contractors will 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.

III.B.2.b. Organizational Structure

Missouri's state government is organized into three branches: the Legislative Branch, the Judicial Branch, and the Executive Branch. The Legislative Branch, consisting of the House of Representatives and the Senate, is responsible for creating and appealing state law. The Judicial Branch is responsible for interpreting the law and consists of the Missouri Courts, including the Missouri Supreme Court and appellate courts. The Executive Branch, headed by the Governor, consists of all state elective and appointive employees and is responsible for executing the laws of the state. Within the Executive Branch are six statewide elected officials and sixteen executive departments, shown in the Executive Branch Organizational Chart below.



The Department of Health and Senior Services (DHSS) is responsible for managing and promoting all public health programs to improve life and wellness for Missourians. The DHSS Director is responsible for the management of the Department and the administration of its programs and services. Department deputy directors assist the director and act in her absence. The offices of general counsel, governmental policy and legislation, human resources, public information, performance management, and special investigations report to the director. The Division of Administration provides fiscal and administrative support to all department units. Services include budgeting, accounting, expenditure control, procurement, grants/contract administration, personnel, general and building services, and continuous improvement operational excellence initiatives. The Division of Senior and Disability Services serves as the State Unit on Aging and carries out mandates regarding programs and services for seniors and adults with disabilities, including oversight, implementation, and administration of state-, federal-, and community-based programs to maximize independence and safety for older adults and adults with a disability. The Division of Regulation and Licensure issues state licenses for a variety of entities providing services that impact health and safety and determines compliance with state and/or federal regulations through inspection of facility premises, care, and services. The Division of Cannabis Regulation is responsible for the implementation, regulation, and oversight of the state's medical and adult use cannabis programs. Pursuant to Article XIV of the Missouri Constitution, the division ensures the right of qualifying medical patients to access medical cannabis and the right for adults, over the age of twenty-one years, to access non-medical cannabis. The Missouri State Public Health Laboratory (MSPHL) provides scientific expertise and promotes, protects, and partners for health by delivering laboratory testing for infectious diseases, genetic disorders, and environmental concerns, both in support of public health programs and as a reference laboratory performing confirmatory or specialized procedures. More than 7 million tests (many required by law) are performed annually by the MSPHL. The Division of Community and Public Health, the Department's largest division, is responsible for the core functions of community and public health, including but not limited to:

- Oversees programs aimed at addressing chronic and communicable disease prevention and control.
- Partners with LPHAs to ensure timely and appropriate responses to public health risks and conditions.

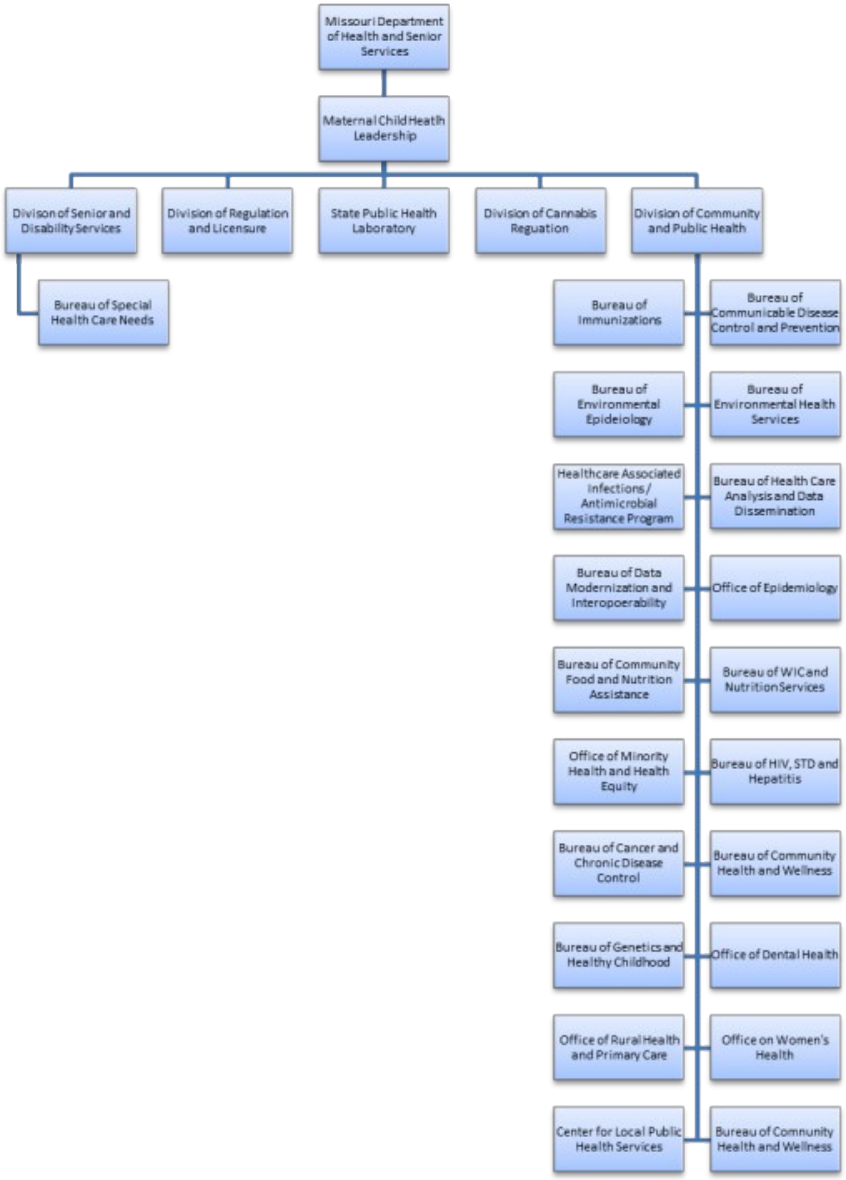
- Ensures food and water safety as well as protection of health from environmental conditions.
- Improves the health of women, infants, children, young adults, and families across the state through injury prevention, nutrition programs (WIC, CFNA), immunizations, dental health, health promotion, newborn screening, rural health, and primary care access initiatives.
- Provides vital records services.
- Provides the resources necessary to prevent, intervene, and control diseases and conditions through data systems, epidemiology, and data analysis.
- Promotes and implements evidence-based interventions to improve health risks and reduce disparities in health outcomes among all Missourians.

Although the MCH Director and Leadership Team are organizationally positioned within the Division of Community and Public Health, MCH Leadership works with leadership and programs across the Director's Office and all DHSS divisions, as well as the Governor's Office and state Departments of Social Services, Mental Health, Elementary and Secondary Education, Transportation, Corrections, and Public Safety. The MCH Director directly manages the MCH Leadership Team and has a dotted-line, or informal, relationship of authority or responsibility with broad MCH programs and initiatives across DHSS and Title V funded programs at DESE. This multisectoral collaboration provides the synergy to accomplish the MCH State Action Plan and assure a strong and coordinated system of family-centered, community-based, and culturally and linguistically appropriate care and services for Missouri's MCH population.

The attached "DHSS Org Chart_MCH Leadership" shows the formal Department chain of command to the DCPH Director and MCH Director.

The attached "DCPH Functional Listing" shows the organizational placement of MCH Leadership, including oversight of Title V programming, within the DHSS Division of Community and Public Health and details the specific initiatives for which MCH Leadership has direct oversight.

The organizational chart below shows how MCH Leadership has indirect/informal leadership across the Department.



III.B.3. Health Care Delivery System

III.B.3.a. System of Care for Mothers, Children, and Families

The greatest service for mothers, children, and families is a robust statewide system of care that provides holistic continuity of access to health services for the full life course trajectory, uninterrupted by lifespan timeline junctures. For example, the most impactful prenatal care starts far before a patient becomes pregnant, and postpartum care does not stop at an arbitrary 6 weeks or 12 months after delivery and has physical and mental ramifications that far exceed those intervals. DHSS protects the mother-infant dyad by supporting efforts to enhance health along the entire lifespan. DHSS efforts to address MCH needs are authentically and effectively person-centered, in contrast to historically disease-based or organ-based initiatives. DHSS upholds the expectation that other health-interfacing sectors similarly follow this exemplary approach to MCH.

By promoting and practicing intentional comprehensive engagement of partners across the broader health ecosystem, including traditional public health, MCH, and the full scope of healthcare providers and community

services, DHSS strives to eliminate the inaccurate, unhelpful, and antiquated “othering” of public health and create a more efficient and responsive healthcare system. In this vein, DHSS hired its first Chief Medical Officer (CMO) to bridge efforts with partners across the state and provide statewide clinical leadership, workforce growth, extensive cross-sector convening, proactive media engagement, and forward-looking policy strategy. The CMO and MCH Director work closely together to collectively advance Title V goals to reduce maternal morbidity and mortality, eliminate disparities in health outcomes, and ensure every family can access high-quality care before, during, and after pregnancy, throughout the postpartum long-term continuum, and continuing through the life of every child and adolescent, including children and youth with special health care needs.

Maternal/Infant Health
MCH Leadership and other DHSS MCH program staff are involved in several efforts to enhance a systems approach to ensure access to quality health care and needed services for Missouri’s MCH population. DHSS and MHA worked together to become an Alliance for Innovation for Maternal Health (AIM) state. This partnership resulted in the development of a statewide Maternal-Child Learning and Action Network (MC-LAN), comprised of over 50 stakeholders who came together to form Missouri’s first perinatal quality collaborative (PQC).

Southeast Missouri is burdened by some of the worst health outcomes and highest social vulnerability in the state and nation, and nine of Missouri’s ten least healthy counties are in the region, highlighting elevated premature mortality, persistent poverty, low insurance coverage and health access, poor access to healthy food, and high prevalence of chronic disease and behavioral risk factors. DHSS partners with several provider agencies and community organizations serving Missouri’s Bootheel counties and the greater southeast region of the state to support health care providers, hospitals, public health, and social support agencies to work together with communities and build on local resources to meet the health care needs of women and newborns and create a clinical-community integration model of service delivery, especially for pregnant and postpartum women and their families.

Through collaboration with DHSS, MO HealthNet was awarded the Maternal Opioid Misuse (MOM) grant to improve quality of care for pregnancy and postpartum Medicaid beneficiaries with opioid use disorder through state-driven transformation of the delivery system surrounding this vulnerable population. The MOM model seeks to support the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery. The MOM model has the potential. Missouri has also received funding through other initiatives like the State Opioid Response (SOR) grant to address the broader opioid crisis.

DHSS executed a MOU with DSS and Children’s Trust Fund (CTF) to facilitate exchange and use of information regarding incidences of child maltreatment and/or neglect among DHSS or CTF Home Visiting (HV) program clients. DHSS had previously received only an aggregate count of the number of screened-in maltreatment or neglect cases from DSS. The revised MOU allows DHSS to receive de-identified (no county information, dummy ID numbers) line-item information on the type of report and whether it was substantiated. The goal is to use the additional information to assess the degree to which families enrolled in HV have lower substantiated/called-in reports, and whether the number of reports for clients with multiple reports declines over time as they are enrolled longer and work with their home visitors to develop their parenting and resiliency skills. In addition, the MOU has been narrowed to collect only the data needed to comply with Missouri’s required Maternal, Infant, and Early Childhood HV (MIECHV) performance measure reporting and assure collection of the same information for Title V funded HV programs and CTF HV for comparison purposes.

Child/Adolescent Health
The Chief Dental Consultant (formerly known as the State Dental Director) plays an essential role in state oral health programs. DHSS entered into an agreement with DSS for Missouri’s Dental Director position to be split between both agencies. The interaction between DSS and DHSS is especially important due to this dual placement. Based on dental expertise and data provided by ODH and DSS staff, the Chief Dental Consultant is able to discuss MO HealthNet dental benefits for maternal and child populations. The Chief Dental Consultant also communicates with other dental professionals about dental public health issues important to both DSS and DHSS.

The Missouri Show-Me School-Based Health Alliance (SMSBHA) has evolved from the 2016 statewide multi-agency task force, which brought together DSS and MPCA, alongside the Missouri School Boards Association and other community organizations, to focus on how schools could assist in addressing unmet mental and physical health needs of students. The SMBSHA is now the Missouri affiliate to the National SBHA. This group meets regularly for updates and is a ready source of researched practices and technical support to ensure effective partnerships between schools and community health providers, resulting in sustainable health care services within Missouri schools. School Health Program staff participated in the initial stages of planning and development of the SMSBHA and continue to work as members of the workgroup to engage schools and establish guidelines. When the Task Force began, only five school districts had some form of school-based health center. That number has now increased to 67 school districts that either have an operating school-based health center or plan to have a school-based health center in the near future, with a presence in at least 49 of the 114 counties in Missouri. Now, students who previously missed school for the day related to having appointments or who did not receive services at all will be able to stay in school and still receive quality care. Continued involvement in the SMSBHA ensures the health care needs of children are met and the integrity of the school environment is preserved as partners work together to improve children's health, educational opportunities, academic achievements, and ultimately, life outcomes.

As the lead agency for the Child Care and Development Fund (CCDF), DESE uses CCDF funding, along with contractually allocated Title V funds, to support the Child Care Health Consultation (CCHC) program. The CCHC program supports LPHA professionals to provide consultation and/or education to all child care providers related to health issues in child care settings and health promotion activities to children in child care. The CCHC program also assists families with children in child care to access MO HealthNet services; developmental screenings; special needs service providers; WIC services; immunization education and administration; blood lead screenings; and other programs available for children and families at risk of child abuse or neglect.

Health Services Infrastructure

Detailed information related to Missouri's health services infrastructure, including the number of birthing hospitals, pediatric hospital beds, maternal specialists, pediatric specialists, and the MO HealthNet Managed Care Program and Managed Care Health Plans, is included in the State Description section of the Overview of the State. The table below provides a breakdown of providers by primary pediatric and maternal health specialty according to the Missouri Workforce Healthcare Registration Exchange (MoHWoRx).

Primary Specialty	Number Registered in MoHWoRx
Pediatrics	1,856
Pediatric Specialists	916
Gynecology	118
Obstetrics	40
Obstetrics and Gynecology	777
Gynecological Oncology	29
Obstetric Critical Care Medicine	6

Integration of Services

DHSS' strategic person-centered and holistic approach to MCH necessitates integration of care across medical, physical, behavioral and mental health, social services, education, public safety, and other sectors influencing MCH outcomes. Examples of integration of care include, but are not limited to:

- Collaboration with, support to, and spreading of the Primary Care Health Home model, fostered by our partners in our Medicaid division, which integrates behavioral health and SUD care into primary care at FQHCs and multiple other nonprofit primary care practices across the state.
- Clinical-community integration and implementation of a Maternal Health Home Model via the HRSA MHI MO C3 grant and associated Maternal Health Task Force.
- Partnership with DMH on numerous initiatives, including the C-STAR program to provide SUD treatment to

pregnant/postpartum women, a statewide standing order for the administration of naloxone, and more.

MO has a projected physician shortage of 2000 physicians by 2026, which would be severely detrimental to MCH. As one evidence-based strategy to address this shortage, MO is investing over $12 million in state general revenue to build and expand Graduate Medical Education residency programs, especially in obstetrics/gynecology, pediatrics, family medicine, and general internal medicine. In developing the state's future workforce, nearly all GME Request for Proposals require 8 weeks of addiction training in the residency curriculum. This exceeds ACGME minimal accreditation requirements and matches DHSS' philosophy and mission to integrate SUD training and care into all general medical care, without sequestering it to rare specialists who don't have the capacity to help all families in MO with SUD.

CMO Contributions to Support MCH

Targeted Public-Health Outcomes

- Clinical governance
  - Provide medical insights and clinical consultation to programs and services in every DHSS division, including but not limited to Pregnancy and Beyond teaching/support booklet, cannabis safety concerns for pregnant/postpartum women, extended Medicaid for women coverage codes, SUD prevention/detection/treatment for pregnant/postpartum women and children, dental health promotion for women and children, evidence-based group prenatal care, breast and cervical cancer detection and treatment programs, lead poisoning prevention and treatment education, immunization education, infant/pregnancy RSV immunization, EMTALA case medical expert consultations for patients with acute failed pregnancy emergencies, and more.
  - Issue standing orders (e.g., naloxone, outbreak guidance).
- Maternal-mortality reduction efforts
  - Use PAMR findings to frame action.
  - Support and contributed initial guidance to the MO Pregnancy Mortality Prevention Plan.
  - Review and strategize priority list of best practices to approach the maternal health deserts in MO.
  - Promote and support integrated substance use and behavioral health care for pregnant and postpartum mothers.
- Continuum-of-care focus
  - Support primary care access and programming to assure a continuous lifelong health trajectory for the maternal-child dyad, by ensuring continuity of care for children reaching adulthood and women before and far beyond any periods of pregnancy.
- Population protections.
  - Contribute to statewide public media educational messaging, annual provider association updates, official stat Health Alerts and Advisories, Dear Colleague letters, presentations via conferences and webinars, and other provider education on updates and opportunities regarding maternal child health in MO. Also provide clinical advising and fact-checking for DHSS social-media channels and Governor's Office health proclamations to amplify evidence-based maternal-child health messages.

MCH Provider Workforce Development

- Physician workforce growth
  - Especially in Ob/Gyn, Pediatrics, Family Medicine, and Internal Medicine physicians who do women's health.
  - Targeting the growth of Graduate Medical Education (GME), co-authored legislation, strategized program development, designed initial budget, and with DHSS collaborative team members launched the first Missouri residency slot-expansion program. Then contributed heavily and strategically with our Office of Rural Health and Primary Care to develop 5 additional RFP funding opportunities to help support the growth and expansion of GME residencies in MO.
- Midwifery pipeline
  - Helped implement and facilitate the inaugural Missouri baccalaureate nursing program convening in MO in 2025, which yielded a focused Certified Nurse-Midwife Workgroup to explore the growth of the CNM workforce, foster integrated models of CNMs working with OB/Gyns, and ascertain if MO should start a

university-based CNM training program (there are none currently in MO).
- Doulas, CHWs, Recovery Support Specialists
  - Provided recent evidence to programs and policymakers to demonstrate the life-saving and cost effectiveness of these vital team members toward comprehensive effective maternal child health.
- Academic synergy. Engage seven medical schools and multiple teaching hospitals to align curricula with Title V priorities.

Essential Synergistic Networking & Convening

- Missouri Interagency Maternal Health Consortium:
  - Co-initiated and chair the first and ongoing convening of state leaders (from DHSS, MO Medicaid, MO Department of Mental Health, MO EMS, MO Hospital Association, MO Primary Care Association, MO Medicaid Managed-Care Organizations, MO Governor's Office)
  - Charge: The purpose of this group is to identify and foster solutions to address limitations in maternal health care availability, capacity, trust, and utilization in Missouri. The goal is for Missouri mothers to have quality access to the entire continuum of pregnancy and postpartum care, thereby improving maternal health mortality and morbidity outcomes.
  - Strategic Approach: (1) Examine current frameworks, systems, barriers, gaps, and best practices. (2) Share emerging concerns, developments, and lessons to work synergistically across agencies. (3) Collectively inform, catalyze, +/- implement policy, programmatic, and payment changes.
- Provided strategic input to MO's participation in the National Governor's Association Improving Maternal and Child Health in Rural America Learning Collaborative, which engaged in-state and inter-state stakeholders in MCH.
- Strong stakeholder outreach to non-governmental leaders influencing MCH. Maintain active relationships with 5 health associations (including MO hospital association, all MO hospital CMOs, MO FQHC CMOs, etc.), 9 physician societies (especially MO-ACOG, MO-AAP, MO-AFP, etc.), 10 + hospital systems, 115 LPHAs, and regional/national partners—working to create alignment and efficiency in maternal-child health.
- National positioning. Appointed to the CDC Director and NHSC Advisory Committees and ASTHO Clinical Service Leaders Steering Committee, ensuring Missouri's needs shape federal MCH policy.

Strategic Direction & Policy Leadership

- Amplify the holistic-person-centered asset of DHSS MCH efforts. Work toward reframing the rest of the department with this MCH best practice, as compared to more antiquated solely disease-based or organ-based initiatives.
- Target measurable ROI and fair health impact to our most vulnerable populations.
- Policy and budget – clinical counsel and communication to policymakers. Advise the legislature and media on MCH bills, testify in committee, and integrate data into budget priorities.
- Public-health integration vision. Lead efforts to create an integrated public-health/health-care ecosystem that shares data, aligns reimbursement, and embeds Title V metrics.

Health Insurance Coverage

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. 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. Medicaid spending for state fiscal year (SFY) 2024 was

approximately $12.6 billion in Missouri, and approximately 70% of Missouri Medicaid/MO HealthNet funds came from the federal government.[50,51] 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 $6,752 a year. In SFY 2024, MO HealthNet covered a monthly average of 674,045 low-income children. The majority of covered adults in families with children were women. Children represented the largest demographic group served by Missouri Medicaid; 48% of all enrollees were under the age of 19.[50] Medicaid and CHIP enrollment in Missouri was 1.3 million as of June 2024, and 87.1% of all uninsured eligible children in Missouri participated in Medicaid/CHIP. Overall, Medicaid covered 39% of Missouri's children and paid for 38% of all births in SFY 2024.[50]

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.[50] The SCHIP program provides the same health services as those covered under Medicaid, except children covered by SCHIP are not eligible for non-emergency medical transportation. Families with gross income above 150% of the FPL pay a tiered premium calculated as a percentage of income based on income brackets. In SFY 2024, an average of 45,265 children had coverage under CHIP in Missouri.[50]

The MO HealthNet for Pregnant Women Program offers Medicaid coverage to pregnant women whose family incomes are up to 196% FPL. Coverage is available for full Medicaid benefits for the duration of the pregnancy and for one year following the end of the pregnancy. In SFY 2022, an average of 30,689 women per month received benefits under the MO HealthNet for Pregnant Women Program.[50] Additionally, a monthly average of 103,631 low-income custodial parents were covered by MO HealthNet.[50]

Medicaid Extension
Over the past couple of years, MO HealthNet has prioritized maternal and infant health, resulting in extended postpartum coverage (July 2023), coverage of doula services (October 2024), self-measured blood pressure cuffs (February 2025), reimbursement for group prenatal care (December 2023), an improved notification of pregnancy process (November 2024), In Lieu of Services (ILOS) reimbursement for home visiting for high-risk pregnant women (July 2025), and various managed care incentives to improve prenatal care and increase healthy birth weight babies. Missouri SB 45 extended 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. 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. Healthy Moms, Healthy Babies was created with several state agencies to help connect women to quality healthcare and supportive services and promote healthier pregnancies and postpartum experiences for both moms and babies.

Data Sharing
Additional data sharing agreements between DHSS and DSS to support MCH systems of care:

- Vital Records shares birth and death data with DSS to determine eligibility for services.
  DHSS shares with DSS opioid data from hospitals for maternal opioid misuse.
- Agreement for DHSS and LPHAs to perform lead screening and home assessments for children who test positive.
- DHSS receives Medicaid data to determine eligibility for WIC and prompt outreach efforts encouraging enrollment in WIC.

Innovative Health Care Delivery
Group family health care delivery models focus on delivering healthcare services to groups of families, often those from the same community or with similar health conditions/needs, in a shared setting. This approach aims to enhance health care value by providing more time for patient education, skill-building, screenings, and resource navigation, alongside standard clinical care and services. Missouri is exploring group family visiting as a cost-

effective innovative model of care for the MCH population. Group Family Health Care Delivery Models emphasize collaboration, family engagement, increased efficiency, and enhanced education and support. Potential benefits include improved individual and family health outcomes, increased interaction and satisfaction with health care, and cost-effectiveness. Challenges may include coordination of scheduling and staffing, protection of privacy and confidentiality. Research is needed to better understand different group models and develop a pilot curriculum for group family visiting.

Note: Additional information describing the state's health services infrastructure, integration of services, and financing of services is included in the State Description section of the Overview of the State, as well as within other Section III narratives. Discussion of collaborative work with other federal, state, and non-governmental partners to provide a systems approach to ensure access to quality health care and needed services for the MCH population and description of the public health infrastructure that addresses the needs of the MCH population is integrated across other Section III narratives. The role of Title V in addressing key MCH issues is integrated across other Section III narratives and State Action Plan narratives by domain.

III.B.3.b. System of Services for CSHCN

Children and Youth with Special Health Care Needs

Public and Private Partners

The Bureau of Special Health Care Needs (SHCN) partners with several public and private entities in support of children and youth with special health care needs (cyshcn) through both formal and informal relationships. Contracts with LPHAs provide service coordination on a regional basis for the SHCN CYSHCN Program. The CYSHCN Service Coordinators in each region specialize in connecting families to community-based resources and work in partnership with a wide range of public and private organizations, including local service providers, nonprofit agencies, and community groups. SHCN Family Partners are also experts in connecting with public and private partners to link families of children and youth with special health care needs with the appropriate resources. SHCN staff members are involved with the various councils and advisory groups, including the Missouri Commission on Autism Spectrum Disorders, the Missouri Assistive Technology Advisory Council, the Missouri Interagency Transition Team, the Missouri Children's Cabinet, and the Missouri Newborn Hearing Screening Standing Committee. In addition, SHCN administers the Missouri Brain Injury Advisory Council. This list highlights how SHCN staff connect with public and private partners to create a system of services, promote collaboration, and improve outcomes for cyshcn. The MOU between the DESE First Steps Program and the CYSHCN Program outlines a joint commitment to deliver a coordinated, statewide system of early intervention services for children from birth to three years.

The Center for Child Well-Being at the University of Missouri is home to the Missouri Child Psychiatry Access Project (MO-CPAP), Infant and Early Childhood Mental Health Initiative (iECMH), and Missouri Children's Health Integration, Learning, and Development Project (MO-CHILD). These projects provide statewide, multi-tiered systems of support to healthcare providers, childcare providers, schools, and communities to improve the access to and coordination of vital mental and behavioral health services. MO-CPAP provides access to child and adolescent psychiatric consultation to any professional working with individuals aged 21 and under, including family medicine providers, nurses, community health workers, social workers, and home visitors. This program has expanded to allow access to school counselors, nurses, social workers, and administrators through the Missouri Schools Access Project. MO-CHILD is a consultative service aimed at improving prescribing practices and providing guidance to reduce the impact of trauma on well-being for children and youth in state custody. The IECMH Initiative is a referral-based program that grants childcare professionals access to trainings and coaching and supports and resources. The Initiative also allows referral of children and families to services and interventions to support the social-emotional development of at-risk children who have displayed persistent challenging behaviors.

DHSS is home to the Vaccines for Children (VFC) program. To promote timely vaccination in children, the VFC program provides free vaccines to children under the age of 19 who are either Medicaid-eligible, do not have health insurance, are American Indian or Alaskan Native, or who are underinsured. If a child is underinsured, vaccinations must be received at a FQHC or Rural Health Clinic. Otherwise, the VFC program can be administered through a child's regular provider or the local health department. The DHSS webpage hosts a VFC

provider map for Missouri citizens to find a participating entity closest to them. The Missouri WIC supplemental nutrition program provides supplemental food benefits, health care referrals, nutrition education, and breastfeeding support to eligible pregnant, breastfeeding, and postpartum women as well as infants and children up to the age of five. WIC provides healthy foods to Missouri children who might not otherwise have access to whole, nutritious foods. The WIC program also covers infant formulas, nutritional supplements for children and women, and metabolic formulas. DHSS also provides financial assistance to qualifying Missouri residents in need of metabolic formula through the Metabolic Formula Program (MFP). In addition to financial assistance for metabolic formula, the MFP also provides an annual examination from one of the metabolic treatment centers in St. Louis or Kansas City. To qualify for the MFP, you must be a Missouri resident, have a medical diagnosis that signals a metabolic formula need, meet financial eligibility guidelines for your age group, and apply for MO HealthNet benefits.

While Missouri has made many strides towards improving the ease of access to services and optimizing available resources to meet the needs of Missouri families and children, including those who have or are at an increased risk for special health care needs, there are areas that will require additional time and attention to best serve Missouri citizens. Among these needs are a lack of available in-home nursing services for cyshcn, especially those in rural areas; a lack of specialty providers in rural areas; access to transportation services; and the availability of qualified childcare facilities for both children with and without a special health care need.

Medicaid
Current operations of SHCN in the DHSS Division of Senior and Disability Services involve three separate MOUs with DSS. The SHCN information system links with the 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 cyshcn under the age of 21 to SHCN for services. MO HealthNet is Missouri's Medicaid program within the DSS. SHCN staff collaborate with MO HealthNet staff in developing and updating policies and processes related to cyshcn. SHCN Service Coordinators and SHCN Family Partners refer participants and families to MO HealthNet for Medicaid eligibility determination and services, as well as provide support to participants and families in navigating the Medicaid system. In particularly complex situations, SHCN consults with a DSS Benefit Program Specialist, who functions as a liaison to assist in resolving MO HealthNet issues. SHCN administers the CYSHCN Program; Medicaid referral or verification of a Medication application is a requirement of CYSHCN Program participants. SHCN also administers the Healthy Children and Youth (HCY) Program through a cooperative agreement with MO HealthNet. This cooperative agreement enables SHCN to obtain funding support for service coordination activities through 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. All children under the age of 21 and eligible for MO HealthNet qualify for the HCY program, giving them access to comprehensive, primary, and preventative health care. Providers follow EPSDT guidelines outlined in the Bright Futures resource toolkit for periodic screenings and interperiodic screenings, when medically necessary. Participants are notified by mail in the month that they are eligible for a screening or when a screening is due. Full medical screenings, including dental, vision, and hearing screenings, can be completed outside of the periodic schedule if documentation supports medical necessity. To better provide comprehensive and continuous care to Missourians, including children and youth who have or at an increased risk for special health care needs, live in underserved areas, or who are at a greater risk for poor outcomes, MO HealthNet will cover telemedicine services for children when the standard of care is comparable to in-person visits.

SHCN also administers the Medically Fragile Adult Waiver (MFAW) Program, which serves medically complex individuals aged 21 and over, who have 'aged out' of the HCY Program. MO HealthNet is the Single State Medicaid Agency; SHCN administers the MFAW Program through an interagency agreement with MO HealthNet. Ongoing communication between MO HealthNet, Managed Care Companies, provider agencies, and SHCN is required to ensure effective service provision as individuals change Managed Care Companies and/or fee-for-service Medicaid, which may inadvertently impact their services. For participants enrolled in the HCY Program, SHCN assists with authorization of in-home services to avoid gaps in services when there are changes in coverage. In addition, SHCN 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 or fee-for-service Medicaid.

Note: Content included and referenced in Section III.B.3.a. System of Care for Mothers, Children, and Families also applies to the Section III.B.3.b. System of Services for CSHCN. Additional information describing families as partners in decision-making, medical home, adequate health insurance, early and continuous screening, ease of community-based services, and transition to adult care is integrated across other Section III narratives and State Action Plan narratives by domain.

III.B.3.c. Relationship with Medicaid

Current operations of the Bureau of Special Health Care Needs (SHCN) involve three MOUs with DSS. The SHCN information system links with the 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 SHCN for services. DSS is Missouri's Single State Medicaid Agency, and MO HealthNet is Missouri's Medicaid program within DSS. SHCN collaborates with MO HealthNet to develop and update policies and processes related to cyshcn. SHCN Service Coordinators and Family Partners provide support to participants and families in navigating the Medicaid system and refer participants and families to MO HealthNet for Medicaid eligibility determination and services. In particularly complex situations, SHCN consults with a DSS Benefit Program Specialist, who functions as a liaison to assist in resolving MO HealthNet issues. SHCN administers the Children and Youth with Special Health Care Needs (CYSHCN) Program, and Medicaid referral or verification of a pending application for Medicaid coverage is a requirement for CYSHCN Program participation. SHCN also administers the Healthy Children and Youth (HCY) Program through a cooperative agreement with MO HealthNet. This cooperative agreement enables SHCN to obtain funding support for service coordination activities through 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 during home visits with participants and families in the HCY Program 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. SHCN also 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. SHCN administers the MFAW Program through an interagency agreement with MO HealthNet. Ongoing communication between MO HealthNet, Managed Care Companies, provider agencies, and SHCN is required to ensure effective service provision as individuals change Managed Care Companies and/or fee for service Medicaid, which may inadvertently impact their services. For participants enrolled in the HCY Program, SHCN assists with authorization of in-home services to avoid gaps in services when there are changes in coverage. In addition, SHCN 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 or fee-for-service Medicaid.

The MCH Director and OWH participate in the DSS MO HealthNet Division Maternal/Infant Health Coordination meetings to collaborate on maternal and infant health projects and initiatives, including increasing access to and

payment models for community-based maternal care providers and services. DHSS collaborates with MO HealthNet Maternal/Infant Health leadership to provide technical assistance and facilitate training for LPHAs, as needed, regarding MO HealthNet for Pregnant Women, Notification of Pregnancy (NOP), prenatal risk assessments, prenatal case management, postpartum benefits, benefits available for substance use treatment and mental health services, etc. MO HealthNet partnered with the MCOs to develop a universal NOP and Risk Screening Form and Portal to collect information about a woman's pregnancy and non-clinical risk factors. MCH Leadership facilitated MO HealthNet communication with the LPHAs to promote engagement with the NOP and associated Risk Assessment process, resulting in increased participant contacts and engagement in Case Management. This initiative centralizes reporting, prompts reporting when the mother is pending eligibility or not enrolled in a Managed Care Plan, captures high-priority information to determine what supports are needed to address community and population-level factors influencing the mother's health, initiates earlier prenatal care, and allows providers to share case management incentives and additional pregnancy related services and resources and provide a warm hand-off to the provider.

Data Sharing

A MOU between DHSS, DSS, and DMH 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.

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 home visiting program clients to assess the degree to which families enrolled in home visiting 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 collects data to comply with required Maternal, Infant, and Early Childhood Home Visiting (MIECHV) performance measure reporting for comparison between MIECHV, Title V funded home visiting programs, and CTF home visiting outcomes.

Additional data sharing agreements between DHSS and DSS include:

- Vital Records shares birth and death data with DSS to determine eligibility for services.
- Allowance for DHSS and LPHAs to perform blood lead screening and home lead hazard assessments for children who test positive for elevated blood lead levels.
- DHSS receives Medicaid data from DSS to determine eligibility for WIC and prompt outreach efforts encouraging enrollment in WIC.

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 participant independence.
- Partner with providers to modernize the care delivery system.
- Become a leader in the implementation of value-based care in Medicaid.

MO HealthNet Transformation Office initiatives include an effort to improve infant mortality rates in Missouri. Low birth weight infants' data is linked with their mothers' data to see what kind of care they received before and after birth. In researching the data, DSS discovered Medicaid claims are typically tied to the head of household's DCN, which could be the father, teenage mother's father, aunt, uncle, foster parent, etc. The data is unreliable and burdensome to make meaningful decisions concerning the impact of care on maternal and neonatal outcomes. To enhance Medicaid linkage to birth certificate data, DSS provides DHSS with a list of all infant DCNs, and DHSS provides data to DSS from the associated birth certificates, provided by the mother when completing birth certificate forms, to identify the care received by the birth mother and provide other data regarding population-level factors that influence infant health outcomes. This provides MO HealthNet with further insight into the socio-economic needs of mothers

that could potentially result in low birth weight infants and Neonatal Intensive Care Unit admissions. It also provides a comparison between healthy births and complicated births.

The goal is to use this collaboration of data to develop value-based payment models and/or quality initiatives within the Medicaid program to address identified socio-economic factors and reduce the number of low birth weight infants. Currently, Missouri is in the lowest quartile for the incidence of low birth weight, and this linkage will drive data-driven decision-making processes and aid with program planning, monitoring, and evaluation.

Note: Additional information regarding the relationship with Medicaid is included across multiple other sections, including the domain narratives.

III.B.4. MCH Emergency Planning and Preparedness

The MCH population has unique needs during an emergency, and Missouri takes an all-hazards approach to enhance emergency preparedness planning and response activities and assure MCH population needs are considered in state, regional, and local planning. The mental health of mothers and children is often impacted during an emergency event, and support for mental health needs is incorporated into mass care planning at the state level. MCH Leadership is involved in public health emergency preparedness planning. Preparedness efforts at DHSS encompass a wide variety of threats while servicing all citizens, including mothers, expecting mothers, and children. The MCH Director serves as a branch manager in the DHSS Emergency Response Center (ERC), and many other MCH team members serve in the DHSS ERC, including serving on the Local Public Health Management and Epidemiology teams. LPHAs play critical roles in responding to public health threats, including threats impacting the MCH population, and the ERC LPHA response team, including MCH team members, provides support and resources to LPHAs in areas impacted during an emergency.

The State Emergency Operations Plan (SEOP), overseen by Missouri's State Emergency Management Agency (SEMA), is reviewed annually and considers a variety of vulnerable populations, including at-risk and medically vulnerable women, infants, and children, in planning elements. SEOP planning assumptions include the MCH Population for all areas of the plan, including Emergency Support Function (ESF) 8, Medical and Health, which is the responsibility of DHSS, including MCH Leadership. The Missouri State Hazard Mitigation Plan works in conjunction with the SEOP, and, where applicable, the hazard profiles take into consideration the needs of the MCH Population. Surveillance and Outbreak annexes for the DHSS Public Health Emergency Operations Plan (PHEOP) development and review include MCH input. Missouri's Pandemic Influenza Response Plan specifically addresses planning assumptions and response needs for the MCH population. The State Health Improvement Plan (SHIP) includes a strategic priority issue related to Emerging Public Health Threat Preparedness (EPHTP). All surveillance and outbreak planning supports initial mitigation and understanding of the emergency response needed to address the impacts of disasters and emerging threats for all populations.

Missouri actively includes vulnerable populations in EPR exercises, and work continues 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 MCH Director and other MCH team members are included in the DHSS Continuity of Operations and Government (COOP) plan and participate in exercises at least twice a year to ensure plan effectiveness and emergency response capability. The MCH Director interfaces with the Emergency Medical Services for Children (EMSC) State Partnership and pediatric pandemic network and serves on the Children and Youth in Disasters workgroup, along with the Associate Chief of the Bureau of Special Health Care Needs. MCH Leadership coordinates with partners at the state and local levels to develop EPR plans, including local healthcare coalition EPR plans specifically focused on pediatric surge disasters, that address the needs of the MCH population, including children and youth with special health care needs (cyshcn). Lessons learned through previous emergency response help strengthen existing and build new partnerships between MCH Leadership, EPR, and MCH programs across the state.

Missouri has a variety of MCH surveillance systems with 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 population:

- National Vital Statistics System (NVSS): Birth and death certificate data are 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 timely estimates for adverse pregnancy and neonatal outcomes.
- 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, and is 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.
- Pregnancy Risk Assessment Monitoring System (PRAMS) – Missouri PRAMS: a key MCH surveillance system during public health emergencies. New questions were added in 2023 to capture data about emergency preparedness activities for families with infants. The survey found that in 2023, new mothers reported preparedness activities that showed a large need for improved emergency preparedness in the MCH population.

Things Some People do to Prepare for a Disaster	**Percentage that Reported "Yes"**
I have an emergency meeting place for family members (other than my home)	38%
My family and I have practiced what to do in case of a disaster	39%
I have a plan for how my family and I would keep in touch if we were separated	41%
I have an evacuation plan if I need to leave my home and community	46%
I have an evacuation plan for my children in case of a disaster (permission for day care or school to release my child to another adult)	36%
I have copies of important documents like birth certificates and insurance policies in a safe place outside my home	36%
I have emergency supplies in my home for my family such as enough extra water, food, and medicine to last for at least three days	64%
I have emergency supplies that I keep in my car, at work, or at home to take with me if I have to leave quickly	39%

- Behavioral Risk Factor Surveillance System (BRFSS): The nation's premier system of health-related telephone surveys that collect state data about U.S. adults regarding health-related risk behaviors, chronic health conditions, and use of preventive services. The population-based surveillance system can add modules during public health emergencies for assessment of emergency preparedness among all Missourians, including the MCH population.
- Missouri School Immunization Survey: All schools in Missouri, both public and private, are required to submit an annual school health report, including a variety of information on student health, including cyshcn, available health staff, visits to the health office, and immunizations. The vaccine information is compiled to produce an online dashboard of immunization rates of kindergarteners and eighth graders by county and by specific

vaccines and tracks the percentage of students who have an exemption and the reason for exemption.

The new Situational Awareness and Response Management System (SARMS) and Situation Awareness Response Emergency Operations Dashboard (SAROD 2.1) add critical infrastructure to enhance preparedness capacity and the ability to quickly identify those who may be at-risk, increasing efficiency in responding to those in need during an emergency, including the MCH population. SARMS advanced mapping features provide the ability to update/monitor the status of critical infrastructures, run infographics to extrapolate demographic information, and view live weather feed of current weather conditions.

During a disaster or public health emergency, MCH programs are relied on to provide leadership and support in delivering critical MCH services and assisting local communities to respond to emerging threats and needs. MCH Leadership and programs coordinate with MCH partners to develop and implement EPR plans to provide support and address MCH population needs.

- Addressing the needs of Missouri's 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. Through the Bureau of SHCN, Service Coordinators and Family Partners promote family preparedness by connecting families with community-based emergency preparedness resources, including the STARS (Special Needs Tracking and Awareness Response System) program. Service Coordinators and Family Partners help families understand the importance of emergency planning and provide them with resources to be prepared for emergency situations. During an 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.
- Under the leadership of the State School Nurse Consultant, the Adolescent and School Health Program provides ongoing support and guidance to schools and school nurses regarding EPR, including hosting virtual learning opportunities for school nurses to assist with implementing best practices in schools, developing guidance for schools, communicating best practices for developing and implementing school health plans, and determining appropriate mitigation strategies.
- Title V funded home visiting programs use guidance plans from HRSA regarding virtual home visiting in the event of emergencies and provide virtual or tele-home visiting services, when appropriate and necessary.

Ready in 3 provides education for individuals on a personal level, including the MCH population. While this campaign helps to prepare families for the impacts of a disaster, it has specific information available regarding emotional preparedness and helpful preparation for breastfeeding mothers.

DHSS partners with the University of Missouri to access valuable MCH-related emergency preparedness resources at the state and local levels. The Missouri Extension Disaster Education Network (Missouri EDEN) operates through MU Extension offices in all 114 Missouri counties. The online resource is available to citizens and government entities and includes a Family Disaster Plan to guide families through emergency preparedness planning specific to their unique MCH needs. Assistance is offered at the local level, as needed, through connections to local emergency management and local officials.

As recovery efforts continued after the recent tornado in St. Louis, it became apparent that long-term recovery for impacted residents would possibly take months to complete. In the initial recovery period, the needs of mothers and children were met with adequate supplies, mental health services, and clinical services available in the area. However, when considering long term recovery efforts, the need to calculate the number of potential births by mothers in the impacted area was identified. Using vital records data, the number of potential births in the impacted St. Louis area was calculated, and this data was provided to planners so that sustainable and comprehensive long-term plans could be created. The lesson learned was to look at the potential for both the immediate impacts to mothers and children and the potential need for prolonged recovery efforts. Knowledge gained will inform ongoing

development of EPR training, communication plans, and tools/strategies to enhance statewide preparedness for responding to disasters and emerging threats and addressing the unique needs of the MCH population.

As previous natural disasters and public health emergencies have highlighted, a competent public health nursing workforce is essential to responding to emergencies and addressing potential short- and long-term impacts of disasters and emerging threats for all populations, including the MCH population. The Community/Public Health Nursing (C/PHN) Competencies define the knowledge, skills, and behaviors necessary for competent public health nursing practice, have relevance to all C/PHNs and the agencies that employ them, and provide the basis for C/PHN's efforts to protect and promote the health of communities. The C/PHN Competencies include skills related to EPR, such as developing and leading partnerships with communities and agencies at local, state, and federal levels with authority over emergency preparedness and public health emergency events/situations; responding to and explaining environmental hazards and emergency preparedness to protect individuals, families, and groups; determining community public health emergency preparedness needs and organizing response activities; and building functional capabilities of public health emergency preparedness across community sectors. All these competencies are essential to protecting the MCH population within each community. DHSS works 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 MCH Director participates in the CDC Public Health Infrastructure Grant work plan, serving as a Project Lead for activities to support public health nursing workforce development, including coordination of a formal agreement between DHSS and the Section for Public Health Nursing at the Missouri Public Health Association to implement a statewide community of public health nursing practice with regional learning communities and promote the C/PHN Competencies.

Recent weather-related emergencies around the state highlight and exacerbate longstanding challenges affecting communities with heightened needs. Ongoing exacerbation of needs and crises for the MCH population, 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, continue to elevate the importance of prioritizing the MCH population in EPR planning and activities. Continuation, evaluation, and expansion of telehealth models, leveraging new and expanded partnerships, and enhancing MCH data collection, analysis, and observation capacity are some of the strategies being pursued to enhance statewide EPR, particularly for those most at risk.

III.C. Needs Assessment

III.C.1. Five-Year Needs Assessment Summary and Annual Updates

III.C.1.a. Process Description

Conceptual Framework

The comprehensive Missouri MCH Needs Assessment process was developed using the conceptual framework provided by the MCH Evidence Center. The nine-step process provided a pathway to ensure a comprehensive review of the needs of mothers, children, and families in Missouri.

Goals

In addition to serving as the lead MCH service provision entity for the State of Missouri, Department and MCH Leadership collaborate closely with LPHAs and other entities to ensure the needs of MCH populations across the state are met. The Title V MCH Block Grant is one of the largest and oldest federal block grant programs in the nation. The purpose of the grant is to facilitate states' capacity to address the health of women, infants, and children, including adolescents and children with special health care needs, and their families. The block grant requires states to conduct a comprehensive statewide MCH needs assessment every five years; states use the needs assessment findings to identify state priorities and allocate resources to address those priority needs. The goal of the Missouri MCH Needs Assessment is to identify MCH priorities for the State of Missouri for the upcoming five-year block grant cycle, using the Title V MCH Block Grant framework. Furthermore, the findings will be used to direct program efforts to confront health challenges for the maternal-child population through effective resource distribution and strategic partnerships.

Organization

Needs assessment activities were coordinated by the MCH Epidemiology Team within the DCPH Office of Epidemiology (OOE). OOE manages key population health surveillance systems, including the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS). OOE also provides epidemiological support across DHSS. It collaborates with the Bureau of Health Care Analysis and Data Dissemination (BHCADD), which oversees a variety of data sources, including vital statistics and hospital data.

OOE's Chronic Disease Epidemiology Team supports MCH Leadership in accessing varied data for the MCH Needs Assessment process and works closely with MCH Leadership, enhancing data capacity and stakeholder engagement. MCH Leadership and programming input was integrated throughout the needs assessment activities.

Methodology

The Missouri MCH Needs Assessment process was based on four components:

1. MCH Listening Sessions
2. Quantitative analysis of surveillance systems
3. Public survey of priorities
4. MCH stakeholder convening

MCH Listening Sessions

DHSS contracted with the University of Missouri–Columbia's Department of Public Health to conduct MCH Listening Sessions around the state.

The MCH Listening Sessions involved conducting focus groups across Missouri to gather geographically and demographically representative community perspectives on maternal and child health needs, gaps, services, and barriers. Participants were recruited through targeted, digital advertisements, collaborations with LPHAs, and partnerships with local community groups and other stakeholders. This approach ensured broad representation,

capturing voices from various regions and backgrounds to provide a rich foundation for understanding statewide challenges.

The University of Missouri team facilitated the sessions using open-ended questions informed by previous health listening sessions. The MCH Listening Sessions aimed to explore maternal and child health challenges while identifying actionable opportunities for improvement. Further, they were meant to align with the Title V Maternal and Child Health Services Block Grant objectives.

The MCH Listening Sessions engaged 227 participants through 18 sessions conducted across Missouri (Cape Girardeau, Columbia, Fredericktown, Houston, Jefferson City, Kansas City, Macon, Maryville, Milan, Miner, Osage Beach, Springfield, St. Louis, Warrensburg). These sessions ensured geographic representation spanning urban, suburban, and rural communities. By capturing voices from various locations, the sessions illuminated the challenges and opportunities related to maternal and child health across the state.

At the conclusion of the MCH Listening Sessions, the University of Missouri research team employed a qualitative, iterative approach to analyze and interpret participants' shared experiences. This process was designed to identify patterns within the data and translate these findings into actionable insights. The analysis began with coding the transcribed discussions, followed by thematic analysis to categorize responses into overarching themes. Key concepts, such as "access to care" and "health literacy," were systematically tagged and refined into broader themes, like "community resources" and "barriers to access." This iterative approach ensured the final themes accurately reflected the varied experiences, challenges, and priorities expressed by participants across Missouri.

Quantitative Analysis of Surveillance Systems

The MCH Epidemiology team analyzed quantitative data on a range of perinatal, infant, child, and maternal health indicators drawn from a broad variety of state and national data sources. Additionally, cross-cutting and systems-building measures were included where applicable. The data sources that were used included:

- American Community Survey 5-Year Estimate (2019-2023)
- Birth certificates (2019-2023)
- Death certificates (2019-2023)
- Feeding America - Map the Meal Gap (2022)
- Missouri County-Level Study (2022)
- Missouri Student Survey (2024)
- Pregnancy Risk Assessment Monitoring System (PRAMS) (2021-2022)

For the first time, the Missouri MCH Needs Assessment process included county-level data analysis and an assignment of overall MCH health risks for the county. There were 30 measures total and represented all Title V domains except CYSHCN (children and youth with special health care needs), which did not have any local data available. CYSHNC data was analyzed only at the state level due to this limitation. Z-scores were calculated for each measure.

Each county was also assigned an overall ranking of MCH risk based on the average z-score across all measures. The rankings were split into quintiles from Very Low Risk to Very High Risk.

Each LPHA in the state will receive a copy of the full quantitative dataset. This file will include their county-level information for each of the 30 measures. It also includes their ranking compared to the other counties for each measure and their overall risk rating. This is the first time DHSS has provided in-depth MCH data to the LPHAs. Given most of these agencies do not have their own epidemiologist on staff, the data are intended to help them identify the highest need areas in their community and use this information to develop their own MCH workplans.

The data from this quantitative analysis is also being shared publicly on the DHSS website as an interactive Tableau dashboard.

The full list of indicators that were included in the county-level analysis is below as Table 1.

Table 1. Quantitative Indicators Used in the Missouri MCH Needs Assessment

Population Domain	Measure Title	Measure Details	Data Source	Year(s)
Adolescent Health	Adolescent Depression	Percentage of 6th to 12th Graders who Reported Feeling Hopelessness	MO Student Survey	2024
Adolescent Health	Bullying Victim	Percentage of 6th to 12th Graders who had Rumors/Lies Spread at School in the Past 3 Months	MO Student Survey	2022
Adolescent Health	School Days Missed	Percentage of 6th to 12th Graders who Missed School due to Safety Concerns	MO Student Survey	2024
Adolescent Health	Suicide Deaths - Children <18 Years	Rate of Deaths to Suicide per 100,000	Vital Records	2019-2023
Adolescent Health & Women / Maternal Health	Adolescent Birth Rate (Ages 10-19)	Rate of Births per 1,000 Females between Ages 10 to 19	Vital Records	2019-2023
Child Health	Child Food Insecurity	Percentage of Children Under 18 Years who are Food Insecure (Lack Access at All Times to Enough Food for an Active Life)	Feeding America	2022
Child Health	Children Below Poverty Level	Percentage of Children Under 18 Years of Age Below the Poverty Level (U.S. Census Bureau's Poverty Thresholds)	ACS	2019-2023
Child Health	Injury Deaths - Children <18 Years	Rate of Deaths due to Injury per 100,000	Vital Records	2019-2023
Child Health	Mortality Rate - Children <18 Years	Rate of Death Among Residents Under Age 18 per 100,000	Vital Records	2019-2023
Child Health	Uninsured Children	Percentage of Children Under 19 Years of Age who are Without Health Insurance	ACS	2019-2023
Cross-Cutting / Systems Building	Education - High School Graduate	Percentage of Adults 25 Years and Over with a High School Diploma (or Equivalent) or Higher	ACS	2019-2023

Cross-Cutting / Systems Building	Median Household Income	Median Household Income in 2023 Inflation-Adjusted Dollars	ACS	2019-2023
Cross-Cutting / Systems Building	Overall Food Insecurity	Percentage of all Individuals who are Food Insecure (Lack Access at All Times to Enough Food for an Active Life)	Feeding America	2022
Perinatal / Infant Health	Infants Ever Breastfed	Percentage of Infants who were Ever Breastfed	PRAMS	2021-2023
Perinatal / Infant Health	Mortality Rate - Infant	Rate of Infant Deaths (within 1 year) per 1,000 Live Births	Vital Records	2019-2023
Perinatal / Infant Health	Safe Sleep	Percentage of Infants Placed to Sleep on their Backs	PRAMS	2021-2022
Women / Maternal Health	Dental Visit During Pregnancy	Percentage of Women who had a Dental Visit During Pregnancy	PRAMS	2021-2023
Women / Maternal Health	Excessive Drinking	Percentage of Women Ages 18 to 44 Reporting Binge or Heavy Drinking	MO County-Level Study	2022
Women / Maternal Health	Injury Deaths - Women Ages 18-44 Years	Rate of Deaths due to Injury per 100,000	Vital Records	2019-2023
Women / Maternal Health	Obesity	Percentage of Women Ages 18 to 44 Reporting a Body Mass Index (BMI) Greater than or Equal to 30	MO County-Level Study	2022
Women / Maternal Health	Physical Inactivity	Percentage of Women Ages 18 to 44 Reporting No Physical Activity or Exercise in the Last 30 Days	MO County-Level Study	2022

Women / Maternal Health	Poor Mental Health Days	Percentage of Women Ages 18 to 44 Reporting 14 or More Days of Poor Mental Health	MO County-Level Study	2022
Women / Maternal Health	Poor or Fair Health	Percentage of Women Ages 18 to 44 Reporting Fair or Poor Health	MO County-Level Study	2022
Women / Maternal Health	Postpartum Checkup	Percentage of Women who had a Postpartum Checkup	PRAMS	2021-2023
Women / Maternal Health	Postpartum Depressive Symptoms	Percentage of Women who Reported Having Postpartum Depressive Symptoms	PRAMS	2021-2023
Women / Maternal Health	Pre-Pregnancy Health Care Visit	Percentage of Women who had a Health Care Visit in the 12 Months before Pregnancy	PRAMS	2021-2022
Women / Maternal Health	Smoking	Percentage of Women Ages 18 to 44 who are Current Smokers	MO County-Level Study	2022
Women / Maternal Health	Suicide Deaths - Women Ages 18-44 Years	Rate of Deaths to Suicide per 100,000	Vital Records	2019-2023
Women / Maternal Health	Unemployment Rate	Percentage of Women Ages 20 to 64 who are Unemployed	ACS	2019-2023
Women / Maternal Health	Uninsured Women	Percentage of Women Ages 19 to 44 who are Without Health Insurance	ACS	2019-2023

Public Survey of Priorities

The survey that was open to the public was developed to provide an opportunity for Missourians to share their input for the MCH Needs Assessment process. The survey was advertised through email to MCH stakeholders, LPHAs, and DHSS social media. The survey gathered information on what barriers people are experiencing relating to accessing health care. It also asked them to provide their opinions on what areas people think DHSS should focus on over the next five years related to MCH.

The questions asked in this survey were:

1. Do you live in Missouri?
2. Which county do you live in?
3. How old are you?
4. What is your sex?
5. Are you a parent?
6. Which age group are your child(ren) in?
7. Does anyone in your household have special health care needs? This includes anyone who needs more medical care, including prescription medication, mental health services, or specialized therapy, than other people their age.
8. Who in your family has special health care needs?
9. Do you have health insurance?
10. What type of insurance do you have?
11. Does your child(ren) have health insurance?
12. What type of insurance does your child(ren) have?
13. How much money does your family make in a typical year?
14. What do you think are the biggest barriers to accessing health care in your community? Select up to 5 options.
    - Cost
    - Could not take time off from work or school
    - Cultural/religious beliefs
    - Immigration status
    - Insurance not accepted
    - Lack of access to transportation
    - Lack of health insurance
    - Lack of provider availability
    - Previous negative experiences with health care
    - Too far away
    - Unaware of services offered
    - Other (Please specify what other barriers there are)
15. Which areas do you think the Missouri Department of Health and Senior Services should focus on? You may select up to 5 items.
    - Access to behavioral and mental health care
    - Access to primary care
    - Access to specialist care
    - Adolescent health
    - Substance use prevention and treatment (including alcohol)
    - Breastfeeding
    - Child development
    - Dental care / Oral health
    - Food security
    - Domestic violence / intimate partner violence
    - Housing instability
    - Immunizations
    - Injury prevention
    - Healthy eating and active living

- Pregnancy and postpartum care
- Reducing health disparities)
- Safe infant sleep
- Tobacco prevention and cessation
- Suicide prevention t) Strengthening families
- Support for children and youth with special health care needs
- Transportation
- Violence prevention
- Women's health
- Other (Please specify what other areas should be focused on)

16. Is there anything else you would like to share with the Missouri Department of Health and Senior Services about the needs of women, mothers, infants, children, adolescents and/or families in Missouri?

MCH Stakeholder Convening

On February 27, 2025, DHSS hosted a MCH stakeholder convening. This in-person meeting gathered almost 80 MCH stakeholders from across the state for a full-day conversation to learn about the data collected through the needs assessment process, discuss the complexity of challenges impacting the MCH system, and build consensus regarding the priority MCH areas of focus for the next five years. Participants represented a variety of domains, including state and local public health, MO HealthNet, the Office of Childhood at DESE, DMH, providers, healthcare systems and organizations, managed care organizations, academia, community-based organizations, HRSA-funded regional initiatives, healthcare coalitions, and philanthropic organizations. The Governor's Office and community and family members also participated. Attendees were briefed on the data collected through the MCH Listening Sessions, quantitative analysis of surveillance systems, and public survey of priorities. Stakeholders engaged in a variety of large and small group discussions and activities to strategize approaches for meeting the needs of mothers, infants, children, adolescents, children and youth with special health care needs, and families. Attendees were asked to rotate between different stations that each focused on a particular aspect of MCH. There were stations for each of the five population domains within Title V, along with one for cross-cutting and systems building. These discussions helped identify challenges and opportunities within each of these areas. Each participant was also asked to write down three things they learned from the data. Additionally, participants were asked to rank their opinions of what the priorities should be, using Question 15 from the public survey. They were surveyed via live polling in Slido at the beginning of the meeting before data was presented and then asked the same question at the end of the day. This pre- and post-meeting survey was intended to assess whether attendees' views changed after being provided an extensive review of the needs assessment data. The results were largely consistent between the two surveys. Attendees were asked to complete a post-convening evaluation. When asked, "Did you feel your input was valued and well-received?", 32% responded "probably yes," and 68% responded "definitely yes." Additional comments, suggestions, or ideas regarding the convening, needs assessment, or next steps included:

- "I really enjoyed being a part of building the strategic plan."
- "Thank you!! Exciting to think about the future."
- "Excited to be part of this important work!"
- "Would like to stay involved and collaborate on the actions"
- "Would be interested in engaging more with cross training or providing training on MCH to healthcare professionals."
- "Thanks for including us/me."
- "Great event!"

The MCH Director received the follow-up email messages below from a few attendees:

- "I just wanted to drop you a note to let you know how well I thought the meeting went yesterday. Everything seemed to go smoothly. There was great discussion, brainstorming, networking, information sharing, etc. I think it was a great compilation of people in the room together. Well done to you and your team."
- "What an amazing and informative event, and it was a pleasure to be included! I have 10+ pages of notes to work off, but I would also love those slide decks so I can share the information with my colleagues. I would also

love to see the survey results and any other data or responses collected this afternoon that could be useful."
- "Thank you for hosting a great event. I look forward to continuing to work with you!"
- "I loved the convening on Thursday. It was so interesting and well run. You have a dream team you have convened. So well organized. So impressive. I had to leave during the small groups but loved every bit of it while I was there."

III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing

MCH Listening Sessions

The listening sessions were conducted by the University of Missouri-Columbia's Department of Public Health. Their findings are summarized here. The full report available on the DHSS MCH webpage.

Key Findings

The following summary of key findings offers a closer look at the available MCH services and programs, the critical gaps, and the barriers preventing access to essential MCH services based on responses collected during all 18 listening sessions.

This section examines the availability and awareness of community resources, the pivotal role of mental health support, and the challenges surrounding pregnancy, delivery, postpartum care, and services for children and youth with special health care needs (cyshcn). Additionally, it discusses the shared experiences and perspectives related to the concept of medical homes and the role of local and state health departments in supporting MCH. These findings highlight the needs and priorities of Missouri's communities, providing a foundation for future actionable recommendations to guide future health initiatives and funding decisions.

Important Available Services & Programs

Participants across Missouri identified numerous programs as important to supporting maternal, child, and adolescent health, providing vital resources for families from pregnancy to adolescence. Despite the many programs, services, and resources available across the state, service gaps remain, impacting the most vulnerable populations.

Missing Services & Programs

The following services and programs were mentioned often as not available in communities:

- Mental Health Support
- Childcare
- Transportation
- Cost-Effective Services
- Community Outreach and Education

Gaps in service and program availability and accessibility were perceived as disproportionately impacting low-income families, rural residents, immigrants, and underrepresented populations.

The Role of Mental Health

Participants discussed the role of mental health services in promoting health and well-being for mothers, infants, children, and adolescents, the availability of these services in their communities, and the barriers preventing access to care. Participants described a patchwork system of care, where services are scattered and stretched thin, leaving many families without the consistent support they need.

Mental Health Programs & Services

While some participants discussed having access to virtual counseling, others talked about relying on local counseling centers, public health departments, or community-based programs for counseling. These resources often

fell short of meeting the demand in most communities. Participants also discussed a lack of substance use treatment and mental health education programs.

Barriers to Mental Health Care Access

Participants identified a range of obstacles that contribute to a system that feels out of reach for many.

- Lack of Providers
- Distrust and Stigma
- Cost

Discussions about mental health revealed a need for systemic improvements in mental health services, with a focus on three key areas to ensure healthier outcomes for mothers, children, and adolescents across MO:

1. Accessibility
2. Affordability
3. Preventative Mental Health Care

Pregnancy, Delivery, & Postpartum Care

Participants highlighted the critical role of postpartum care in ensuring the health and recovery of both mother and baby, identifying key supports that contribute to successful outcomes. However, many participants shared stories of barriers, including financial stress, limited access to care, and a lack of social and systemic support, underscoring the challenges that families face during this transformative time.

Positive Pregnancy & Delivery

For many participants, a positive pregnancy and delivery experience is rooted in education, autonomy, and support. Attendees highlighted the importance of being informed about available resources and understanding their rights during delivery. Others emphasized the importance of being heard and supported by providers and family members.

Support systems such as doulas and midwives were often mentioned. Participants stressed the value of broader support networks, such as the positive impact of family, social workers, and care coordinators on the delivery experience.

Support & Resources for Postpartum Care

Participants emphasized the importance of numerous accessible resources, including follow-up care, lactation support, home visiting, nutritional support, mental health services, and paid leave.

Participants also expressed the importance of compassionate and culturally competent providers, access to safe cribs, parenting education, and ongoing community support to help mothers navigate this period effectively. Limited access to services and financial stress were recurring themes. The lack of continuity of care and feeling unsupported were particularly challenging, too.

Common Barriers

The barriers to achieving a healthy pregnancy and postpartum period were consistent across sessions:

- Lack of Access to Care
- Financial Stress
- Lack of Awareness
- Limited Support Networks

CYSHCN

CYSHCN face unique challenges that require tailored services, coordinated care, and comprehensive support

systems. Beyond the commonly cited programs such as First Steps, PAT, and the public school system, participants acknowledged several other valuable resources, such as:

- Special Learning Centers
- MO Family to Family and Camp Wonderland
- Knights of Columbus for financial aid
- Accessible playgrounds

Participants emphasized gaps such as early diagnostic evaluations, mental health support for families, and adequate funding for community-based programs. Many noted that rural families face additional challenges due to distance and limited availability of local services.

Accessibility of Specialized Health Services

Participants voiced concerns about the limited accessibility of specialized health services for cyshcn. A minority of participants identified resources available for cyshcn in their communities, such as PAT, First Steps, and the public school system. Many participants expressed frustration with gaps in service and program availability. Participants felt, too often, these services fell short of meeting the extensive needs of cyshcn and their families. Participants repeatedly highlighted three barriers experienced by cyshcn:

1. Absence of a centralized system to access medical, educational, and social services.
2. Insufficient outreach and advocacy related to available resources and services.
3. Funding and cost constraints.

One of the most significant challenges identified was the scattered nature of care, where parents often become the primary coordinators for navigating medical, educational, and social services. Families pointed to the absence of a centralized system to access programs and services, which left them feeling isolated and unsupported. Frequently emerging in listening sessions, parents described compounding barriers – inadequate advocacy and outreach about existing resources.

Discussions recurringly focused on inadequate funding and burdensome expenses for programs and services. Participants stressed how restrictive income caps exclude middle-income families from financial support.

Medical Home

The idea of a medical home was unfamiliar to most participants. Often, in the Listening Sessions, if someone understood or was familiar with the term, the person worked in the social services field. However, among the few who had experience with medical homes, challenges such as lengthy waitlists, high costs, and limited integration of dental and mental health services were common. Participants pointed out four other systemic issues preventing the establishment of effective medical homes:

1. Lack of Awareness
2. Resource Constraints
3. Access and Affordability Issues
4. Limited Accessibility

Role of the Health Department

Participants emphasized the important role of local and state health departments in prioritizing funding and education to advance MCH. While local health departments were viewed as direct providers of services and community engagement, state health departments were seen as architects of guidelines, regulations, and overarching frameworks. This section delves into the perceived responsibilities of these agencies, highlighting their complementary roles in raising awareness, addressing systemic gaps, and improving access to essential services.

Funding and Education as Priorities

Funding was consistently identified as a critical responsibility of local and state health departments. Participants

stressed the need for sustained financial support for programs like WIC and Show Me Healthy Women.

Education emerged as another key focus. Participants discussed the need for health literacy initiatives, public service announcements to disseminate critical information, and community assessments to identify gaps in care.

Raising Awareness & Access

Many listening sessions emphasized the responsibility of raising awareness and improving access to available resources. Participants advocated for information hubs, culturally competent outreach, and partnerships with community organizations. Barriers like transportation challenges, staff shortages, and lack of childcare were frequently mentioned.

Distinct and Interconnected Roles

Participants identified distinct yet interconnected roles for local and state health departments. Local health departments were viewed as community-focused entities responsible for providing direct services, evaluating community health trends, and promoting awareness about county-level resources.

State health departments were viewed as providing overarching support. Participants expected state agencies to set guidelines, facilitate communication with local departments, and address cross-cutting, system-level issues such as workforce shortages and systemic gaps. Many also called for improved collaboration between state and local agencies to align priorities and foster better outcomes. The participants often underscored the essential roles of local and state health departments in bridging systemic gaps, improving access, and promoting community well-being.

Insights

The listening sessions revealed significant opportunities to enhance MCH outcomes across MO. Participants highlighted gaps in services, systemic barriers, and the critical need for improved engagement between health departments and communities. Addressing these challenges requires strategies grounded in evidence-based practices. This section outlines targeted strategies in three key areas:

1. Strengthening community engagement
2. Advancing MCH actions and services
3. Removing barriers to access.

Strengthening Community Engagement

Participants emphasized the need to build stronger connections between health departments and communities to raise awareness about available resources and foster trust. Effective engagement strategies should focus on culturally competent outreach, accessible information hubs, and consistent feedback mechanisms.

Strategies

1. Develop Culturally Tailored Outreach Programs:
    a. Establish multilingual and culturally competent health education initiatives targeting varied populations.
    b. Employ community health workers to serve as trusted liaisons.
2. Implement Digital and Community-Based Information Hubs:
    a. Create centralized online platforms with comprehensive MCH resource directories.
    b. Partner with local organizations to distribute printed materials in underserved areas.
3. Host Regular Community Health Forums:
    a. Conduct open forums and focus groups to gather feedback and share updates on health programs.
4. Leverage Technology for Broader Reach:
    a. Use social media and mobile apps for real-time updates on services and health tips.
    b. Expand telehealth services for educational consultations.
5. Enhance Public Awareness Campaigns:
    a. Launch campaigns featuring success stories and testimonials to build credibility.

b. Highlight key services such as WIC, mental health resources, and postpartum care.

Strengthening community engagement could improve trust, awareness, and participation in programs.

Targeted MCH Strategies

Improving MCH requires investments in preventative services, mental health support, and infrastructure expansion. The following strategies address gaps in current services and emphasize the need for innovative and sustainable programs.

Strategies

1. Invest in Preventive Care and Early Intervention:
    a. Support early prenatal care, developmental screenings, and routine maternal mental health evaluations.
    b. Enhance programs like First Steps to address developmental delays more effectively.
2. Expand Maternal Mental Health Resources:
    a. Provide postpartum mental health services such as counseling, hotlines, and group therapy for the first six months to one year.
    b. Integrate routine mental health screenings into all stages of maternal care.
3. Enhance Support for cyshcn:
    a. Increase funding for medical homes to provide coordinated care for children with special needs.
    b. Train health care providers in trauma-informed and culturally competent care.
4. Build Health Care Infrastructure in Rural Areas:
    a. Establish mobile clinics and telemedicine hubs to serve rural communities.
    b. Incentivize health care providers to work in underserved areas.
5. Support Workforce Development:
    a. Recruit health care professionals through scholarships and competitive salaries.
    b. Train care coordinators and community health workers to address growing service demands.

Expanding preventive care and investing in infrastructure and mental health support can address long-standing MCH service gaps. With these improvements, health departments can focus on removing persistent barriers to access.

Removing Barriers to Access

Barriers such as financial strain, transportation challenges, and provider shortages disproportionately affect families' access to essential health services. Removing these obstacles is critical to ensuring optimal health outcomes for all Missourians.

Strategies

1. Reduce Financial Barriers:
    a. Expand Medicaid eligibility and simplify application processes.
    b. Offer sliding-scale fees for services not covered by insurance.
2. Improve Transportation Access:
    a. Provide subsidized or free transportation for medical appointments.
    b. Partner with rideshare companies or establish shuttle services in rural areas.
3. Address Community and Population-Level Factors Influencing Health Outcomes:
    a. Increase access to affordable housing, childcare, and nutritious food.
    b. Develop programs like diaper banks and formula distribution for low-income families.
4. Expand Provider Availability:
    a. Recruit and train more health care professionals, including lactation consultants and mental health providers.
    b. Incentivize specialists to work in underserved regions.
5. Streamline Care Navigation:
    a. Implement centralized case management systems for families accessing multiple services.
    b. Train community health workers to guide families through available programs.

Session Themes

Several recurring themes emerged. These highlight the interconnected nature of issues such as access to care, mental health support, resource awareness, and the role of established systems in shaping health outcomes. These themes included:

Services and Programs

1. Resource Awareness and Accessibility
2. Mental Health Support
3. Childcare Availability
4. Transportation Barriers
5. Financial Constraints

Mental Health Services

1. Critical Role of Mental Health
2. Lack of Providers
3. Stigma and Awareness
4. Limited Postpartum Support
5. Cost and Insurance

Pregnancy, Delivery, and Postpartum Care

1. Importance of Education
2. Support Systems
3. Access to Follow-Up Services
4. Barriers to Continuity of Care
5. Financial and Workplace Challenges

CYSHCN

1. Fragmented Systems
2. Awareness Gaps
3. Insufficient Funding
4. Rural Accessibility
5. Challenges with Education Systems

Role of Local & State Health Departments

1. Funding and Resource Allocation
2. Awareness and Outreach
3. Community Assessments
4. Collaborative Partnerships
5. Direct Community Engagement

Quantitative Analysis of Surveillance Systems

This quantitative analysis summarizes key MCH indicators across MO. The analysis incorporates 30 MCH measures, including cross-cutting systems metrics. Data were drawn from multiple sources, such as the American Community Survey (ACS), MO Pregnancy Risk Assessment Monitoring System (PRAMS), MO Vital Statistics, and the National Survey of Children's Health (NSCH).

Women's and Maternal Health

Women of Childbearing Age (18 to 44) Reporting Poor or Fair Physical Health

The statewide average of women, aged 18 to 44, who report poor or fair physical health is 13.5%. County-level rates range from 1.0% (Clark) to 36.4% (Hickory). Source: MO County-Level Study (CLS) 2022.

Percentage of Women of Childbearing Age (18 to 44) Reporting 14 or More Days of Poor Mental Health

The statewide average of women, aged 18 to 44, who report poor mental health is 25.6%. County-level rates range

from 6.2% (Monroe) to 50.7% (DeKalb). Source: MO CLS 2022.

Percentage of Women of Childbearing Age (18 to 44) Reporting a Body Mass Index (BMI) Greater than or Equal to 30
The statewide average of women, aged 18 to 44, with a weight classification of obese by BMI is 35.4%. County-level rates range from 13.9% (Audrain) to 68.9% (Schuyler). Source: MO CLS 2022.

Percentage of Women of Childbearing Age (18 to 44) Reporting Binge or Heavy Drinking
The statewide average of women, aged 18 to 44, who report excessive drinking is 7.3%. County-level rates range from 0.0% (10 different counties) to 20.8% (Benton). Source: MO CLS 2022.

Percentage of Women of Childbearing Age (18 to 44) who are Current Smokers
The statewide average of women, aged 18 to 44, who are current smokers is 12.0%. County-level rates range from 1.0% (Holt) to 44.7% (Wayne). Source: MO CLS 2022.

Percentage of Women of Childbearing Age (18 to 44) Reporting No Physical Activity or Exercise in the Last 30 Days
The statewide average of women, aged 18 to 44, who are physically inactive is 17.8%. County-level rates range from 7.7% (Lincoln) to 47.6% (Bollinger). Source: MO CLS 2022.

Percentage of Women of Childbearing Age (19 to 44) Who Are Uninsured
The statewide average of women, aged 19 to 44, without health insurance is 13.1%. County-level rates range from 4.5% (Andrew) to 37.8% (Scotland). Source: ACS 5-Year Estimate 2019–2023.

Percentage of Women Aged 20 to 64 who are Unemployed
The statewide unemployment rate of women, aged 20 to 64, is 3.8%. County-level rates range from 0.0% (Dallas, Knox, Scotland, Worth) to 17.3% (Hickory). Source: ACS 5-Year Estimate 2019–2023.

Rate of Deaths due to Injury for Women of Childbearing Age (18 to 44) per 100,000
The statewide rate of injury deaths for women, aged 18 to 44, is 45.48 per 100,000. County-level rates range from 0.0 (10 different counties) to 114.1 (Iron). Source: MO Vital Statistics (MVS) 2019–2023.

Rate of Deaths due to Suicide for Women of Childbearing Age (18 to 44) per 100,000
The statewide suicide rate of women, aged 18 to 44, is 9.1 per 100,000. County-level rates range from 0.0 (35 different counties) to 84.1 (Mercer). Source: MVS 2019-2023.

Percentage of Women who had a Dental Visit During Pregnancy
The statewide average for dental visits during pregnancy is 46.5%. Regional rates range from 35.2% (Southeast) to 52.2% (Greater St. Louis). Regions in this measure are based on BRFSS regions. Source: PRAMS 2021–2023.

Percentage of Women who had a Health Care Visit in the 12 Months before Pregnancy
The statewide average of women who had a pre-pregnancy health care visit is 66.2%. Regional rates range from 61.0% (Greater Kansas City) to 71.6% (Northeast). Regions in this measure are based on BRFSS regions. Source: PRAMS 2021–2022.

Percentage of Women who had a Postpartum Checkup
The statewide average for postpartum checkups is 89.4%. Regional rates range from 85.7% (Northeast) to 91% (Greater St. Louis). Regions in this measure are based on BRFSS regions. Source: PRAMS 2021–2023.

Percentage of Women who Reported Having Postpartum Depressive Symptoms
The statewide average for women with postpartum depressive symptoms is 13.8%. Regional rates range from 12.1% (Southwest) to 20.2% (Northwest). Regions in this measure are based on BRFSS regions. Source: PRAMS 2021–2023.

Perinatal and Infant Health

Rate of Infant Deaths (Within 1 Year) per 1,000 Live Births
The statewide infant mortality rate is 5.95 per 1,000 live births. County-level rates range from 0.0 per 1,000 live births (10 different counties) to 18.1 (Dade). Source: MVS 2019-2023.

Percentage of Infants Placed to Sleep on Their Backs
The statewide average for safe sleep (back placement) is 82.9%. Regional rates range from 77.9% (Central) to 89.2% (Northwest). Regions in this measure are based on BRFSS regions. Source: PRAMS 2021–2022.

Percentage of Infants who were Ever Breastfed
The statewide average for infants ever breastfed is 89.5%. County-level rates range from 80.1% (Southeast) to 91.5% (Greater St. Louis). Regions in this measure are based on BRFSS regions. Source: PRAMS 2021–2023.

Children's Health

Percentage of Children (Under Age 18) who are Food Insecure (Lack Access at All Times to Enough Food for an Active Life)
The statewide average for childhood food insecurity is 18.7%. County-level rates range from 9.1% (St. Charles) to 35.5% (Pemiscot). Source: Feeding America - Map the Meal Gap 2022.

Percentage of Children (Under 19 Years of Age) Who are Uninsured
The statewide average for children without health insurance is 6.1%. County-level rates range from 1.1% (Sullivan) to 45.4% (Scotland). Source: ACS 5-Year Estimate 2019–2023.

Rate of Deaths due to Injury for Children (Under Age 18) per 100,000
The statewide rate of injury deaths of children, under age 18, is 13.8 per 100,000. County-level rates range from 0 (13 different counties) to 66.4 (Knox). Source: MVS 2019-2023.

Rate of Death Among Children (Under Age 18) per 100,000
The statewide child mortality rate is 57 per 100,000. County-level rates range from 10.7 (Cooper) to 152.1 (Dade). Source: MVS 2019-2023.

Adolescent Health

Rate of Births per 1,000 Adolescent (Aged 10 to 19) Females
The statewide adolescent birth rate is 9.0 per 1,000 females, aged 10 to 19. County-level rates range from 3.0 (St. Charles) to 26.3 (Pemiscot). Source: MVS 2019-2023.

Rate of Deaths due to Suicide for Children (Under Age 18) per 100,000
The statewide suicide rate of children under age 18 is 2.7 per 100,000. County-level rates range from 0 (55 different counties) to 28.5 (Caldwell). Source: MVS 2019-2023.

Percentage of 6th to 12th Graders who had Rumors/Lies Spread at School in the Past 3 Months
The statewide average for adolescents who had rumors/lies spread at school in the past 3 months is 40.3%. Regional rates range from 35.3% (Southeast) to 42.4% (Central). Regions in this measure are based on BRFSS regions. Source: MO Student Survey 2024.

Percentage of 6th to 12th Graders who Reported Feeling Hopelessness
The statewide average for 6th to 12th Graders who reported feeling hopelessness is 16.2%. Regional rates range from 14.5% (Northeast) to 19.4% (Greater St. Louis). Regions in this measure are based on BRFSS regions. Source: MO Student Survey 2024.

Percentage of 6th to 12th Graders who Missed School due to Safety Concerns
The statewide average of children who missed school due to safety concerns is 6.8%. County-level rates range from 6.6% (Southwest) to 13.5% (Greater St. Louis). Regions in this measure are based on BRFSS regions. Source: MO Student Survey 2024.

Cross-Cutting / Systems Building

High School Graduation Rate for Adults at Least 25 Years Old
The statewide average for adults (at least 25 years old) with at least a high school diploma (or equivalent) was 91.3%. County-level rates range from 78.4% (Scotland) to 96.7% (Platte). Source: ACS 5-Year Estimate 2019–2023.

Percentage of all Individuals who are Food Insecure
The statewide average for food insecurity of all individuals is 15.0%. County-level rates range from 10.1% (St. Charles) to 22.6% (Wayne). Source: Feeding America - Map the Meal Gap 2022.

Median Household Income
The median household income in 2023 inflation-adjusted dollars is $68,920. County-level rates range from $35,084 (Hickory) to $102,912 (St. Charles). Source: ACS 5-Year Estimate 2019–2023.

Percentage of Children (Under Age 18) in Poverty
The statewide average of children below the federal poverty level per the U.S. Census Bureau's poverty thresholds is 16.0%. County-level rates range from 4.1% (Schuyler) to 37.3% (Carter). Source: ACS 5-Year Estimate 2019–2023.

CSHCN

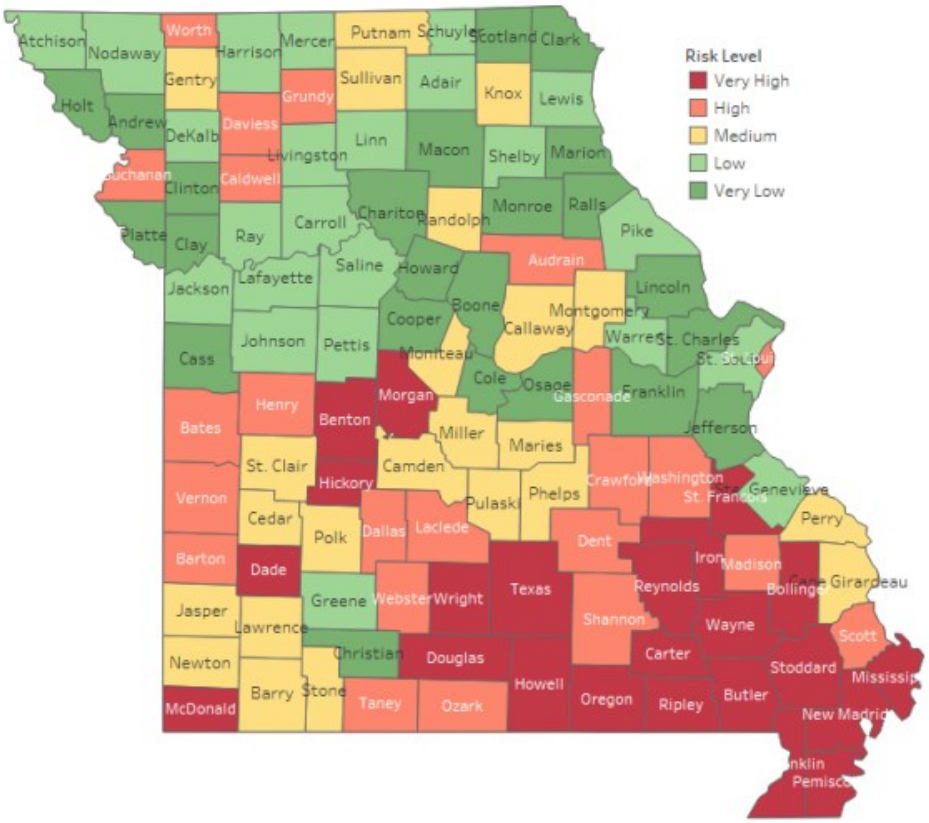
Local and regional data were unavailable for the CSHCN population, so analysis was limited to statewide information.

Prevalence of CSHCN
The statewide prevalence of CSHCN is 21.9%. Source: NSCH 2022.

Health Conditions Impacting Daily Activities (Aged 0 to 5)
A third of MO children aged 0 to 5 experienced a health condition that affected their daily activities as reported by their parents. 3.7% of children were consistently affected, often a great deal. Another 30.5% of children reported their daily activities were moderately affected some of the time. Source: NSCH 2022.

Developmental Screening in the Past Year (9 to 35 Months)
The statewide average for children, aged 9 to 35 months, having received a developmental screening is 32.4%. Source: NSCH 2022.

Overall County Rankings
Counties in MO were ranked using aggregated z-scores across 30 MCH indicators. These rankings help identify areas of low to very high health risk and support data-driven planning and resource allocation. The counties were categorized into five tiers based on overall risk: Very Low, Low, Medium, High, and Very High.



Very Low Risk Counties
Andrew, Boone, Cass, Chariton, Christian, Clark, Clay, Clinton, Cole, Cooper, Franklin, Holt, Howard, Jefferson, Lincoln, Macon, Marion, Monroe, Osage, Platte, Ralls, Scotland, St. Charles

Low Risk Counties
Adair, Atchison, Carroll, DeKalb, Greene, Harrison, Jackson, Johnson, Lafayette, Lewis, Linn, Livingston, Mercer, Nodaway, Pettis, Pike, Ray, Saline, Schuyler, Shelby, St. Louis, Ste. Genevieve, Warren

Medium Risk Counties
Barry, Callaway, Camden, Cape Girardeau, Cedar, Gentry, Jasper, Knox, Lawrence, Maries, Miller, Moniteau, Montgomery, Newton, Perry, Phelps, Polk, Pulaski, Putnam, Randolph, St. Clair, Stone, Sullivan

High Risk Counties
Audrain, Barton, Bates, Buchanan, Caldwell, Crawford, Dallas, Daviess, Dent, Gasconade, Grundy, Henry, Laclede, Madison, Ozark, Scott, Shannon, St. Louis City, Taney, Vernon, Washington, Webster, Worth

Very High Risk Counties
Benton, Bollinger, Butler, Carter, Dade, Douglas, Dunklin, Hickory, Howell, Iron, McDonald, Mississippi, Morgan, New Madrid, Oregon, Pemiscot, Reynolds, Ripley, St. Francois, Stoddard, Texas, Wayne, Wright

Public Survey of Priorities

Survey Purpose
The MCH public survey was designed to collect input from MO residents on the key barriers they face in accessing health care and their priorities for MCH. The survey included three primary sections: demographics, health care access barriers, and priority focus areas for DHSS.

Responses
Data was collected between December 10, 2024, and February 5, 2025 via REDCap survey. A total of 1053

responses were received. There were responses from 111 out of 115 counties.

Demographics of Respondents

Sex
• 93% female
• 7% male

Parental Status
• 90% of participants were parents

Age
• <1% were under 18
• 13% were aged 18–29
• 39% were aged 30–44 years
• 23% were aged 45–54
• 17% were aged 55–64
• 8% were 65 or older

Ages of Respondent's Children (Multiple Selections Allowed)
• 3% were currently pregnant
• 6% had children younger than 1 year
• 26% had children aged 1–5
• 30% had children aged 5–11
• 28% had children aged 12–17
• 51% had children aged 18 or older

Insurance Coverage
• 95% had health insurance
- 85% used private insurance
- 12% had public insurance
- 3% had other coverage
• 88% of children had health insurance
- 79% used private insurance
- 18% had public insurance
- 3% had other coverage

Special Health Care Needs
• 66% of households had at least one member with special health care needs
• Among these:
- 60% reported their child as having special health care needs
- 43% reported themselves as having special health care needs
- 31% reported another household member as having special health care needs

Barriers to Accessing Health Care
Participants were asked to identify the five biggest barriers to accessing health care in their community.

Barriers	Responses	Percentage
Cost	851	82%
Lack of Provider Availability	533	51%
Couldn't Take Time off School/Work	531	51%
Lack of Health Insurance	420	40%
Lack of Access to Transportation	356	34%
Insurance Not Accepted	294	28%
Previous Negative Experiences with Health Care	251	24%
Unaware of Services Offered	230	22%
Too Far Away	199	19%
Immigration Status	52	5%
Other	34	3%
Cultural/Religious Beliefs	22	2%

Priorities for DHSS

Respondents were asked to rate their top five priority areas.

Priorities	Responses	Percentage
Access to behavioral and mental health care	614	59%
Access to primary care	368	35%
Dental care / oral health	330	32%
Substance use prevention and treatment (including alcohol)	324	31%
Housing instability	268	26%
Access to specialist care	262	25%
Healthy eating & active living	235	23%
Pregnancy and postpartum care	233	22%
Food security	224	22%
Women's health	218	21%
Strengthening families	200	19%
Suicide prevention	193	19%
Transportation	190	18%
Support for CYSHCN	182	18%
Child development	176	17%
Reducing health disparities	167	16%
Adolescent health	126	12%
Immunization	118	11%
Domestic violence / intimate partner violence	117	11%
Breastfeeding	92	9%
Violence prevention	53	5%
Tobacco prevention and cessation	47	5%
Safe infant sleep	46	4%
Injury prevention	32	3%
Other	22	2%

Open-Ended Feedback

Over 200 participants provided additional comments. Recurring themes included:

- Need for more promotion of DHSS programs
- Frustration with care system navigation

• Quality, affordable childcare
• Lack of child disability services
• Rural transportation difficulties

Stakeholder Convening

The 2025 MCH Stakeholder Convening brought together professionals across MO to discuss priorities, gaps, and strategies for improving MCH.

Ranking of Priority Domains

Attendees were asked to rank priorities for the next 5-year grant cycle both at the beginning and at the end of the meeting. The resulting rankings are presented in the table below.

Priority Domains	Initial Ranking	Final Ranking	Change
Access to behavioral and mental health care	1	1	-
Access to primary care	2	2	-
Pregnancy and postpartum care	5	3	+2
Reducing health disparities	3	4	-1
Substance use prevention and treatment (including alcohol)	4	5	-1
Housing instability	7	6	+1
Transportation	12	7	+5
Women's Health	6	8	-2
Food security	8	9	-1
Access to specialist care	9	10	-1
Strengthening families	10	11	-1
Child development	11	12	-1
Support for CYSHCN	13	13	-
Dental care / Oral health	14	14	-
Adolescent health	20	15	+5
Domestic violence / intimate partner violence	15	16	-1
Immunization	16	17	-1
Breastfeeding	17	18	-1
Healthy eating and active living	18	19	-1
Suicide prevention	19	20	-1
Injury prevention	23	21	2
Violence prevention	21	22	-1
Safe infant sleep	22	23	-1
Tobacco prevention and cessation	24	24	0

Small Group Discussions

The meeting included small group discussions around each of the five population domains and crosscutting/systems-building issues. Participants were asked to help identify barriers and opportunities. Each station asked for ideas for quick wins and long-term system-level changes.

Concerns Identified for MCH in MO:

- Lack of standardized definitions and measurement across sectors
- Confusion over Medicaid billing
- Youth needs vary greatly by age
- Need for social services, including childcare and transportation

Suggestions for Improving MCH in MO

- Providers need tools to use screening effectively and know where to refer
- Child development milestone checklists made available through multiple platforms
- Group prenatal care
- Promotion of healthy relationships for adolescents
- Help youth develop self-advocacy skills
- Safe driving training

III.C.1.b.ii. Title V Program Capacity

III.C.1.b.ii.a. Impact of Organizational Structure

Missouri's state government is organized into three branches: the Legislative Branch, the Judicial Branch, and the Executive Branch, which is headed by the Governor. Within the Executive Branch are 16 executive departments, including Health and Senior Services. DHSS is the designated state agency for the allocation and administration of the Title V MCH Services block grant funds and oversight of all Title V programming. DHSS is organized into the Office of the Director and six divisions: Administration, Regulation and Licensure, Cannabis Regulation, Senior & Disability Services, State Public Health Laboratory, and Community and Public Health (DCPH). DCPH is the largest of the six divisions and is responsible for supporting and operating more than 100 programs and initiatives addressing public health issues.

DCPH is further organized into six organizational groupings, as depicted in the attached "DCPH Functional Listing,". DCPH serves as the umbrella agency that facilitates access to numerous MCH-targeted programs. Structurally, the MCH Leadership Team, led by the MCH Director, is located with the DCPH Director's Office. The MCH Leadership team also includes the Children and Youth with Special Health Care Needs (CYSHCN) Director, MCH Coordinator, who also serves as the State Adolescent Health Leader, the MCH Family Leader, and the Fetal and Infant Mortality Review (FIMR) Coordinator. The MCH Director serves as the chief strategist and architect for maternal and child health initiatives in Missouri and administers and oversees the Title V MCH Services Block Grant.

The MCH Director and Leadership Team work vertically and cross-functionally across division, agency, and system boundaries to address health gaps, respond to emerging MCH challenges, and assure the infrastructure, workforce, and public health strategies necessary for a strong system to meet the needs of Missouri's women, children, youth, and families, and the providers and organizations that serve them. Since the MCH Director position is not part of DCPH or DHSS senior leadership, operationalization of the statewide chief MCH strategist and architect role requires an individual a unique blend of visionary long-term foresight, strategic thinking and analytical prowess, influential leadership, collaborative relationship building, business acumen, and adaptability. With responsibility for envisioning the future of MCH for Missouri, shaping MCH strategic direction, and translating that vision into a concrete architectural blueprint for success, the MCH Director needs an experienced and effective MCH Leadership Team to help lead strategic planning, program development and implementation, policy development, budget management, staff supervision, grant coordination and management, data analysis and reporting, and ongoing quality improvement. Missouri's MCH Leadership Team provides the synergy to plan and accomplish the MCH State Action Plan and assure a strong and coordinated system of family-centered, community-based, and culturally and linguistically appropriate care and services for Missouri's MCH population.

Core MCH Leadership

Martha Smith, MSN, RN, State Director, Maternal and Child /State Lead, Public Health Nursing, has over 16 years of state tenure and over 39 years of experience in nursing and MCH, including advanced practice nursing and nursing administration, education, and consultation. She has served as the state MCH Director since March 2019, previously serving as the Interim Director of the Center for Local Public Health Services and the MCH Services Program Manager. (1.0 FTE supported with Title V funding)

Andrea Tray, MPH, CYSHCN Director, has been with DHSS since 2021, serving in her current role since October 2023. She previously served as the MCH Senior Research/Data Analyst. Andrea is the mother of a child with special health care needs. (1.0 FTE supported with Title V funding)

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 epidemiology lead for the MIECHV, Title V, and Children's Trust Fund Home Visiting Programs. (0.85 FTE supported with Title V funding)

Taufa Ahmed, MPH, MCH Senior Research/Data Analyst, has been with DHSS since 2022, serving in her current role since February 2024. Prior to working for the State of Missouri, she was a Clinical Data Coordinator for Washington University School of Medicine. (1.0 FTE supported with Title V funding)

Katrina Fernandez, MPH, IBCLC, MCH Coordinator and **State Adolescent Health Leader,** has been with DHSS since November 2024. She has a background in the nonprofit sector, focusing on education, program development, community engagement, and evaluation in the fields of vaccination and fertility health care. (1.0 FTE supported with Title V funding)

Jada Turley-Winchester, MPH, MCH Family Leader/AMCHP Family Delegate, has been with DHSS in her current role since November 2024. She also serves as the MCH Program Associate, providing support to the MCH Services contract, and previously served as a graduate intern for the DHSS Office on Women's Health, supporting the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASEMM) grant, the Informant Interviewer process initiative, and the State of Action Sexual Violence Prevention meetings. (1.0 FTE supported with Title V funding)

Sara Gorman, MSN, RN, MCH Services Program Manager, has over 17 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. (1.0 FTE supported with Title V funding)

Jami L Kiesling, BSN, RN, Chief, Bureau of Genetics and Healthy Childhood, has worked in state public health for over 14 years, with a focus on maternal and child health. She has served in her current role since 2018, overseeing the TEL-LINK, MCH WarmLine, MCH Navigator, Newborn Screening, Newborn Blood Spot Screening, Prenatal Substance Use Prevention, and Newborn Health programs. (0.66 FTE supported with Title V funding)

Family Leaders
The MCH Family Leader is a new role for Missouri. The MCH Family Leader's charge is to work with community systems of care and MCH leaders and partners to advocate for all families, children and youth, including cyshcn, and use her passion and voice to effect statewide positive change for women, children and families in Missouri. Family partnerships that include active father involvement are crucial for positive child development and well-being, and the MCH Family Leader works to elevate the importance of building strong, meaningful, and authentic relationships with fathers and supporting fathers to create and sustain family environments where everyone feels valued and supported. The MCH Family Leader also serves as the AMCHP Family Delegate.

The Special Health Care Needs (SHCN) Family Partnership Program provides resource information and peer support to families of cyshcn. The Program employs four part-time professional Family Partners, funded through the Title V MCH Block grant, who are parents of individuals with special health care needs. Each SHCN Family Partner serves a specific region of the state to support families, as well as plan, schedule, and facilitate all SHCN Family Partnership events. SHCN Family Partners bring demonstrated leadership skills and lived experience working with community agencies that support children and youth who face barriers to health and well-being. The SHCN Family Partnership Program also employs two part-time professional Family Partners for Deaf and Hard of Hearing. These two SHCN Family Partners are funded through the HRSA Universal Newborn Hearing Screening and Intervention Program Grant and serve in a statewide capacity.

The State Adolescent Health Leader, previously the State Adolescent Health Coordinator, brings an adolescent focus to broader MCH and public health initiatives, works to address system issues affecting adolescent health, and elevates youth leadership and voice. Working in close collaboration with the Adolescent and School Health Program, the State Adolescent Health Leader focuses on strengthening MCH systems, fostering collaboration, and contributing to lifelong, positive impacts for adolescents, young adults, and their families.

MCH Leadership Team members are a strong and capable group, with shared goals and vision, who bring a wide-ranging set of skills and capabilities and are committed to collaboratively, efficiently, impactfully, and cost-effectively leading MCH initiatives to improve MCH outcomes for Missouri. MCH Leadership Team members are

recognized as leaders and partners by internal and external stakeholders, providing a solid platform for leveraging resources across programs, organizational units, department divisions, other state agencies, and multisectoral partners across the state and assuring coordinated response to emerging and ongoing MCH needs. Community and stakeholder engagement in the MCH Needs Assessment process and commitment to ongoing engagement and collaboration around key MCH priorities are testament to the strength of Missouri's MCH system and provide the synergy necessary to respond to the findings of the needs assessment, maximize opportunities for innovation and improvement, and create meaningful change that will benefit the MCH population, especially those at greater risk for poor health and life outcomes.

III.C.1.b.ii.b. Impact of Agency Capacity

In 1883 the citizens of Missouri realized the state could not prosper if the health of its residents was not protected. Concerned physicians led a citizens' campaign to establish a state agency responsible for the promotion of the people's health and the prevention of disease. On March 29, 1883, the Missouri Legislature responded by creating a State Board of Health. The steady increase in the population and the extended life expectancy of Missourians show that the first State Board of Health successfully fulfilled its mandate to build an effective state public health agency. When state government was reorganized in 1945, the Board of Health was superseded by the Division of Health of the Department of Public Health and Welfare. In October 1967, the Legislature again created a State Board of Health but within the framework of the Division of Health. Members of the Board of Health are appointed by the Governor with the advice and consent of the Senate. State government reorganization in 1974 placed the Division of Health in the Department of Social Services. At that time, the Missouri Crippled Children's Service became a part of the Division of Health. The Department of Health was created in 1985 through passage of Senate Bill 25, and the Department was officially empowered, charged with supervising and managing all public health functions and programs formerly administered by the Division of Health. In 2001, Executive Order 01-02 transferred the Division of Aging to the Department of Health, to become the Department of Health and Senior Services (DHSS). Combining senior and public health issues into one system has allowed the Department to more effectively focus on prevention and quality of life for all Missourians.

In 2022, DHSS announced the launch of a new logo and identity to better reflect the department and its vision for the future of public health in Missouri. The key tenets of the Department's vision of Missouri's journey to better health are highlighted in the infographic below.

DHSS is nationally accredited by the Public Health Accreditation Board (PHAB) and recently achieved reaccreditation, demonstrating continued commitment to maintaining high standards of public health practice. This accreditation signifies DHSS meets or exceeds nationally recognized standards for public health agencies. Through investment in public health accreditation for all LPHAs, DHSS supports accreditation-related activities to enhance

the readiness and effectiveness of public health services statewide.

Missouri's MCH programming, supported by the Title V MCH Services Block Grant encompasses DHSS programs, programs at DESE, LPHAs, and numerous private and community partners. Title V funded program staff are positioned throughout multiple DHSS divisions and bureaus, offices, and units, working across all five MCH population domains. MCH team members play key roles in the community by participating on coalitions and initiatives, providing technical assistance, and representing parents of children with special health care needs. As MCH and public health champions, they share their knowledge and expertise, develop resources to promote health and improve the public health system, give voice to the needs of the MCH population, and leverage resources to meet MCH needs.

Children and Youth With Special Health Care Needs
Programming for children and youth with special health care needs is coordinated through the Bureau of Special Health Care Needs (SHCN) in DSDS, with 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. State and federal funding support SHCN services, including the Title V MCH Block Grant. SHCN accomplishes its mission in collaboration with families, health care providers, and other community, state, and national partners.

Individuals 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 Healthy Children and Youth (HCY) or Children and Youth With Special Health Care Needs (CYSHCN) programs are exempt from the medical review and are automatically qualified to choose either Managed Care or fee for service.

The Supplemental Security Income (SSI) program, established under Title XVI of the Social Security Act, provides monthly payments to individuals with disabilities, including children under 16, who have limited income and resources. In Missouri, like other states, children can qualify for SSI if they have a medically determinable physical or mental impairment that causes marked and severe functional limitations and is expected to last for at least 12 months or result in death. Eligibility for Children under 16 requires a child have a medically determinable physical or mental impairment, or combination of impairments, that results in "marked and severe functional limitations" that significantly limit the child's ability to function in age-appropriate activities; and the impairment must be expected to last for a continuous period of not less than 12 months or be expected to result in death. In Missouri, children under the age of 16 who are eligible for Supplemental Security Income (SSI) benefits under Title XVI (the Supplemental Security Income for the Aged, Blind, and Disabled Program) may be able to receive rehabilitation services for blind and disabled individuals, to the extent that medical assistance for such services is not provided under Title XIX (Medicaid). Children under the age of 18 may qualify for SSI if they have a physical or mental impairment that causes severe limitations in their daily life and is expected to last at least 12 months. Missouri's Rehabilitation Services for the Blind (RSB) offers services to help individuals with visual impairments reach their goals, including employment, and may be relevant for children who are blind or visually impaired. This program, administered alongside the Blind Pension Program, provides a monthly cash grant and MO HealthNet coverage for eligible individuals, including those under 18, who are blind or visually impaired. The MO HealthNet for the Aged, Blind and Disabled (MHABD) waiver program aims to enable children with developmental disabilities to remain with their families. The Division of Vocational Rehabilitation assists individuals with disabilities, including children, to prepare for, secure, retain, or regain employment.

The HCY and CYSHCN programs provide services to children under the age of 16 who are eligible for/receiving SSI benefits. Title V funding supports HCY program staff, however, services provided by HCY are covered as Medicaid-eligible benefits. Supported by Title V funding, the CYSHCN Program provides assistance for individuals statewide 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 require more medical services than children and youth generally. The program focuses on early identification and service coordination for individuals who meet medical eligibility guidelines. As

payor 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. CYSHCN participants are not required to have private insurance or Medicaid. If participants do have one or both, as payor of last resort, CYSHCN provides gap filling medically necessary services that are not covered by private insurance or Medicaid. Some of these rehabilitation services include but are not limited to durable medical equipment, assistive devices, physical therapy, occupational therapy, and speech therapy above and beyond what is allowed by Medicaid.

The Kids Assistive Technology (KAT) Program, administered through a contract with DESE, can provide limited funding for assistive technology, vehicle access modifications, and some home access modifications for children under age 21. KAT has two main purposes: to help when no other funding source is available, and to assist when other sources of funding are not enough to cover the costs of needed assistive technology or access modifications. Examples of items covered through KAT include: adaptive vehicle modifications (i.e. wheelchair lifts, turney seats, power chair carriers, etc.), owner occupied home access and bathroom modifications (i.e. stairway lifts, materials and labor related to wheelchair ramps, widening doorways, grab bars, elevated toilet seats, safety rails, etc.), hearing aids, augmentative communication devices, mobility aids, vision and braille devices, environmental controls, assistive technology services (i.e. evaluation and training costs).

Data Capacity
DHSS has a great deal of MCH epidemiology capacity built into its organizational structure. All components, including programmatic and data, that impact MCH practice in the state are organized within the Division of Community and Public Health (DCPH). Integrating data collection, analysis and program services provides flexibility in 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 DCPH. The centralized location of all these units catering to Missouri's MCH population and receiving support from the Missouri Title V MCH agency within one Division underscores the need for an MCH epidemiology workforce that can provide data and analytical support in a coordinated manner.

DCPH houses the core MCH epidemiology and data analysis capacity for DHSS. The Office of Epidemiology (OOE), which includes the MCH, Chronic Disease, and Communicable Disease epidemiology teams, is the Division's principal link between information science and public health, conducting much of the Division's data collection, analysis, and reporting. It also supports 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 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, infant mortality, vital statistics, reportable conditions data, and program-specific data.

The Bureau of Data Modernization and Interoperability (BDMI) was formed to enhance existing data infrastructure by modernizing old data systems while increasing interoperability across various data sources. The work of BDMI has significant benefits for MCH data analyses and dissemination. Some highlights include:

1. A new reportable disease management system that automates 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. 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 enhance the ability of MCH programs to monitor childhood vaccination data for timely program interventions.
3. The BDMI team collaborates 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 LPHA staff capacity to customize data to meet their community needs.
4. Enhanced data systems provide the MCH epidemiology team with tools to analyze MCH data and better understand and address the community and population-level factors influencing health and disparities in health outcomes. The efforts of BDMI help fill MCH Leadership to plan programs and initiatives from a more holistic and synergistic perspective.

DHSS, inclusive of MCH Leadership, looks forward to continued partnership across the state to identify opportunities for positive and sustained impact for the MCH population and communities overall. DHSS will 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.

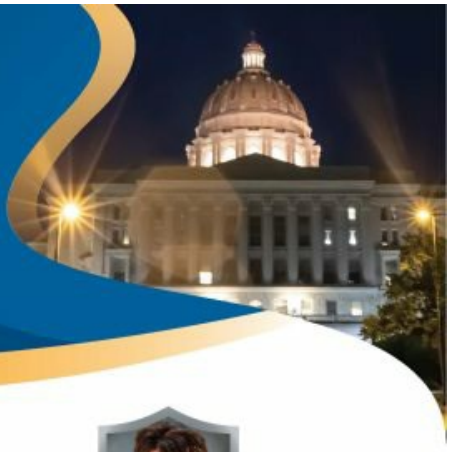
Note: Discussion of Agency Capacity is also included in Section III.C1.b.ii.a. Impact of Organizational Structure. Additional information related to agency/Title V capacity is included in Section III.B.3. Health Care Delivery System and Section III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development. The Department Overview, inserted below, provides an overview of DHSS priorities, core services, leadership, organizational structure, funding sources, budgeting, and strategic public health system efforts.


DEPARTMENT OVERVIEW
We have approximately 1,900 team members responsible for the stewardship of $2.47 billion in taxpayer funding.
What we do
Mission: To promote health and safety through prevention, collaboration, education, innovation and response.
Vision: Optimal health and safety for all Missourians, in all communities, for life.
Our core services
Disease and injury prevention
Emergency preparedness and response
Food and nutrition services
Foundational public health services
Health, animal and environmental testing
Maternal and child health services
Regulation enforcement and licensure
Senior and disability support and protection
Vital records and statistics
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
Legislative Inquiries:
Email: info@health.mo.gov
Phone: (573) 751-6003
Visit us online at
Health.Mo.Gov


WHO WE ARE
Our team is organized into six divisions in addition to the department Director's Office.
Director's Office
The DHSS Director's Office provides leadership and coordination across the department and articulates the department's vision and goals.
SARAH WILLSON
Director
RICHARD MOORE
Deputy Director
TIM VAN ZANDT
Deputy Director
Specialized Services
In addition to the Director's Office, several teams and individuals provide specialized support to team members across the department.
Chief Medical Officer
Office of Emergency Coordination
Office of General Counsel
Office of Health Transformation
Office of Legislative Affairs
Office of Special Investigations
Office of Public Information
Family Care Safety Registry
MISSOURI DEPARTMENT OF
HEALTH &
SENIOR SERVICES
Page 2

WHO WE ARE

Our team is organized into six divisions in addition to the department Director's Office.



Division of Administration

Chad Ritter
Division Director

Responsible for budget, accounting, expense control, procurement, grants, contracts human resources and other general services.

Division of Cannabis Regulation

Amy Moore
Division Director

Licenses and inspects comprehensive cannabis facilities for medical and adult-use, and issues patient identification cards.

Division of Community and Public Health

Lori Brenneke
Division Director

Manages vital records, Missouri WIC, maternal-child health, and programs that address chronic and emerging health issues.

Division of Regulation and Licensure

Bill Koebel
Interim Division Director

Regulates long-term care and health care, and designates Trauma, Stroke and STEMI centers.

Division of Senior and Disability Services

Melanie Highland
Division Director

Serves seniors and disabled individuals by investigating abuse claims, connecting them to care, and advocating for their needs.

Missouri State Public Health Laboratory

Adam Perkins
Division Director

Performs food, environmental and health testing, and protects Missourians from biological and chemical threats.


HOW WE DELIVER SERVICES
Funding requests are supportive of the strategic goals that are most impactful to the Citizens of Missouri.
Total DHSS Funding
$2.47 billion
General Revenue
$617,267,605
25%
Other
$194,854,156
8%
Federal Funds
$1,657,743,559
67%
General Revenue
$617 million
Other DHSS Programs
$122,728,237
20%
Home and Community Based Services
$494,539,368
80%
The FY26 DHSS Governor's Recommended budget for DHSS is $2.47 billion. The majority of funding comes from federal resources with the largest amount of general revenue for Medicaid Home and Community Based Services. Much of the remaining GR is required for match on the federal funds.
Board of Health and Senior Services (RSMo. Section 192.014)
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's Foundational Public Health Services
Missouri's FPHS model describes a minimum set of measurable capabilities under each area of expertise that are truly essential in every Missouri community. Areas of expertise include disease and injury prevention, environmental health, linkage to care, and maternal, child and family health.
Local Public Health Agencies
DHSS contracts with 115 LPHAs to improve public health.
Area Agencies on Aging
DHSS contracts with 10 AAAs to improve the lives of older adults.
Health.Mo.Gov
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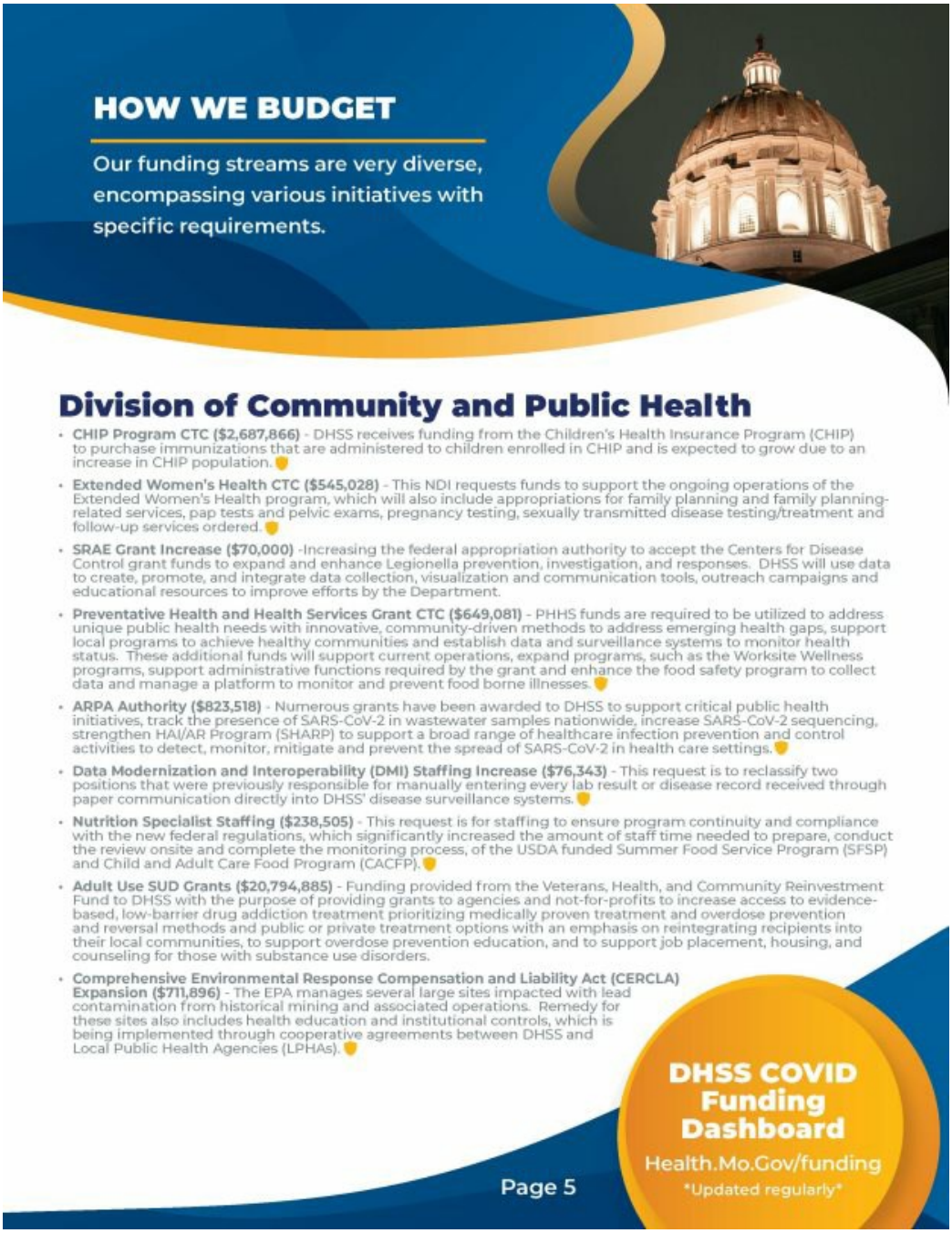
HOW WE BUDGET
Our funding streams are very diverse, encompassing various initiatives with specific requirements.
Division of Community and Public Health
• CHIP Program CTC ($2,687,866) - DHSS receives funding from the Children's Health Insurance Program (CHIP) to purchase immunizations that are administered to children enrolled in CHIP and is expected to grow due to an increase in CHIP population.
• Extended Women's Health CTC ($545,028) - This NDI requests funds to support the ongoing operations of the Extended Women's Health program, which will also include appropriations for family planning and family planning-related services, pap tests and pelvic exams, pregnancy testing, sexually transmitted disease testing/treatment and follow-up services ordered.
• SRAE Grant Increase ($70,000) -Increasing the federal appropriation authority to accept the Centers for Disease Control grant funds to expand and enhance Legionella prevention, investigation, and responses. DHSS will use data to create, promote, and integrate data collection, visualization and communication tools, outreach campaigns and educational resources to improve efforts by the Department.
• Preventative Health and Health Services Grant CTC ($649,081) - PHHS funds are required to be utilized to address unique public health needs with innovative, community-driven methods to address emerging health gaps, support local programs to achieve healthy communities and establish data and surveillance systems to monitor health status. These additional funds will support current operations, expand programs, such as the Worksite Wellness programs, support administrative functions required by the grant and enhance the food safety program to collect data and manage a platform to monitor and prevent food borne illnesses.
• ARPA Authority ($823,518) - Numerous grants have been awarded to DHSS to support critical public health initiatives, track the presence of SARS-CoV-2 in wastewater samples nationwide, increase SARS-CoV-2 sequencing, strengthen HAI/AR Program (SHARP) to support a broad range of healthcare infection prevention and control activities to detect, monitor, mitigate and prevent the spread of SARS-CoV-2 in health care settings.
• Data Modernization and Interoperability (DMI) Staffing Increase ($76,343) - This request is to reclassify two positions that were previously responsible for manually entering every lab result or disease record received through paper communication directly into DHSS' disease surveillance systems.
• Nutrition Specialist Staffing ($238,505) - This request is for staffing to ensure program continuity and compliance with the new federal regulations, which significantly increased the amount of staff time needed to prepare, conduct the review onsite and complete the monitoring process, of the USDA funded Summer Food Service Program (SFSP) and Child and Adult Care Food Program (CACFP).
• Adult Use SUD Grants ($20,794,885) - Funding provided from the Veterans, Health, and Community Reinvestment Fund to DHSS with the purpose of providing grants to agencies and not-for-profits to increase access to evidence-based, low-barrier drug addiction treatment prioritizing medically proven treatment and overdose prevention and reversal methods and public or private treatment options with an emphasis on reintegrating recipients into their local communities, to support overdose prevention education, and to support job placement, housing, and counseling for those with substance use disorders.
• Comprehensive Environmental Response Compensation and Liability Act (CERCLA) Expansion ($711,896) - The EPA manages several large sites impacted with lead contamination from historical mining and associated operations. Remedy for these sites also includes health education and institutional controls, which is being implemented through cooperative agreements between DHSS and Local Public Health Agencies (LPHAs).
DHSS COVID Funding Dashboard
Health.Mo.Gov/funding
Updated regularly
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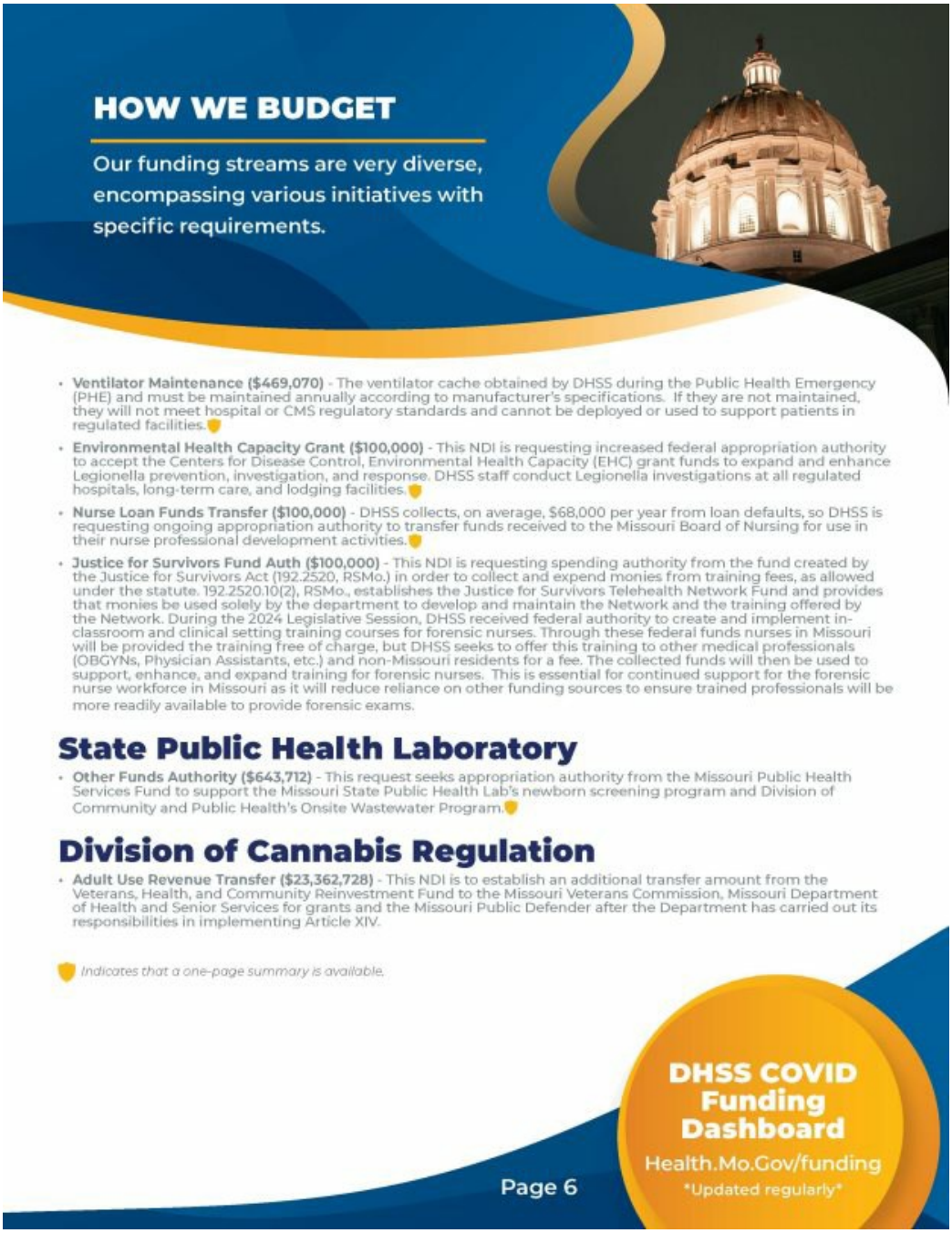
HOW WE BUDGET
Our funding streams are very diverse, encompassing various initiatives with specific requirements.
• Ventilator Maintenance ($469,070) - The ventilator cache obtained by DHSS during the Public Health Emergency (PHE) and must be maintained annually according to manufacturer's specifications. If they are not maintained, they will not meet hospital or CMS regulatory standards and cannot be deployed or used to support patients in regulated facilities.
• Environmental Health Capacity Grant ($100,000) - This NDI is requesting increased federal appropriation authority to accept the Centers for Disease Control, Environmental Health Capacity (EHC) grant funds to expand and enhance Legionella prevention, investigation, and response. DHSS staff conduct Legionella investigations at all regulated hospitals, long-term care, and lodging facilities.
• Nurse Loan Funds Transfer ($100,000) - DHSS collects, on average, $68,000 per year from loan defaults, so DHSS is requesting ongoing appropriation authority to transfer funds received to the Missouri Board of Nursing for use in their nurse professional development activities.
• Justice for Survivors Fund Auth ($100,000) - This NDI is requesting spending authority from the fund created by the Justice for Survivors Act (192.2520, RSMo.) in order to collect and expend monies from training fees, as allowed under the statute. 192.2520.10(2), RSMo., establishes the Justice for Survivors Telehealth Network Fund and provides that monies be used solely by the department to develop and maintain the Network and the training offered by the Network. During the 2024 Legislative Session, DHSS received federal authority to create and implement in-classroom and clinical setting training courses for forensic nurses. Through these federal funds nurses in Missouri will be provided the training free of charge, but DHSS seeks to offer this training to other medical professionals (OBGYNs, Physician Assistants, etc.) and non-Missouri residents for a fee. The collected funds will then be used to support, enhance, and expand training for forensic nurses. This is essential for continued support for the forensic nurse workforce in Missouri as it will reduce reliance on other funding sources to ensure trained professionals will be more readily available to provide forensic exams.
State Public Health Laboratory
• Other Funds Authority ($643,712) - This request seeks appropriation authority from the Missouri Public Health Services Fund to support the Missouri State Public Health Lab's newborn screening program and Division of Community and Public Health's Onsite Wastewater Program.
Division of Cannabis Regulation
• Adult Use Revenue Transfer ($23,362,728) - This NDI is to establish an additional transfer amount from the Veterans, Health, and Community Reinvestment Fund to the Missouri Veterans Commission, Missouri Department of Health and Senior Services for grants and the Missouri Public Defender after the Department has carried out its responsibilities in implementing Article XIV.
Indicates that a one-page summary is available.
DHSS COVID Funding Dashboard
Health.Mo.Gov/funding
Updated regularly
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HOW WE BUDGET

Our funding streams are very diverse, encompassing various initiatives with specific requirements.

Division of Regulation and Licensure

- **Prescribed Pediatric Extended Care (PPEC) Program ($115,504):** - Beginning August 28, 2025, childcare facilities licensed by the Department of Elementary and Secondary Education (DESE) that wish to operate as a Prescribed Pediatric Extended Care (PPEC) facility are required to obtain a license issued by the Department of Health and Senior Services (DHSS) (Section 192.2552, RSMo.). DHSS is tasked with licensing and inspecting PPEC facilities, along with promulgation of rules and regulations to establish standards of service and care (Section 192.2554.1, RSMo.).
- **Central Office Medical Review Unit (COMRU) Service Enhancement ($365,000):** - The Division of Regulation and Licensure, Central Office Medical Review Unit (COMRU) is experiencing a 28% increase in the volume of level of care applications and Pre-Admission Screening and Resident Review (PASRR). Failure to timely review and approve applications results in payment delays to long-term care facilities, creating a financial hardship on facilities that are already having trouble in making ends meet and paying their employees and vendors timely.
- **Board of Narcotics and Dangerous Drugs Database Replacement ($1,700,000)** - Funds for database, software maintenance and technical support. DHSS receives over 35,000 applications and issues registrations to 27 different types of licensees that issue prescriptions. The database used for license tracking is 11 years old, a new database with an online application, click and pay and certificates printed from website is necessary for continuity of operations.
- **Supplemental Health Care Services Agency (SHCSA) Program Database ($100,000) -** This request is not for new funding. This NDI request to have funds reappropriated in Fiscal Year 2026 that was appropriated in Fiscal Year 2025 as one-time funds to the Division of Regulation and Licensure (DRL) Supplemental Health Care Services Agency (SHCSA) to secure a reliable electronic program database to meet all program expectations. Due to the unknown future of the department's contract with ESRI and Qualtrics not meeting platform expectations, the Department is asking to carry over this funding to Fiscal Year 2026.

Division of Senior and Disability Services

- **Older American's Act Authority ($4,000,000)** - To allow the AAAs to expend carryover funding currently awarded from the US Department of Health and Human Services in a timely manner and to avoid returning grant dollars dedicated for senior services back to the federal government, DHSS requests an NDI of $4M federal funds. This NDI will also ensure all AAA invoices to DHSS for reimbursement are paid timely and do not cause a disruption to services for seniors.
- **Medicaid HCBS CTC ($97,732,262)** - This NDI funding is requested to continue providing Home and Community Based Services (HCBS) for Medicaid participants receiving long-term care in their homes and communities.

Indicates that a one-page summary is available.

DHSS COVID Funding Dashboard

Health.Mo.Gov/funding

Updated regularly

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DHSS State Fiscal Year 2026 Organizational Finances (All Funds)		Amount	Percent	FTE
Director's Office		**$1,060,932**	**0.04%**	**11.00**
Division of Administration		**$16,399,222**	**0.66%**	**82.35**
	Department Operational Services	$11,389,772	0.46%	82.35
	Health Initiatives Transfer	$759,624	0.03%	0.00
	Debt Offset Escrow	$50,000	0.00%	0.00
	Refunds	$401,200	0.02%	0.00
	Federal Grants and Donated Funds	$3,598,626	0.15%	0.00
	Medical Preceptor Transfer	$200,000	0.01%	0.00
Division of Community and Public Health		**755,090,110**	**30.57%**	**581.17**
	Cancer and Chronic Disease Control	$10,141,387	0.41%	21.60
	Communicable Disease Control & Prevention	11,065,688	0.45%	40.56
	Community Health & Wellness Initiatives	$16,391,543	0.66%	21.16
	SUD Grants Operations	$62,785	0.00%	1.00
	Tobacco Addiction Prevention	$300,000	0.01%	0.00
	Tobacco Cessation	$200,000	0.01%	0.00
	Community and Public Health Admin	$5,814,290	0.24%	68.40
	Emergency Preparedness & Response	$17,137,694	0.69%	36.76
	Environmental Public Health	$10,892,200	0.44%	76.66
	Genetics & Newborn Health Services	$4,772,186	0.19%	19.20
	Health Informatics & Epidemiology	$6,714,278	0.27%	55.16
	HIV, STI, and Hepatitis Services	$109,992,359	4.45%	50.50
	Local Public Health Agency Support	$18,877,192	0.76%	3.84
	Nutrition Services	$215,550,645	8.73%	68.45
	Rural Health & Primiary Care Initiatives	$16,284,111	0.66%	8.06
	Oral Health Services & Initiatives	$3,952,425	0.16%	9.43
	Minority Health Initiatives	$494,787	0.02%	4.48
	Women's Health & Wellness	$21,875,180	0.89%	17.51
	Fetal Infant Mortality Review	$1,831,926	0.07%	0.00
	Vital Records Certification & Issuance	$3,315,280	0.13%	28.40
	COVID Response & ARPA Initiatives	$279,424,154	11.31%	50.00
State Public Health Laboratory		**$19,047,241**	**0.77%**	**113.51**

DHSS State Fiscal Year 2026 Organizational Finances (All Funds)		Amount	Percent	FTE
Division of Senior and Disability Services		**$1,515,132,134**	**61.34%**	**624.69**
	Senior & Disabilty Services Program Operations	$38,356,005	1.55%	624.69
	DSDS Non-Medicaid Programs	$8,325,554	0.34%	0.00
	Medicaid HCBS/Consumer Directed Services	$721,869,457	29.23%	0.00
	Medicaid Home & Community Based Services	$655,858,136	26.55%	0.00
	Services Enhancements	$0	0.00%	0.00
	Senior Growth & Development Tranfer	$10,618,433	0.43%	0.00
	Area Agencies on Aging Contracts ^ *	$77,804,549	3.15%	0.00
	Alzheimer Grants	$1,700,000	0.07%	0.00
	Senior Independent Living Programs	$400,000	0.02%	0.00
	Naturalization Assistance	$200,000	0.01%	0.00
Division of Regulation and Licensure		**$45,752,312**	**1.85%**	**394.03**
	Regulation & Licensure Program Operations	43,471,459	1.76%	387.03
	Time Critical Diagnosis	820,927	0.03%	7.00
	Long Term Regulation (QIPMO)	$1,459,926	0.06%	0.00
Division of Cannabis Regulation		**$117,383,368**	**4.75%**	**156.50**
	Adult Use Cannabis	$14,792,924	0.60%	133.00
	Adult Use - SUD Grant	$25,318,179	1.03%	0.00
	SUD Grant to DMH	$150,000	0.01%	0.00
	Youth Services Liaisons	$1,825,325	0.07%	0.00
	Peer Respite Services	$1,500,000	0.06%	0.00
	Alcohol Abuse Prevention	$500,000	0.02%	0.00
	SUD Grants for Judicial	$250,000	0.01%	0.00
	Drug Abuse Resistance Education	$350,000	0.01%	0.00
	Medical Marijuana	$9,038,355	0.37%	23.50
	Adult Use Cannabis Transfer	$50,658,585	2.05%	0.00
	DHSS Vets Commission Transfer	$13,000,000	0.53%	0.00
DHSS Legal Expense		**$1**	**0.00%**	**0.00**
	Total	**$2,469,865,320**	**100%**	**1,963.25**
	General Revenue	**$617,267,605**	**24.99%**	**656.93**
	Federal Funds	**$1,377,563,162**	**55.77%**	**953.31**
	ARPA Federal Funds^	**$79,309,113**	**3.21%**	**12.00**
	COVID-19 Federal Funds*	**$200,871,284**	**8.13%**	**38.00**
	EFMAP Federal Funds #	**$0**	**0.00%**	**0.00**
	Other Funds	**$194,854,156**	**7.89%**	**303.01**

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

Recruitment and Retention

The state of Missouri, DHSS, is the public health system have appreciated a rebound in workforce recruitment and retention over the past couple of years. Many DHSS staff have worked for the Department for many years, and DCPH senior leaders have years of tenure with DHSS, strengthening the knowledge base and expertise in public health and MCH. In-person New Team Member Orientation for new DHSS team members creates buy-in from new team members, communicates a unified message regarding expectations and required documentation, and assures consistent “welcoming” of new team members to DHSS. Managers and supervisors are responsible for ensuring staff are qualified, properly trained, informed on current public health issues, and receive orientation specific to their

position and role.

DHSS recognizes raining and development of the workforce, including assessing the workforce and identifying gaps in knowledge, skills, and abilities, and addressing those gaps through training and workforce development opportunities, is the foundation to providing the essential services of public health. Workforce development starts with the recruitment of talented new team members and continues through the ongoing development of team members. DHSS values creating and sustaining a culture of learning and has devoted key elements of its strategic plan to the topic of workforce development and ensuring a healthy and responsive public health workforce. This workforce development plan will serve as the roadmap for investing in the workforce, offering professional development and critical training opportunities, and enhancing and strengthening public health workforce capacity.

The state MO Appreciation website encourages team members to show appreciation to colleagues and strengthen the culture of recognition. The website was designed by state team members and provides team members access to resources, ideas, and recognition opportunities. The new statewide MOMENTS initiative is aimed at connecting ambitious mentees with proven leaders to promote shared learning, strengthen teams and deepen a sense of belonging through mentoring relationships.

MO Careers (HireTrue) 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 has continued to evolve and change how state agencies hire and onboard new team members. Expansion of MO Careers requires less staff time to move positions/applicants through the hiring process and has increased consistency and efficiency in overall hiring processes. Historic pay and benefit improvements have been realized for the state workforce over the past five years, including a new years-of-service pay and retention plan provides a 1% pay differential provided to eligible state employees for every two years of continuous state service, up to a maximum of 10% with 20 or more years of service. On average, wages for state team members have increased by 27 percent since 2019, and a $75 per month match to deferred compensation contributions was implemented.

Training and Professional Development Opportunities

Missouri's Breakthrough Leadership is an introductory, foundational-level program intended to acclimate team members to working in state government and prepare team members for future leadership opportunities. The program was developed to engage new team members who are new to state government and interested in developing their public service careers and engages the three core pillars of leadership: Lead Self, Lead Others, and Lead Change.

The Missouri Leadership Academy, an innovative program that brings together emerging leaders from across all executive departments to build new skills and develop as leaders, aims to:

- Accelerate professional growth through leadership development, building new skills to lead others, and learning how to drive change.
- Prepare emerging leaders to take on new responsibilities and roles.
- Build emerging leaders with skills and understanding of how to improve government performance.

The Missouri Way training equips state team members with tools and techniques to drive change for the citizens of Missouri. This training is an essential part of the state's plan to improve its performance and develop a culture of continuous improvement by:

- Accelerating professional growth through individual leadership development, building new skills to lead others and lead change;
- Providing leaders the skills and shared understanding to improve team performance and cultivate a strong, positive work environment; and
- Developing skills across the state workforce to improve government performance.

All state employees have access to online professional development content through the new Missouri Vital

Enterprise Resource System (MOVERS), the state's enterprise-wide system for financials, human resources, budget, procurement, and more. The new system will provide enhanced functionality and improved business processes to benefit staff and leadership. State employees have access to an online library of over 16,000 high-quality courses on a wide range of professional development topics.

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 delivering excellent results, going above and beyond their day-to-day role, and consistently demonstrating a commitment to grow and learn.

The Professional and Leadership Development Award (PLDA) leverages ENGAGE to identify top performers and reward and recognize excellent work performance. Top DHSS team members are selected to receive up to $1,500 for an approved professional development opportunity, and several MCH team members have been recipients.

The FY 2021-2025 Title V MCH State Action Plan included development and implementation of a Core MCH training plan to build core competencies of internal program staff and external contractors and increase knowledge of the basic principles of MCH, Life Course Perspective, trauma-responsive care, family engagement, social drivers of disparities in health outcomes, and access to the full scope of health care. MCH Leadership provides presentations to internal and external partners on core MCH content. The MCH Director also serves as the state lead for Public Health Nursing (PHN), providing PHN leadership and facilitating PHN workforce development and other PHN initiatives. The MCH Director serves as a member of the Missouri Public Health Association (MPHA)-SPHN Section for Public Health Nursing (SPHN) Executive Committee, and other MCH team members are also active members of MPHA and SPHN. DHSS co-sponsors public health conferences and convenings to support networking and knowledge sharing across the public health system.

To expand capacity, 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, as applicable. Program staff, LPHAs, and other community stakeholders are encouraged to participate in regional and statewide trainings. 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 variety of team members to participate and benefit.

MCH Leadership is developing a specialized MCH training for Community Health Workers (CHWs) to promote utilization of CHWs with the MCH population. The training curriculum will include content related to perinatal health, maternal health, infant health, child/adolescent health, children and youth with special health care needs, and general MCH.

The MCH Learning Community, convened monthly, supports individual and collective learning and provides an ongoing forum for MCH team members to share information and resources gained from conferences, webinars, and other professional development opportunities. During the April 2025 MCH Learning Community, 2025 AMCHP Conference attendees shared key takeaways, including insights relevant to family/youth engagement, cross-collaboration, system strengthening, and new strategies, activities, interventions, and/or changes to existing processes they plan to implement. Missouri was well represented at the 2025 AMCHP Conference, with 9 DHSS team members attending.

Staffing Structures and Workforce Financing

The Special Health Care Needs (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

provides funding to employ four Family Partners who are parents of children with special health care needs, and the Universal Newborn Screening and Intervention Program grant provides funding to employ two additional Family Partners who are parents of children and youth who are deaf or hard-of-hearing. When vacancies occur in Family Partner positions, recruitment strategies include posting on multiple platforms and through Family Partner listservs. In addition, Family Partners and Service Coordinators distribute the announcement and encourage individuals who benefited from SHCN programs to apply for vacant positions. More information on the SHCN Family Partnership can be found in the CSHCN Annual Report narratives.

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, the Life Course Perspective and broad MCH and public health topics, 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.

Accomplishing the strategies to meet the objectives and evidence-based strategy measures included in the FY 2026-2030 State Action Plan and meeting the required HRSA/MCHB Title V MCH deliverables will require competent MCH Leadership and adequate support and MCH program FTEs. Many of the programs and FTEs supported by Title V funding are also supported by other 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 funding for ongoing support.

Epidemiology Workforce

Missouri's Title V MCH Block Grant provides funding support for 8.54 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 16 different individuals, as most staff in this area have braided funding through Title V and other individual program grants.

The core data team supporting Title V includes the Lead MCH Epidemiologist, a MCH Senior Research/Data Analyst, and a MCH Research/Data Analyst. The Lead MCH Epidemiologist has a Master of Public Health from an accredited university and is pursuing a Doctor of Public Health degree. She has served as the Lead 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 the Missouri Pregnancy Risk Assessment Monitoring System (PRAMS), the Pregnancy Associated Mortality Review, the Pregnancy Mortality Surveillance System (PMSS), the new statewide Fetal and Infant Mortality Review (FIMR) Network, and the Title V MCH Block Grant. This team is also responsible for disseminating MCH data to support program planning and evaluation, grant reporting, program evaluations, scholarly publications, fact sheets, and dashboards. The MCH Senior Research/Data Analyst has a Master of Public Health from an accredited university. She works full-time on epidemiological support for the Title V MCH Block Grant and is involved in ongoing needs assessment, data requests, program evaluation, and data dissemination. The MCH Research/Data Analyst has a Bachelor of Science in both political science and economics. His position is fully paid through the SSDI grant, and he works full-time on epidemiological support for the Title V MCH Block Grant, including ongoing needs assessment, data requests, program evaluation, and data dissemination.

Given the highly specialized nature of the work, DHSS relies primarily on virtual and out-of-state training for epidemiological staff, including opportunities offered by CityMatCH, the Association of Maternal and Child Health Programs (AMCHP), the CDC, and HRSA. MCH leadership supports applications for one or two staff members each year to attend the CityMatCH MCH Epidemiology training. Additionally, staff have access to on-demand virtual training on specific tools such as SAS, Tableau, REDCap, Qualtrics, and ArcGIS.

A new MCH Epidemiologist position was created to provide epidemiological support for the new statewide FIMR Network. In addition to mentoring by the Lead MCH Epidemiologist and the training detailed above, DHSS will rely

on the National Center for Fatality Review and Prevention for specialized training and technical support on the FIMR operating principles, process and data collection, analysis and reporting methods.

Like on the national stage, over the past few years, Missouri has experienced a wave of senior state and local public health professionals leaving public health, creating gaps in institutional and system knowledge and experience. Uncertainty surrounding state and federal funding, programs, and processes and fatigue from rapid and cumulative change depletes human resource capacity, inhibits productivity, stifles creativity, and overwhelms workplace resilience and coping.

Note: Discussion of the key partnership with LPHAs and efforts to enhance capacity of the MCH workforce to meet statewide goals is included in Section III.C.1.b.iii.Title V Program Partnerships, Collaboration, and Coordination.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

MISSOURI SSDI PERFORMANCE NARRATIVE

Project Identifier Information

1. Grant Number: H18MC00028
2. Project Title: Missouri State Systems Development Initiative (SSDI)
3. Organization Name: Missouri Department of Health and Senior Services
4. Mailing Address: 930 Wildwood Drive, Jefferson City, MO 65109
5. Primary Contact Information:
    1. Name and Title: Dr. Venkata PS Garikapaty, Ph.D., MPH,
       Assistant Deputy Director, Division of Community and Public Health
    2. Phone: (573) 526-0452
    3. E-mail: Venkata.Garikapaty@health.mo.gov

Accomplishments and Barriers

The purpose of the Missouri SSDI project is to develop, enhance, and expand State Title V Maternal-Child Health (MCH) data capacity to allow for informed decision-making and resource allocation that supports effective, efficient, and quality programming for women, infants, children, and youth, including children and youth with special health care needs. The primary purpose of the SSDI project is to develop a robust state data infrastructure and enhance existing systems to better support Missouri's Title V agency through improved data access and linkage. The Missouri SSDI project received funding for the 2023-2027 project cycle with the following 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 metrics for community and population-level factors that influence MCH outcomes.
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 (OOE). 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 easy access to various 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 technical assistance to develop effective work plans to address ongoing maternal and child health challenges.

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), 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 MCH needs assessments. Integrating many different data systems, the SSDI project played a critical role in the completion of the 5-year MCH needs assessment.

SSDI resources are utilized for MCH projects of special significance to the state and the 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:

- Needs assessment
- Maternal mortality initiatives
- Establish a new statewide Fetal and Infant Mortality Review (FIMR).

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

Summary of Missouri SSDI Project Accomplishments

1. The Missouri Title V agency successfully submitted the fiscal year (FY) 2025 Title V block grant application and FY 2023 report per the associated guidance. The application was funded without restrictions.
2. Supported the completion of the 5-year MCH needs assessment, including a report, dashboard, and detailed spreadsheet for LPHAs.
3. Supported identifying and integrating Title V performance measures with other data sources, including vital records, the Pregnancy Risk Assessment Monitoring System (PRAMS), and maternal mortality.
4. The Missouri PRAMS project successfully completed another year of data collection and analysis. The SSDI project contributes to Missouri PRAMS operations, including data collection, management, analysis, and dissemination.
5. Continue to support the state's maternal mortality reduction initiatives, including both the Pregnancy Mortality Surveillance System (PMSS) and the Missouri Pregnancy Associated Mortality Review (PAMR), the state’s Maternal Mortality Review Committee (MMRC) projects.
6. Missouri is providing birth, fetal death, and death data to the Division of Reproductive Health (DRH) at the CDC for automated linkage for PMSS, MMRC, and PRAMS needs through the STEVE database, thus avoiding manual intervention.
7. The MCH Epidemiology team maintained public dashboards for several MCH programs, including PRAMS, PAMR, Newborn Screening, Newborn Hearing, and Risk Appropriate Care.
8. Continued development of the statewide FIMR program.

Barriers and Strategies/Steps Taken to Overcome Them

The Missouri SSDI project has not experienced any significant barriers that have caused notable delays in accomplishing the grant's stated objectives. The following table summarizes the barriers and some strategies/steps the Missouri SSDI project has undertaken to overcome them during this project period.

Barrier/s	Strategies / Steps to Overcome Barriers
Continued challenges with Missouri PRAMS funding – a key perinatal surveillance project that Missouri SSDI supports. MO PRAMS provides valuable data to Title V and other MCH programs for program planning, evaluation, and improvement.	While the PRAMS project has seen a decrease in funding in recent years, resources from the Missouri SSDI project have been complementing the MO PRAMS project. In conjunction, they ensure that MCH programs have access to policy and program-relevant information and data.
Need for resources to enhance MCH epidemiology workforce knowledge, quality, and technical skills.	Missouri's SSDI project continues to serve as a key resource for staff working in MCH epidemiology data-related issues to attend professional training/meetings to enhance their skill set and provide quality service to the Missouri Title V agency.

Goals and Objectives

The following sections outline the progress toward the goals and objectives outlined in the Missouri SSDI grant application.

Goal 1. Build and expand State MCH data capacity to support Title V program efforts and contribute to data-driven decision-making in MCH programs.

The primary purpose of the SSDI initiative is to enhance Title V MCH programs' ability to use a wide variety of vetted, well-linked data for informed decision-making. The Missouri SSDI project has provided data support for both the Title V block grant application and ongoing needs assessment. SSDI project staff positions are also core Title V MCH positions. In such capacities, staff have central roles in key Title V MCH initiatives, including needs assessments.

Objective 1a: To strengthen MCH Epidemiological/data analysis capacity to monitor Title V performance measures. The program continues to evaluate data quality from existing sources. It also continually monitors existing surveillance systems for changes that may lead to potential new data sources relevant to the MCH population.

*Objective 1b: Provide data support to the Missouri Title V Agency for the purposes of MCH program planning and evaluation***.** The SSDI project in Missouri is housed in the MCH Epidemiology team, and the PI for the SSDI project is the Assistant Deputy Director for the Division of Community and Public Health, which includes the entire OOE. Other key SSDI staff include the Missouri SSDI Project director, who is also the project director for the Missouri PRAMS project. The MCH Epidemiology team led the 2025 Title V MCH Needs Assessment. SSDI will support Title

V and MCH efforts through data provision and analysis services to allow LPHAs to identify high-risk areas within their counties through local needs assessment, as needed.

The SSDI project will continue to provide data support to the ongoing needs assessment efforts, including continuous efforts to streamline the collection of data related to Title V/MCH structural and/or process measures. It will also assist with evaluating program outcomes.

Goal 2. Advance evaluation and development of health equity and social determinants of health metrics.

Objective 1: Utilizing existing data sources to understand health disparities and improve health equity.

BRFSS, PRAMS, and vital records data currently include measures such as race and education that allow for analyses addressing community and population-level factors that influence MCH outcomes. DHSS uses this data, available on the DHSS Minority Health webpage, to conduct analyses of community and population-level factors that influence MCH outcomes using existing data to better understand disparities affecting the MCH population.

Goal 3: Advance the development and utilization of linked information systems between key MCH datasets in the state.

Objective 3a: Improve the availability of longitudinal data on MCH indicators.
One ongoing challenge the Missouri Title V Agency faces as it seeks to ensure that its program planning and evaluation efforts are data-driven is the absence of readily available longitudinal data.

DHSS participated in the CDC's Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) initiative to study the potential impact of COVID-19 infection during pregnancy on the health of mothers and babies. The COVID part of SET-NET has been completed. DHSS has applied for funding to continue participation in SET-NET for other diseases of significance to pregnant women and their infants.

Objective 3b: Improve the timeliness of linkages. The SSDI project in Missouri will continue to develop, enhance, and support data surveys and systems as needed that enhance access to timely data (e.g., provisional vital statistics data). This allows Missouri to develop and utilize linkages between a variety of datasets containing items pertinent to MCH-related data inquiries. In addition, the Missouri SSDI project also analyzes linked data to identify priorities for programmatic intervention and opportunities for improvement, conduct smaller-scale rapid cycle change projects (e.g., Plan-Do-Study-Act "PDSA" cycles), and assess progress toward strategy implementation with structural/process measures.

Goal 4. Support surveillance systems development to address data needs related to emerging MCH issues.

Objective 4: Enhance the ability of MCH programs to use data from surveillance systems such as PRAMS.
PRAMS was initiated in 1987 as part of the Centers for Disease Control and Prevention (CDC) initiative to reduce infant mortality and low birth weight. PRAMS is an ongoing, population-based surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy, as well as during the child's early infancy among a stratified sample of women delivering a live birth. This initiative supports the data collection and dissemination efforts of the Missouri PRAMS project. PRAMS is a key data source for a variety of perinatal health indicators, ranging from preconception, prenatal, and postpartum health to life course performance metrics and community and population-level factors that influence MCH outcomes. The aims of the MO

PRAMS project are:

- Collect high-quality, population-based data as per CDC PRAMS guidelines.
- Translate the PRAMS data into information that informs policies and programs for improving the health of Missouri mothers, infants, and children.
- Build state capacity.
- Conduct and facilitate applied research that will shed new light on the issues affecting the health of mothers, infants, and children in Missouri.

The SSDI project in Missouri has supported Missouri PRAMS since 2011 and is considered vital for Missouri PRAMS operations and logistics. The Principal Investigator for the SSDI project is also the PI for the Missouri PRAMS project. The Lead MCH Epidemiologist for DHSS also serves as the program director for both projects. The Missouri PRAMS project began data collection for the Phase 9 survey and is awaiting receipt of weighted data for Phase 8 data collected in 2023 in accordance with the CDC PRAMS protocol. The program has consistently achieved CDC-recommended threshold response rates for MO PRAMS data to be included in multi-state analyses and dissemination.

Significant Changes

There were no changes to the goals and objectives of the project or staffing.

Plans for the Upcoming Budget Year

The goals and objectives for the Missouri SSDI project remain essentially the same as those listed in the original grant application and are progressing as expected.

The specific objectives for SSDI for the next fiscal year:

1. Release the new Missouri County Maternal and Child Health Risk Level dashboard. This dashboard utilizes the data from the 2025 Title V Needs Assessment and is an interactive map highlighting each county's overall risk level for the health of the MCH population, along with data for each individual indicator. The dashboard will be publicly released in coordination with the submission of this application and report. This dissemination will include notice to LPHAs and will also include an email announcement to MCH stakeholders and social media posts from DHSS.
2. Work with the state Title V program to complete the MCH Block Grant application and report.
3. Support ongoing needs assessment activities.
4. Support the newly established statewide FIMR project with respect to data collection, quality assurance, and analysis.
5. Perform data linkage activities for MCH activities using vital records, hospital records, and other data systems to support programs, including maternal mortality and morbidity reduction initiatives. This is an ongoing activity throughout the grant cycle.
6. Provide essential support to the Missouri PRAMS project with respect to data collection, quality assurance, and dissemination. The SSDI project will also collaborate with other surveillance systems, such as the Youth Risk Behavior Surveillance System (YRBSS), Behavioral Risk Factor Surveillance System (BRFSS), and National Violent Death Reporting System (NVDRS), to derive perinatal health-related data. This is an ongoing activity throughout the grant cycle.
7. Produce data dissemination products, including fact sheets, infographics, and dashboards. This is an

ongoing activity throughout the grant cycle.

8. Support Missouri's Title V programs and application by providing epidemiological support regarding performance measures reporting and future objectives. This is an ongoing activity throughout the grant cycle.
9. Enhance MCH epidemiology capacity within the state of Missouri through technical assistance and participation in HRSA MCH epidemiology training and other national workshops. This is an ongoing activity throughout the grant cycle.

III.C.1.b.ii.e. Other Data Capacity

Surveillance

Missouri Behavioral Risk Factor Surveillance System (BRFSS)

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 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).

Missouri County Level Study (CLS)

The Office of Epidemiology (OOE) collaborated with the University of Missouri-Columbia Health and Behavioral Risk Research Center (HBRRC) to conduct the 2022 Missouri County-level Study (CLS). This survey provides county-level data on a variety of chronic disease and MCH indicators. This project was a key data source for the 2025 MCH needs assessment.

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, 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. 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.

Missouri Pregnancy Risk Assessment Monitoring System (PRAMS)

The Missouri Pregnancy Risk Assessment Monitoring System (PRAMS) was initiated in 1987 as part of the CDC initiative to reduce infant mortality and low birth weight. PRAMS is an ongoing, population-based surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before pregnancy, during pregnancy, and during the child's early infancy.

PRAMS provides statewide estimates of selected perinatal health indicators representative of women who have recently delivered a live birth. It collects data through a mailed survey, an online survey, and telephone follow-up for non-responders.

PRAMS began Phase 9 in 2023. This new version of the survey added questions to support MCH, including respectful care and emergency preparedness.

Data Dissemination

Missouri MCH Needs Assessment Dashboard

As detailed in the needs assessment Sections III.C.1.a. and III.C.1.b., OOE developed a dashboard to display the

county-level data collected through the quantitative portion of the needs assessment. Each measure is displayed at the county level. It also includes the overall risk assessment of MCH in that county. The document will be published on the DHSS MCH website.

MCH Data Sources Website
DHSS has a webpage that lists a variety of MCH data sources. This site is intended to provide a central reference point to help people identify data sources relevant to MCH.

OOE has developed several publicly available dashboards to support MCH programs. The MCH program dashboards currently available include:

- Missouri MCH Dashboard: As part of the Maternal Mortality Prevention Plan and supported with both federal MCH funding and state general revenue, DHSS developed an interactive dashboard in June 2024 to display a variety of MCH indicators. The dashboard is designed to be user-friendly and does not require any special software or analytical expertise to use. To avoid duplication of efforts, this dashboard only includes data that was not already available online in a user-friendly format. By summarizing seven years of data (2016-2022) from both state and federal MCH sources, the dashboard serves as an invaluable resource for health professionals, policymakers, and the public. The dashboard aims to enhance the accessibility of data, facilitating informed decision-making that can lead to improved health outcomes. The data is organized by the Title V population domains, including a cross-cutting category.
- Missouri Pregnancy Risk Assessment Monitoring System (PRAMS): 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): 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): 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: 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.
- Birthing Facilities by Levels of Care Assessment Tool (LOCATe): The CDC developed 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. The map shows both maternal and neonatal levels of care.

The MCH Epidemiology Team also produces fact sheets on various MCH topics. New fact sheets, published in December 2023, are available on the DHSS MCH webpage. Fact sheet topics include Adolescent Suicide, Breastfeeding, Children and Youth, Infant Death and Injury, Obesity and Physical Activity, Oral Health, Pregnancy and Delivery Care, and Substance Use.

Building MCH Workforce Data Capacity
OOE travelled around the state to share information on the MCH needs assessment at the regional LPHA administrator meetings. Local administrators were briefed on the process, as well as the findings of the needs assessment. Part of the needs assessment that was new this year was including county-level data for a variety of MCH indicators. Each LPHA will be provided a spreadsheet that provides their data on all 30 indicators. This data includes both the value of that measure, along with the county's ranking in that area compared to other counties. Given that most LPHAs do not have an epidemiologist on staff, this detailed information is being shared so local public health officials have access to detailed local data without needing statistical expertise in-house. LPHAs will be able to use this information to develop their individual MCH work plans.

OOE also presented information on needs assessment to the MCH Learning Community in March 2025. This presentation educated MCH professionals on why and how we do the needs assessment and shared the findings of the assessment. Additionally, it educated attendees on MCH-related data sources that are available to support their programs.

Data Modernization and Integration

The goal of 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. Data modernization and integration efforts include:

- Working with data submitters at laboratories, hospitals, clinics, LPHAs, and long-term care facilities to transmit data electronically.
- Engaging with other DHSS programs, LPHAs, and 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.
- Automating processes when possible.

A number of projects in BDMI will impact MCH programs. First, the communicable disease system is undergoing a major upgrade. The MCH population is 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 vaccination coverage among children and adolescents.

Data Modernization Initiatives

Birth defects surveillance in the state of Missouri has historically relied on an extensive linkage between vital records (birth, death, and fetal death certificates) and the Patient Abstract System (PAS), including hospital and ER visits from hospital discharge billing information. Healthcare providers throughout the state report various health conditions through electronic case reporting (eCRs) through the Reportable Conditions Knowledge Management System (RCKMS). RCKMS currently includes 43 birth defects and infant disorders. The Bureau of Health Care Analysis and Data Dissemination (BHCADD) is partnering with the Bureau of Data Modernization and Interoperability (BDMI) to improve the birth defects surveillance system by incorporating information on birth defects reported through electronic case reporting. This one-year project is being funded through the Public Health Infrastructure Grant (PHIG) Implementation Center project, and technical support and expertise are being provided through Guidehouse. In this pilot project, DHSS is focusing on five defects with plans to expand in the future. eCRs have a distinct advantage over the current data sources used to identify birth defects in that they are reported near real-time, whereas the PAS is received on a significant delay, with final data not being available for linkage until approximately 18 months following the calendar year. This project aims to identify birth defects in eCRs and then compare this data to information found through the traditional linkage between vital records and PAS. This project will leverage the WorldCare system already being used for case management of reportable conditions and eCR ingestion. BDMI will turn on the data flow from RCKMS through Rhapsody to automatically receive birth defect eCRs and set up WorldCare to ingest and store the relevant information on birth defects. BCHADD will access this information through the WorldCare database and compare that information with the traditional birth defects information for verification and further analysis. It is anticipated this eCR data will eventually be fully incorporated into birth defects surveillance and serve as an additional source of data that will help identify birth defects in a timelier manner, as well as potentially identify more defects than what has been possible through our standard passive surveillance processes.

Public health data and surveillance systems are core components of state public health infrastructure and are critical

for communicating information with partners and the public, driving policies and actions, and assessing the health impact of policy, programs and initiatives. The first priority in Missouri's State Health Improvement Plan is Public Health System building, and one of the priority goals is to improve the Missouri public health data landscape. Toward achieving that goal, in late 2023, DHSS hired a Chief Public Health Informatics and Data Strategy Officer to advance state information systems, research, and data modernization, analysis and quality improvement. More recently, through a collaborative development effort across DHSS, DSS, DMH, and the state Office of Administration, this role now serves in an advisory and consultative capacity to facilitate strategic alignment, interagency collaboration, and implementation of a consortium model unifying health data strategy and advancing State data priorities.

Missouri Public Health Data Landscape Survey, Transformation Maturity and Strategic Assessment Report
The "Missouri Public Health Data Landscape Survey, Transformation Maturity and Strategic Assessment Report," published in January 2025, offers a detailed overview of Missouri's public health data usage, systems interoperability, and the strengths and opportunities within our public health data infrastructure. The comprehensive report is divided into three key sections: the Landscape Survey, Transformation Maturity Score, and Strategic Assessment. This report is the result of robust and collaborative efforts that have highlighted the status of data modernization in Missouri. This report guides work to enhance and modernize Missouri's data infrastructure and serves as a foundation for future strategies and areas of focus to achieve better health for all Missourians.

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

As the state's chief MCH strategist, the MCH Director works to broaden the scope of partnerships beyond DHSS and other state agencies. DHSS brings partners and programs together across programmatic silos and organizational boundaries to enhance a systems approach to ensure access to quality health care and support services and address disparities in MCH outcomes. MCH Leadership participates in the MO HealthNet Maternal/Infant Health Coordination meetings to collaborate on maternal and infant health projects and initiatives. The MCH Director serves on several Advisory Boards, including the Center of Excellence for MCH Education, Science and Practice; Missouri Child Psychiatry Access Project (MO-CPAP); Missouri Maternal Health Access Project (MO-MHAP); Missouri Congenital Syphilis Review Board; ParentLink; Substance Use Disorder Community Grant; Missouri Association for Infant and Early Childhood Mental Health (MOAIMH-EC); Missouri Public Health Association-Section for Public Health Nursing; and Missouri Institute for Community Health. DHSS contracts with ParentLink to manage TEL-LINK, Missouri's toll-free MCH hotline; implement a statewide MCH Navigator program to connect parents, caregivers, and families, especially the underserved, with information, resources, and support; and maintain the MCH WarmLine. Through partnership with the University of Missouri Kansas City-Institute for Human Development, MCH Leadership engages with Missouri Family to Family to provide tools, resources, training, and peer support to people with disabilities, their families, and providers.

Key Partnerships
LPHAs are the foundation of the local public health system and are a critical link in the state's MCH system. Partnership with the LPHAs enhances capacity of the Title V workforce to meet its goals and protect and improve community well-being by preventing disease, illness, and injury and impacting social, economic, and environmental factors fundamental to optimal health. Workforce and capacity challenges faced by local public health mirror the challenges faced in public health across the state and nation. Staff turnover, lower wages compared to the private sector, difficulty recruiting qualified staff, especially in rural areas, and regional disparities in workforce distribution and capacity, especially impacting rural LPHAs, result in longstanding vacancies and create a strain on agencies and the system overall.

Many LPHAs continue to experience turnover, with an average of one to two local MCH Coordinators resigning each month. The MCH Services team provides one-on-one MCH orientation to new LPHA MCH coordinators, administrators, and other staff working with the MCH population. The program provided 63 orientations in FY 2024 and have provided 27 orientations so far in FY 2025. Program staff also provide ongoing technical assistance on the MCH Services contract and work plan, MCH initiatives/activities, and broad public health and public health nursing topics. The MCH Director provides an introductory overview of MCH and the Title V MCH Block Grant as part of the

annual orientation for new LPHA administrators.

In early 2025, the MCH Services Program team hosted three LPHA networking meetings. Meeting content included various topics identified from feedback reported on the Annual MCH Services Program Evaluation LPHA Survey. The survey asked about training needs, aligned with the Spectrum of Prevention framework, to help move MCH-related work forward. The sessions featured content experts who shared the evidence behind what was working well and provided tangible strategies to realize improved outcomes. In addition, the MCH Services Program hosts quarterly MCH Huddles with LPHA partners to facilitate cross-agency collaboration. Participants discuss challenges and identify possible solutions, while making a commitment to work together toward improvement and achieve MCH contract deliverables and outcomes. In addition to a presentation by a content expert, each MCH Huddle includes priority-specific breakout room discussions. To build rapport and trust with LPHA partners, MCH Program staff email a monthly “MCH Exclusive” to provide resources and support and “check-in” with LPHA partners. A shareable Contract Work Plan Toolkit increases visibility of LPHA contract work, provides an opportunity for peer-to-peer sharing, and increases knowledge of evidence-based strategies.

The Adolescent and School Health Program (ASHP) partners with the Missouri Chapter of the AAP to sponsor conferences and training opportunities for school nurses and local physicians. ASHP staff serve on advisory committees for the Medicaid in Schools Program, Center of Safe Schools, Missouri Association of School Nurses, and MO Eating Disorders Council. ASHP partners with the Missouri Foundation for Health, Missouri Legal Aid Society, and DSS Family Support Division to provide training on assisting families to understand the Medicaid system; DESE Food Service regarding family applications for free and reduced meals; DESE School-Based Mental Health Providing trainings to school districts to utilize the School Health Assessment and Performance Evaluation System (SHAPE); and Missouri School Board Association regarding new laws and policies related to children in schools. ASHP maintains a strong partnership with the MCH Services Program to encourage relationship building between school districts and their local LPHAs to further integrate child and family health from a community perspective. ASHP partners with the MCOs to educate school health staff and families about the benefits available from the Managed Care Health Plans.

To support school health workforce development, the Adolescent and School Health Program:

1) Developed and launched online learning modules to address the unique needs of medically fragile students attending school, as well as continuing education courses for those new to working in a school health office, puberty education for school nurses, and comprehensive school nursing.
2) Provides training, resources, and technical assistance to school districts who wish 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.
3) Provides 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 parents, community members, and school staff have an increased understanding of infection control and confidence in the school as a safe place to learn. Missouri received permission from the AAP to adapt the existing TEAMS framework to look at infection control and disease prevention, thus this program is unique to Missouri.
4) Partnered with the Association for Professionals in Infection Control and Epidemiology to develop a MOKIDS TEAMS Toolkit with modules for a variety of stakeholders on infection control and communicable disease prevention in the school setting.

State early childhood (EC) programs, including Child Care Inclusion and Child Care Health Consultation, are consolidated in the Office of Childhood (OOC) at DESE. To meet the authorizing legislation requirements of Section 509 of the Social Security Act, an interagency contract between DHSS and DESE establishes: DHSS 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. The MCH Director, DMH EC Wellness Expert, and OOC work together to maximize resources, reduce duplication of services, provide a coordinated and comprehensive statewide system ofservices, and improve

system-level leadership, alignment, capacity, and coordination of program activities. . System-wide implementation of the AMCHP's A Roadmap for Collaboration among Title V, Home Visiting, and Early Childhood Systems Programs: Accelerating Improvements in Early Childhood Outcomes (Roadmap) is facilitated via EC Summits, convened by DMH.

The Children's Trust Fund (CTF) coordinates state evidence-based home visiting reporting, performance evaluation, and collective impact, including the Title V funded home visiting contracts administered by DHSS. DHSS will execute a MOU with CTF to establish a framework for collaboration and coordination, outlining shared intentions, objectives, and responsibilities. MCH Leadership and the MCH Services Program will collaborate with CTF to align Title V funded home visiting contracts and evaluation metrics with other statewide home visiting services. MCH Leadership will convene a group of subject matter experts in home visiting, group care models, MCH, and curriculum development, along with CTF, to research group family visiting models and develop a curriculum for piloting implementation of group family visiting.

Regional Special Health Care Needs (SHCN) Children and Youth With Special Health Care Needs (CYSHCN) Service Coordinators connect families to community-based resources and work in partnership with a wide variety of stakeholders and organizations. SHCN engage with various councils and advisory groups, including the Missouri Assistive Technology Advisory Council, the Missouri Commission on Autism Spectrum Disorders, the Missouri Interagency Transition Team, and the Missouri Developmental Disabilities Council to promote collaboration and improve outcomes for cyshcn. Another example of partnership is the MOU between the DESE First Steps Program and the CYSHCN Program, which outlines a joint commitment to deliver a coordinated, statewide system of early intervention services for children from birth to age three.

The Newborn Screening Program collaborates with birth hospitals, midwives, LPHAs, and community health workers to disseminate information and education to families about newborn screening. The Newborn Hearing Screening Program (NHSP) contracts with Missouri State University for the MOHear Project and audiology consultants. MOHear consists of five regional consultants located in each area of the state (Northwest, Northeast, Central, Southwest, and Southeast) and comprises audiologists, speech-language pathologists, or educators of deaf or hard of hearing (DHH). MOHear helps parents understand their baby's diagnosis and early intervention options. As part of a collaborative effort, infants who fail their newborn hearing screenings and diagnostic evaluations are referred to the DESE First Steps Program. This partnership allows infants and toddlers to be evaluated for early intervention services and increases the likelihood of DHH children advancing their language and literacy milestones. NHSP also contracts with Family Partnership (FP), a family-based organization of parents whose child is DHH. The FP-DHH team offers parent-to-parent support to families with an infant newly diagnosed as DHH and provides resources, opportunities to network with other families, and emotional support through parent retreat workshops, in-person events, and virtual webinars. FP also sends out weekly newsletters to families with activities throughout the state to provide awareness and create a partnership between the hearing and DHH communities. The Early Hearing Detection and Intervention Quality Improvement workgroup, the Missouri Genetic Advisory Committee's Newborn Hearing Screening Standing Committee, and the Kansas City Early Hearing Detection and Early Intervention-Learning Community, along with the contracted MOHear Project and Family Partnership, contribute to the improvement of the Missouri Early Hearing Detection and Intervention (EHDI) system as part of the NHSP.

The State Breastfeeding Coordinator (SBC) is supported by Title V and WIC funding, allowing the SBC to integrate MCH breastfeeding initiatives into WIC local agency (LA) services and ensure promotion of MCH breastfeeding initiatives to LA staff. Partnering with WIC increases community participation in initiatives like the Breastfeeding Friendly Worksite and Breastfeeding Friendly Childcare programs to increase breastfeeding support in the community. Many WIC LAs also participate in local breastfeeding coalitions and encourage hospitals to become Baby-Friendly or to be recognized as a Show-Me 5 hospital. WIC staff are included in hospital breastfeeding task forces and committees as community representatives, and they provide valuable input about the needs of mothers with the lowest initiation and duration rates. The SBC works with BCHW to plan and deliver breastfeeding initiatives for the CDC State Physical Activity and Nutrition (SPAN) grant. The SBC and SPAN program staff partner on the Missouri Baby-Friendly Hospital Collaborative, a monthly webinar series that provides learning and networking

opportunities to hospital staff. The SBC also participates in the Missouri Breastfeeding Coalition, which hosts bi-monthly virtual networking opportunities for local breastfeeding coalitions and other stakeholders. The SBC works with community partners, such as the Bootheel Resource Network (Unite Us), a collaborative closed loop electronic resource and referral platform, and doula organizations around the state to promote, protect, and support breastfeeding. The SBC provides or coordinates training for stakeholders throughout the state on an as-needed basis, including hospital staff, dietetics students, home visiting nurses, and other community organizations.

The Chief Dental Consultant and ODH partner with DSS, the Missouri Coalition for Oral Health (MCOH), MPCA, and the Missouri Dental Association (MDA) to promote oral health education. MDA is integral in increasing Medicaid enrollment rates and advancing innovative methods to deliver dental care to the underserved and coordinates the Missouri Mission of Mercy (MOMOM), which provides free dental care to Missourians of all ages who cannot otherwise afford or access care. MCOH is integral in promoting the benefits of being a Medicaid provider to dental professionals and facilitating provider onboarding with MO HealthNet and the MCOs. MPCA provides a vital communication bridge to the FQHC dental directors by providing them with the latest oral care information and updates from ODH.

Note: Additional information regarding Program Partnerships, Collaboration, and Coordination is included in the individual State Action Plan Narratives by Domain. Discussion of stakeholder engagement in programmatic decisions is included in other Section III.C. narratives.

III.C.1.b.iv. Family and Community Partnerships

MCH Leadership and programs continue 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 2026-2030 State Action Plan. As part of the 2025 statewide Five-Year MCH Needs Assessment, 18 listening sessions were held across Missouri to solicit feedback on important and missing maternal and child health services, barriers to maternal and child mental health, postpartum supports, and services and supports for children and youth with special health care needs. Raising awareness of and access to available resources was a pervasive theme throughout the focus group discussions, and the need to intentionally promote partnerships with individuals, families, and youth-led, family-led, and community-based organizations to ensure youth, family, and community engagement in decision-making, program planning, service delivery, and quality improvement activities was identified as a core value to be applied across all priorities, performance measures and strategies in the FFY 2026-2030 State Action Plan. Family partnership across the full scope of MCH is a priority area of focus for the Children and Youth with Special Health Care Needs (CYSHCN) Director. MCH Leadership remains committed to engaging with families at all levels and across all aspects of the FFY 2026-2030 State Action Plan and encourages all programs to pursue intentional partnership with families and family-led organizations.

As part of the State Health Assessment (SHA) conducted by DHSS to identify leading health issues facing Missourians and develop a strategic plan for strengthening Missouri's public health system, qualitative feedback was gathered during listening sessions conducted in geographically, socioeconomically, and demographically varied communities across the state. The SHA informed the development of priorities to be addressed in the State Health Improvement Plan (SHIP), which describes how DHSS, stakeholders, and the communities served can work together to improve the health of Missouri's citizens. DHSS strategic priorities include focusing on building partnerships and transparency and using clear and consistent communication to educate and build trust.

A DHSS workgroup, including the MCH Director, was convened to update the administrative policy regarding advisory bodies, including boards, commissions, committees, and task forces appointed by the governor or department director or developed as a result of grant requirements or urgent needs or conditions. The policy outlines the roles, compensation, appointment procedures, and departmental coordination of such bodies. The policy includes provision requiring the board to include members and reflect the demographic composition of the community when an advisory body exists to provide advice on any specific community. In alignment with other department and state policies, all appointments to advisory bodies appointed by the governor or department director will be contingent upon passing a background check, including employment history, criminal history, disqualification from working with consumers receiving services from the department (Employee Disqualification List), and history of debarment or suspension in accordance with 45 CFR Part 76. To allow more intentional engagement of community

members and families and not exclude community and family members based on employment or criminal history, a provision was added delineating groups that do not require appointments from the governor or department director as falling outside the purview of the policy. Gatherings of partners, stakeholders, community members, or professionals providing their expertise are not required to go through an application or appointment process. Based on the updated policy, a new MCH Alliance, including community and family members, individuals with experiential insight, and youth representation, is being convened to serve as a MCH think tank, sharing information and ideas, identifying new/emerging MCH needs, brainstorming solutions to priority MCH issues, and providing feedback on MCH plans, initiatives, and outcomes.

MCH Leadership is actively engaged with and supportive of numerous local and regional community-based organizations that center individuals with experiential insight and community member leadership. For example, Generate Health builds collective power to advocate for fair and impartial policies and practices that center, support, and celebrate Black families throughout their pregnancy and parenthood journeys. Generate Health brings together wide-ranging and geographically and demographically representative stakeholders from community, nonprofit, government, and academia to leverage pooled resources and expertise. The Generate Health Community Leaders Cabinet co-designs decision making and accountability structures with the Governance Committee, and a Transformation Team, consisting of members of the community, board, and staff, provides accountability.

The Missouri Bootheel Regional Consortium (MBRC), one of Missouri's Healthy Start programs, convenes a Community Action Network, comprising a wide-ranging, cross-sectoral representation of families and community members, agencies, and businesses, to establish a common agenda, with shared mission and priorities, to address the complex perinatal health issues in the communities served. MBRC facilitates a virtual Maternal Child & Family Health Learning Community for Healthy Start participants, Consortium volunteers, providers, and partners. MBRC's Fatherhood Program engages fathers and offers a space for men of all ages and backgrounds to share from their wealth of personal experience, obtain one-on-one education, and participate in open forum Rap sessions to discuss topics they value as important.

Nurture KC's, Missouri's other Healthy Start program, Community Action Team (CAT) works on the Cribs for Kids National Infant Safe Sleep Initiative to get all Kansas City metro hospitals certified in infant safe sleep practices and ensure staff educate parents on infant safe sleep before they leave for home with their babies. The CAT includes community advocates and a mom who participates in the Healthy *Start program.*

In partnership with the Missouri Hospital Association, as part of the Maternal Mortality Prevention Plan, standardized evidence-based protocols and protocol toolkits for maternal-fetal health care have been and are being developed and implemented. One of the protocol toolkits being developed will address obstetric emergency triage and care, including stabilizing and ensuring appropriate levels of care for mother and baby. Community forums are being conducted in rural obstetric deserts to gather community input on ways to improve rural health care for moms, babies, and communities.

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 Program hosts statewide events to benefit families through development of leadership skills, networking among peers, and staying current with trends and issues regarding special health care needs. SHCN utilizes input and guidance from the Family Partners, and the families served, to enhance the quality of services and support for children and youth with special health needs. This includes seeking input from Family Partners to support the integration of the family perspective when developing SHCN publications and educational/outreach materials. Family Partners, who are parents of individuals with special health care needs, provide information and peer-to-peer support to families. They are experts in connecting with community partners to link families to the appropriate resources. In addition to supporting families, the Family Partners plan, schedule, and facilitate all Family Partnership meetings, including the Family Partnership Parent and Caregiver Retreat. This ensures these events are led by

families for families. The SHCN 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 also provides the opportunity for family input on various activities, such as the development of SHCN materials related to medical home and the Five-Year MCH Needs Assessment. 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. SHCN hosts the Retreat annually. This year's retreat will be held in August, and the theme will be "Just Keep Swimming". Related information can be found in the Children with Special Health Care Needs (CSHCN) Application Narrative under the Medical Home – Family-Centered Care NPM.

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 and resources to achieve a good life.

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 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 SHCN Family Partnership originated in 2001. 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 cyshcn so they can make informed decisions about their children's health. They 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 program staff across DHSS. They also provide education to Service Coordinators on the services provided by the Family Partnership Program and the unique issues facing families of cyshcn. In collaboration with the Newborn Hearing Screening Program, SHCN expanded the Family Partnership Program by adding two additional Family Partners. These two 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 and youth 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.

As a result of collaboration between Family Partners and Tri-County Health Department, an invite was extended on August 26, 2024, to submit a proposal to present at the Missouri Coordinated School Health conference. Family Partners and Tri-County Health Department will also be presenting at the Public Health Conference in September 2025. The presentation is titled "Advancing Public Health Through Coordinated Pediatric Care: The Care Notebook Model". These connections have led to meaningful results, including opportunities for the Family Partners to share the information through presentations and outreach efforts. For example, Family Partners plan to highlight the Resource Guide for Missouri Families of Children From Birth to Age 12 and Your Child's Care Notebook at future Retreats, conferences, and requested presentations. One such event includes a presentation for System Point of Entry staff for Missouri First Steps in September 2025. Another example of these ongoing efforts is Missouri Family to Family's planned presentation at the 2025 SHCN Family Partnership Parent and Caregiver Retreat.

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. The state has established four regional PAC sites. Each regional site has created a core leadership team of parents to help guide the work and provide leadership in planning and hosting community cafés. A Missouri state PAC has also been convened, including representatives from each of the four regional PACs and several child-serving state departments

Home Visiting Family Engagement
The Title V 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 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 requirement to include 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 completed via the data collection program, REDcap, 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 featuring 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 and informs the vital role they have in improving the lives of Missouri babies.

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 participated 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 created 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 promotions includes 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. Training for child care providers frequently 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 in the development of Individualized Health Plans (IHPs); notification of the child not being up to date on routine immunizations; referrals to outside resources, such as MO HealthNet, developmental screening, and WIC; and to create dialog between the child care provider, the parent/guardian, and the child's health care provider, as necessary. Activities and priority needs are informed by feedback from Child Care Health Consultants. Future plans include capturing feedback on priority needs from child care programs as well. 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 112 LPHAs whose efforts include addressing risk and protective factors that influence disparities in health outcomes within families and communities through the Life Course Perspective. The MCH Services contracts requires LPHAs to identify the strengths, weaknesses, and needs of the community's MCH population. LPHA reporting includes discussion of efforts to engage families in work plan development, implementation and outcome evaluation, programming efforts, and the local MCH needs assessment process.

The Child Care Inclusion Services (IS) Program 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 experiences that include all children with or without disabilities and their families includes a sense of belonging and membership, positive social interactions and friendships, and development and learning to reach their full potential. The Inclusion Specialists provide referral services, outreach, technical assistance, and training to child care professionals and families of children with special needs. They provide training on including children with special needs in the child care setting and full range of activities available and training with a social-emotional component based on the research-based Pyramid and Conscious Discipline models. Program outreach to families and community awareness occurs through newsletters, calendars, websites, and other media. Families are engaged and inclusion services are promoted at community events such as child care conferences, at meetings related to early childhood or child care, and through local agencies that support and assist with placement of children in child care settings through phone calls, emails, and in-person contact.

NOTE: Information regarding the Missouri Maternal Health Action Network and the Network's efforts to engage families and community members, including the Moms' Advocacy Network and Moms' Leadership Academy, is included in the State Action Plan Women/Maternal Health Domain narrative. Additional content related to family partnership across all MCH efforts, including strategic planning, quality improvement, workforce development, Block Grant development and evaluation, and program outreach, is integrated throughout the State Action Plan Narratives by Domain and other Section III narratives.

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

The needs assessment was designed to enable DHSS to assess its activities and services in relation to the state's MCH needs identified through qualitative and quantitative data sources. Representative MCH stakeholders participated in an in-person convening in February 2025, where they were provided an overview of the Title V MCH Block Grant and the broader state MCH system and informed of findings from the MCH Needs Assessment process to that date. Stakeholders then rotated through impact matrix activities for each of the MCH population domains (maternal health, infant health, child health, adolescent health, and children and youth with special health care needs), as well as cross-cutting and systems building needs, evaluating potential strategies based on impact and difficulty. During the activity, comments were recorded from stakeholders, particularly regarding the most pressing issues affecting each population domain, potential strategies, and the MCH system's capacity to address those issues. Stakeholders were invited to nominally rank each potential priority option at three points during the convening: first, prior to the presentation of findings; second, after reviewing the data and key insights; and finally, after participating in the impact matrix activities. This approach allowed for a comparison of how stakeholder perspectives on the priorities evolved with increased information and engagement. The qualitative and quantitative data, in combination with the stakeholder meeting feedback, led to the identification of 8 MCH priority needs for Missouri, including 7

National Performance Measures (NPM) and 1 State Performance Measure (SPM).

Priority Areas
Based on the findings of the comprehensive MCH needs assessment, 8 priority areas have been identified, representing issues across each population domain, including a cross-cutting and systems building priority.

1. Access to patient-centered, coordinated, and comprehensive postpartum care.
2. Preventive oral health care services during pregnancy.
3. Safe infant sleep practices and environments to promote safe infant sleep and reduce sleep-related infant deaths.
4. Access to holistic oral health care services for children.
5. A stable and supportive relationship with a caring non-parental adult to enhance adolescent psychological well-being and empower youth with the tools and training to reach their full potential.
6. Smooth and successful transition from child-centered to adult-oriented health care, promoting continuity of care, improving health outcomes, and empowering youth to manage their own health.
7. Access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children with and without special health care needs.
8. Strengths-based services and supports to promote healthy family relationships and functioning, enhance resilience, foster social connections, develop knowledge of parenting and child development, and support children's social and emotional development.

Methodologies
The selection of priorities was based on a review of the full needs assessment data by the MCH Leadership Team. The needs assessment included two components that requested input on priorities for MCH in Missouri - a public survey and live polling at the MCH Stakeholder Convening. In both surveys, participants were asked to rank potential priority areas from a list of 24 choices. Both surveys had similar results, showing a consensus in priority recommendations across both the public and professional audiences. The full survey results for that section are included in the Section III.C.1.b.i. Findings – MCH Population Health and Wellbeing narrative.

Topics Not Selected
The surveys gave a very large number of possible choices to choose from. Not all issues that received support through the survey are able to be included as priority areas due to limitations on the scope of Title V and its funding. Some issues were not selected as priorities due to them being addressed through other programs, such as substance use prevention and treatment. To avoid duplication of effort and prevent inefficiency, MCH Leadership will focus targeted Title V efforts and funding support on MCH priorities not already receiving other substantial effort and/or support. Other priority issues, such as housing instability, food insecurity, and transportation, will be addressed through leveraged partnerships with other agencies that work more directly in those areas. Title V funding will be allocated to target MCH needs that fall more directly within the scope of health/public health.

Factors Contributing to Changes in Priority Needs
The list of priorities changed for this grant cycle due to a combination of information gathered throughout the needs assessment process. Public and professional input clearly identified needs around health care access. Additionally, this needs assessment included a more in-depth quantitative analysis, allowing for more insight into specific areas with poor outcomes. Finally, some issues were not included due to progress that has been made since the previous needs assessment in 2020. One example of this improvement is policy changes, such as Medicaid expansion and extending coverage of MO HealthNet for Pregnant Women to a full year after delivery, related to the previous priority area of "preconception, prenatal, and postpartum health care services for women of childbearing age." Priorities related to health and wellness promotion, such as nutrition, physical activity, unintentional injury prevention, and tobacco prevention and control, will be addressed across the new priorities as strategies to promote the targeted state and national performance measures.

Relationship Between the Priority Need and Performance Measures
Each priority measure is associated with specific measures that utilize large surveillance systems such as PRAMS

and NSCH. This will allow Title V to measure the impact of its efforts on the entire population, rather than focusing on only the specific people who receive direct services. It also avoids creating an administrative burden for data collection on individual programs by utilizing existing data sources. Each performance measure selected assesses outcomes, not processes. These data sources will also allow for analysis of the measure on specific sub-groups to identify groups that experience health disparities in that area. There are SMART goals for each measure, including baseline data and the goal for the next 5 years. Progress for each measure will be assessed by OOE on an ongoing basis as each system releases new datasets.

Stakeholder Involvement
As detailed in the *Process Description* section, there were multiple opportunities for stakeholders to contribute to the development of priority areas. The listening sessions were open to the public and provided an opportunity for in-person conversation on MCH issues and opportunities for improvement. The REDCap survey was also open to the public and specifically asked what the priorities should be for Missouri MCH. The MCH Stakeholder Convening included input from a professional audience, allowing them to share their thoughts on priorities. All of the information from those efforts, along with the full quantitative analysis, informed the final decision on priorities.

Maternal and Infant Health Priority
In response to the ongoing maternal health crisis and significant disparities in maternal and infant health outcomes, state and department leadership have prioritized perinatal health. DHSS leadership, including the Chief Medical Officer, OWH, and MCH Director, are actively engaged in, and, in some cases, leading, multiple initiatives to address gaps in perinatal health care, strengthen the maternal health workforce, and improve maternal and infant health outcomes. These strategic initiatives, funded and leveraged in part by Title V, include:

- Interagency Maternal Health Consortium - Additional information regarding the Interagency Maternal Health Consortium may be found in the State Action Plan Women/Maternal Health Domain narrative. 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; includes maternal health providers and workforce members with a variety of educational backgrounds and representative of the communities they serve; 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.
- DHSS State Health Improvement Plan (SHIP)-Priority 2 - Additional information regarding the SHIP may be found in the State Action Plan Women/Maternal Health and Perinatal/Infant Health Domain narratives.
- FIMR - as detailed below.
- Maternal Mortality Prevention Plan - Additional information regarding the MMPP may be found in the State Action Plan Women/Maternal Health Domain narrative.
- Maternal health care landscape analysis – The Chief Medical Officer and MCH Director, along with other leadership, as available and relevant, are intentionally meeting with maternal health care partners, organizations, and providers and partners around the state to identify barriers to care, including but not limited to provider/workforce availability; payment and coverage issues; supportive infrastructure; successful and innovative strategies; strategize new and alternative approaches; engage with stakeholders; and identify appropriate entities to address barriers and design potential solutions. The information gathered will inform and direct system-level strategies.

DHSS' state FY 2026 budget includes $1.83 million to administer the statewide Fetal and Infant Mortality Review (FIMR) Network. FIMR is an evidence-based process of identification and analysis of factors that contribute to fetal and infant death through medical chart review and interview of individual cases. The purpose of the FIMR process is to prevent a wide range of social, economic, public health, education, environmental, and safety factors that contribute to the tragedy of fetal and infant loss. When FIMR teams review individual cases, they are better able to understand families' experiences and how those experiences may affect maternal and child outcomes. Systematic review also leads to identification of state, regional, and local factors contributing to fetal and infant mortality and recommendations for innovative actions to improve care, services, and resources for women, infants, and families. The goals of the state FIMR Program are to:

- Provide coordinated leadership, and cohesive guidance, training, and technical assistance to regional and

local community FIMR teams.

- Standardize participation in and support of the national Case Reporting System, including standardized data collection and quality improvement efforts.
- Disseminate data and key findings from FIMR teams to inform prevention efforts, including innovative, user-friendly data visualization tools and data summaries.
- Facilitate the translation of FIMR data and recommendations into practice, system and policy change.

III.D. Financial Narrative

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$13,088,625	$10,199,806	$13,064,561	$10,790,951
State Funds	$9,987,230	$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	$23,075,855	$20,187,036	$23,051,791	$20,778,181
Other Federal Funds	$0	$0	$0	$0
Total	$23,075,855	$20,187,036	$23,051,791	$20,778,181

	2024		2025	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$13,186,864	$10,941,680	$14,494,582	
State Funds	$9,987,230	$9,987,230	$10,870,937	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$23,174,094	$20,928,910	$25,365,519	
Other Federal Funds	$0	$0	$0	
Total	$23,174,094	$20,928,910	$25,365,519	

	2026	
	Budgeted	Expended
Federal Allocation	$12,934,797	
State Funds	$9,987,230	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$22,922,027	
Other Federal Funds	$0	
Total	$22,922,027	

III.D.1. Expenditures

The State of Missouri maintains Title V MCH Services Block Grant funding allocations and expenditures for reporting in the Statewide Accounting Management System (SAM) II. Total FY 2024 expenditures reported for this application are from actual expenditures October 1, 2024 through July 11, 2025, and estimated expenditures July 1, 2025 through September 30, 2025. The Title V amount awarded to the state in FY 2024 was $12,742,189, and $10,941,680 had been spent through July 11, 2025. Total actual expenditures from July 11, 2025 to September 30, 2025, will be included in the expenditures on the FY 2024 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, Genetics and Healthy Childhood, WIC programs, Maternal Mortality Prevention, and the general funding expended by DOC for the health care costs for female offenders of childbearing age as match for the Title V MCH Services Block Grant.

The majority of Title V FY 2024 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 protective factors for youth and families, perinatal and childhood lead poisoning prevention, MCH epidemiology support, ongoing MCH Needs Assessment, and contracts with LPHAs. The principles of family engagement and access to fair and impartial care and services were interwoven throughout all Title V funded programs and initiatives. Title V funding supported MCH team members' and partners' time to participate in trainings, convenings, and collective efforts to advance health literacy, create a work environment that promotes input and trust from all levels and people, collaborate with health care partners to access data and tailor services to resolve access issues for at-risk communities and populations, and address the community and population-level factors that influence and contribute to disparities in MCH outcomes.

Missouri complied with the 30%-30%-10% requirement, as specified in the guidance. The FY 2024 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 $3,462,627 (31.6%)
- Children with Special Health Care Needs $3,522,376 (32.1%)
- Administrative Costs $928,541 (8.5%), which is less than the allowable 10%

Form 3a Expenditure Details by Types of Individuals Served

Expenditures by the Types of Individuals Served:

- Pregnant Women $1,583,571
- Infants < 1 year $1,437,666
- Children 1 through 21 years $3,462,627
- Children with Special Health Care Needs (CYSHCN) $3,522,376
- All Others $6,899

Form 3b Expenditure Details by Types of Services

Detailed expenditures by Types of Services:

- Direct Services $299,340
- Enabling Services $3,410,382
- Public Health Services and Systems $7,231,958

Although the specific expenditure amounts are different due to lower actual FY 2024 total expenditures, the percentage of Title V funding expended by population domain and type of service remained generally consistent with the planned budget.

As illustrated in the table below, the MCHBG funding supported key programs within the DHSS divisions of DCPH and DSDS, the Office of Childhood at DESE, and contracts with the LPHAs and other key partners to improve the health and wellbeing of Missouri mothers, infants, and children, including CYSHCN. These program efforts and associated outcomes were not covered or reimbursed through the Medicaid program or another provider and could not have been achieved without federal MCH Block Grant funding support.

DHSS	Federal Expenditures (Title V)	State Match
Special Health Care Needs	$1,374,673	$1,271,028
Community Health Services and Initiatives	$3,626,871	$125,248
Environmental Public Health	$84,954	
Epidemiology for Public Health Practice	$730,210	
Genetics and Healthy Childhood	$834,318	$764,696
Office for Women's Health	$205,319	
Office of Dental Health	$598,246	
State Public Health Laboratory		$5,574,888
DCPH Director's Office	$634,808	$502,849
Vital Records	$130,763	
Administrative	$928,541	
DESE Office of Childhood		
Personnel	$82,902	
Home Visiting	$979,904	
Safe Cribs	$58,700	
Child Care Health Consultation	$194,213	
Child Care Inclusion Services	$331,700	
Contract Indirect	$55,921	
Office of Administration		
Information Technology Services Department	$89,637	
Department of Corrections		
Services for Incarcerated Women		$1,748,521
TOTAL	**$10,941,680**	**$9,987,230**

The expenditures above illustrate the breakdown of Missouri's FY 2024 MCHBG funding to address the health and wellbeing of women of childbearing age, infants, and children, including CYSHCN. Title V funds are allocated to support the provision of health services and related activities, including planning, administration, education, and evaluation, consistent with the identified MCH priorities, planned State Action Plan, and emerging MCH needs. Actual FY 2024 expenditures are less than the projected FY 2024 budget total of $13,186,864 due to a combination of factors. Workforce turnover and shortages continued into FY 2024, other federal funding was available to offset some planned expenditures, and subcontractor expenditures were lower than anticipated due to similar workforce and funding influences. Compared to planned and budgeted activities included in the FY 2024 planned budget, the majority of planned activities have been accomplished as planned, and actual program expenditures are on track. In instances where programs or contractors were not able to accomplish planned activities, funding has been reallocated to other programmatic activities and/or special initiatives to meet ongoing and emerging MCH needs. 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 45% ($4,927,965) 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 FY 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 36% ($3,903,110) 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 MCH Epidemiology staff who provided data to evaluate Missouri's priorities, and the MCH Leadership Team who manage the Title V application and budget, provide state MCH leadership, and lead implementation of MCH initiatives. Funding for personnel support to provide Information Technology Services is also included in this amount. FY 2024 personnel expenditures also supported implementation of the Maternal Mortality Prevention Plan and statewide Fetal and Infant Mortality Review.

A total of 8.5% ($928,541) of the funding was expended for administrative costs. This was less than the maximum allowable amount of 10%.

The remaining 10.5% ($1,181,945) 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 broad MCH program implementation and workforce development. FY 2024 E&E expenditures also included expenditures related to the Five-year MCH Needs Assessment.

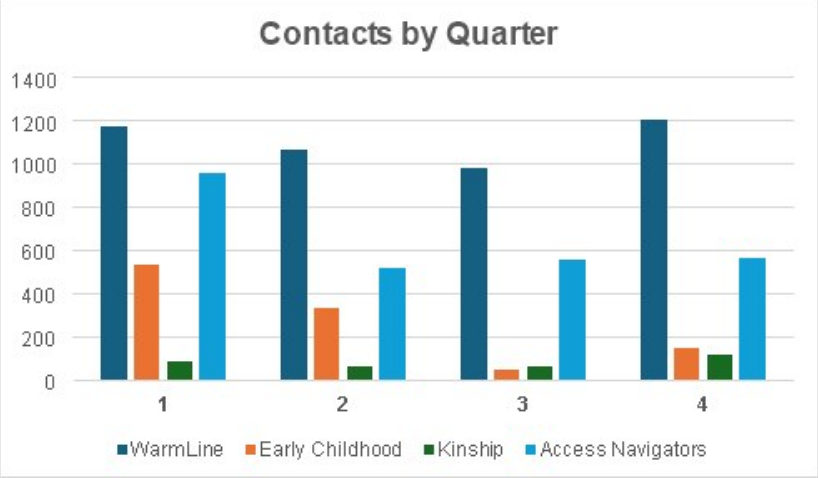
As noted in the field notes provided for Form 2, Form 3a, and Form 3b, total expenditures through July 11, 2025 are included in the FY 2024 expenditure reporting. Total expenditures through July 11, 2025, met the minimum requirement of 30% for Preventive and Primary Care for Children and 30% for CYSHCN, and remaining funding will be expended to assure at least 30% of total FY 2024 expenditures through September 30, 2025, meet the minimum requirements for Preventive and Primary Care for Children and CYSHCN. All remaining FY 24 funds will be expended by the end of the two-year grant cycle, ending September 30, 2025, and the total expenditure amounts for each population, all individuals served, and types of services provided through September 30, 2025, are expected to be higher, and final expenditure data will be reported in the annual Federal Financial Report.

Title V financial resources were allocated to support FY 2024 expenditures in alignment with the FY 2021-2025 MCH State Action Plan and to support activities and achieve outcomes as described in the FY 2024 annual report narratives by population domain. Title V funds were leveraged to support MCH Leadership efforts to promote the health of all mothers, infants, children/adolescents, including CSHCN, and families, build capacity and resources related to family and community partnerships, and intentionally and meaningfully engage families and community partners to improve MCH care and outcomes. The Maternal Health Action Network's Moms' Advocacy Network and Leadership and Self-Advocacy Academy engaged mothers with past experience with substance use during the perinatal and/or postpartum period in discussions where service delivery, policy, and support decisions are explored. At the Networks annual in-person Summit, "It Starts with Us: Innovative Approaches to Improve Maternal Behavioral Health," the voices of mothers with experiential insight were amplified and featured in a panel discussion with

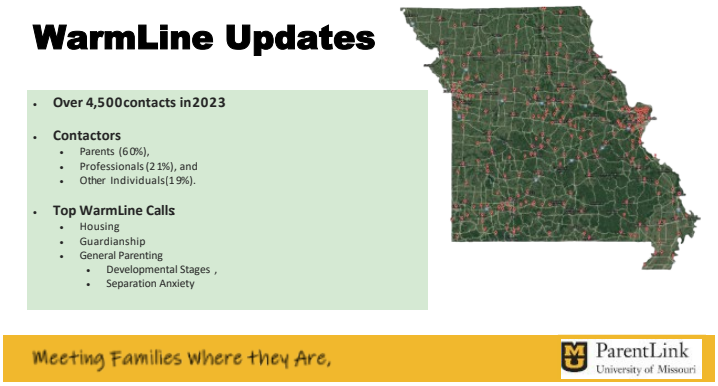
Leadership and Self-Advocacy Academy participants. Summit participant evaluations included the following comments:

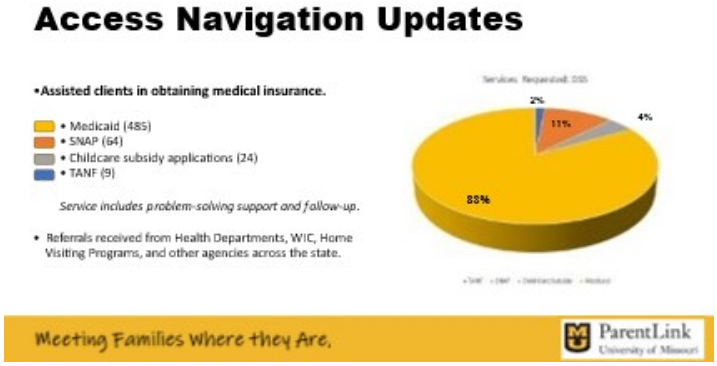
- “Anyone who works with MCH or other programs to support moms needs to come here! We cannot help moms without putting in the work and learning.”
- “Well-rounded panel of Speakers, and having mothers from the academy gave, amazing insight.”
- “I loved how the conference was action-oriented. I felt like the conversations we were having were going to actually make a difference and launch change.”
- “I thought the summit was a great way to connect with others in the community who work with this very specific demographic. Building this sense of community is what we need to spread information all throughout Missouri.”
- “I feel some buy-in this advocacy circle. I wish it were more frequent than annually.”
- “This meeting was great to network with our colleagues around emerging issues facing our families. It was incredible to hear directly from the moms with lived experience and really inspired me as I returned to work.”

DHSS continued to contract with ParentLink to administer TEL-LINK, Missouri’s toll-free MCH information line, and provide statewide MCH WarmLine and MCH Navigator services. TEL-LINK was expanded to provide same-line texting service, and 2,361 callers contacted TEL-LINK, with housing, transportation, and WIC being the three top resource needs identified. The graph below shows the number of WarmLine, Early Childhood, Kinship Navigator, and MCH Navigator contacts by quarter for calendar year 2023, with a total of 3,422 callers, representing 104 different counties, for a total of 7,326 contacts.



Through community outreach events in Southeast Missouri, over 500 boxes of food were distributed to families. The images below detail the number of contacts, categories of individuals served, and top resource needs addressed by the WarmLine and MCH Navigators in 2023.





"Together with parents and caregivers, ParentLink works to "detoxify the soil," so developmental nutrients in the lives of children can do their developmental work."

FY 2024 expenditures assured programs and contracted partners had essential support to address priority MCH needs and plan and provide services and activities to promote optimal MCH outcomes, especially for at-risk communities and maternal-child populations.

III.D.2. Budget

The Title V MCH Services Block Grant FY 2026 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 and youth with special health care needs (CYSHCN). These services are managed by the programs within DHSS and through contracts with DESE, LPHAs and other community-based 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, MCH Leadership Team, and DCPH/DHSS leadership further review and approve the budget for the next fiscal year.

FY 2026 budget projections are based on the approved award amount for the Title V MCH Block Grant in FY 2024. DHSS uses the prior year award amount since the total current year award is not known during the budget proposal phase and/or until after the grant application is submitted. With the FY 2026 proposed use of funds, every effort will be made to maintain Title V support for essential MCH programs, services, and partnerships. The final FY 2025 MCH budget exceeded the anticipated award by $1,955,270, and MCH leadership worked strategically with programs and senior leadership to identify areas for enhanced efficiency without compromising essential programs or services. This year, program requests and budget projections to support emerging needs and new initiatives totaled $12,934,797, which is $192,608 above the amount of FY 2024 funding received. Projected budget needs exceed the anticipated award due to multiple factors. State employee salaries have been increased to account for rising inflation. Funding is needed to support FTEs necessary to establish and manage new initiatives, such as the FIMR Network and other state-funded maternal and infant health programming, and the Universal NPMs require adequate workforce support to implement the strategies necessary to achieve the targeted outcomes. The need for resources, support, system and resource navigation, and parent/caregiver support is ever-growing. While Title V funding has remained relatively level, the cost to maintain essential and required MCH programs and services continues to increase. As noted in the field notes provided for Form 2, Form 3a, and Form 3b, the amount of funding included in the FY 2026 application 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. The ongoing goal is to assure maintaining or increasing services for the MCH population in Missouri, and any additional budget needs not covered by the FY 2026 Title V MCH Block Grant award will be funded with lapses in FY 2025 funding and other funding, as needed and available. Lapses in FY 2025 funding are primarily due to personnel vacancies, availability of other federal funding, and lower subcontractor expenditures than anticipated. If the FY 2026 funding received and/or FY 2025 lapsed funding is less than anticipated and/or needed, MCH leadership will prioritize FY 2026 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 emerging needs and to 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. An excel workbook, specifically created for development of the annual MCH budget and tracking and managing ongoing MCH expenditures, is used to assure planned budget allocations and services address the state’s priority needs, improve performance related to the targeted MCH outcomes, and expand its systems of care for both the MCH and CYSHCN populations. The planned 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 CYSHCN. At 8.2%, the budget used to administer Title V MCH Block Grant funds is less than the 10% maximum amount allowed. The principles of family engagement and access to fair and impartial care and services are interwoven throughout all Title V funded programs and initiatives. Title V funding supports MCH team members' and partners' time to participate in trainings, convenings, and collective efforts to advance health literacy, address community and population-level factors that influence and drive disparities in MCH outcomes, and implement strategies and initiatives to address priority MCH issues and advance optimal MCH outcomes. 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: $ 4,065,948 (31.4%)
- Children with Special Health Care Needs: $ 4,248,638 (32.8%)
- Administrative Costs: $ 1,060,397 (8.2%)

Form 3a Budget by Types of Individuals Served

Budget by the Types of Individuals Served:

- Pregnant Women: $1,739,368
- Infants < 1 year: $1,815,098
- Children 1 through 21 years: $4,065,948
- CYSHCN: $4,248,638
- All Others: $5,348

Form 3b Budget by Types of Services

Detailed budgets by Types of Services:

- Direct Services: $276,697
- Enabling Services: $4,290,301
- Public Health Services and Systems (includes administrative costs): $8,367,799

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 does not include the costs of clinical services that are reimbursed by Medicaid, CHIP, or other public or private payers. Examples of direct services in Missouri include, but are not limited to, the Kids Assistive Technology (KAT) project, Oral Health Preventive Services Program (PSP), and lead blood level testing. KAT projects include communication and mobility devices, hearing and visual devices, seating and mobility enhancements, and home and vehicle modifications for CYSHCN. PSP is an evidence-based fluoride varnish and oral health education program that anticipates serving over 100,000 children in the 2025-2026 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. Specific examples in Missouri include contracts for Home Visiting services, CYSHCN Service Coordination and Family Partnership, some Child Care Health Consultation services, some services provided by the LPHAs through the MCH Services contract, Child Care Inclusion services, and MCH WarmLine and Navigator services provided through a contract with 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. Specific examples in Missouri include system-building, health and safety promotion, maternal and infant mortality prevention, adolescent and comprehensive school health programming, safe sleep promotion, newborn screening, obesity prevention, breastfeeding promotion, prenatal substance use prevention, oral health services outreach and education, and the Maternal Health Multisector Action Network. Also included are MCH Epidemiological Services, program evaluation, MCH workforce capacity-building, technical assistance (TA) 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		
FY 2026 PROPOSED USE OF FUNDS		
FUNDING	**PROPOSED FY 2026**	
TOTAL FUNDS BUDGETED	$ 12,934,797	
FUNDING BY SERVICE LEVELS	**PROPOSED FY 26**	**SUBTOTAL**
Direct Care Services		
Assistive Technology	$ 100,000	
Oral Health Services	$ 171,097	
Childhood Lead Poisoning Prevention, Screening, and Referral	$ 5,600	
Total Direct Care Service		**$ 276,697**
Enabling Services		
Child Care Health Consultation and Inclusion Services	$ 549,865	
LPHA MCH Services Contracts	$ 880,848	
Service Coordination for Children and Youth with Special Health Care Needs	$ 1,347,020	
Family Partnership	$ 88,609	
Lead Hazard Reduction/Abatement	$ 15,400	
Oral Health Services	$ 141,783	
MCH WarmLine & MCH Navigators (ParentLink)	$ 1,266,776	
Total Enabling Services		**$ 4,290,301**
Public Health Service and Systems		
Adolescent and School Health	$ 10,000	
DESE Office of Childhood	$ 265,264	
Coordination and Systems Development	$ 3,306,121	
Epidemiological Services	$ 878,389	
Healthy Families	$ 24,650	
LPHA MCH Services Contracts	$ 2,642,543	
Nutrition Projects	$ 2,526	
Obesity Prevention	$ 10,000	
Oral Health Services	$ 28,500	
Outreach and Education (TEL-LINK)	$ 36,869	
Women's Health Initiatives	$ 102,540	
Total Public Health Service and Systems		**$ 7,307,402**
Administration (Indirect and Network Charges)	$ 1,060,397	
		$ 1,060,397
Grand Total		**$ 12,934,797**

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

Title V funds are allocated to support the provision of health services and related activities, including planning, administration, education, and evaluation, consistent with the FY 2026-2030 MCH State Action Plan and to support activities and achieve outcomes as described in the FY 2026 application narratives by population domain. MCH Leadership works closely with the Lead MCH Epidemiologist and broader epidemiology team to identify communities and populations most at risk for poor MCH outcomes and allocate Title V funding to leverage capacity, partnerships, and resources to address priority needs and disparities in health outcomes.

Funding for the MCH Services contracts with the LPHAs is based on the following formula:

"A Combined Poverty Index Score is determined for each county in Missouri by the Section of Epidemiology for Public Health Practice (EPHP). The Combined Poverty Index Score is a composite of two factors for each of the 112 participating jurisdictions. The Maternal-Infant Indicator is an unduplicated count of the most recent 5-year period (2019-2023 for FY2025) for the following resident counts from Missouri Vital Statistics birth data: 1) births to mother under 18, 2) infant and fetal deaths, and 3) low birth weight births. The Female/Child Poverty Indicator uses the most recent American Community Survey 5-year estimates (2019-2023 for FY 2025) for poverty data. It is the sum of the 1) estimated number of women 18-44, males under age 18, and females under age 15 at 185% of the federal poverty level. A base-funding amount of $15,000 is multiplied by 112 (# of LPHAs accepting contract) and subtracted from the total funding amount for the contract. The difference is then multiplied by the Combined Poverty Index Score for each county and added to the base-funding amount to arrive at the total award amount for each LPHA."

Title V funds will be leveraged to support MCH Leadership efforts to promote the health of all mothers, infants, children/adolescents, including CYSHCN, and families, continue to build capacity and resources related to family and community partnerships, and intentionally and meaningfully engage families and community partners to improve MCH care and outcomes. The MCH Director travels extensively around the state to actively engage with health professionals and community partners working at various levels across the health care system and MCH community partner landscape, including direct care providers, organizational design and governance leaders, policy advocates and decision-makers, social support providers, faith-based organizations, and various other community-based organizations and community members.
A total of $6,344,522 (49%) of the funding is for contracts with the LPHAs and other community organizations. Contracted funds will support the state priorities and associated activities listed in the FY 2026-2030 State Action Plan.

A total of $4,917,088 (38%) of the funding is for personnel to provide program oversight and TA. TA is provided to programs and contractors to assist with implementation of services and activities that impact the MCH priorities and population. This amount also supports MCH Epidemiology staff who provide data to evaluate Missouri's priorities

and the MCH Leadership Team who manage the Title V MCH Services Block Grant application and budget, provide statewide MCH leadership, and lead implementation of MCH initiatives. Funding for personnel support to provide Information Technology Services is also included in this amount.

A total of $1,060,397 (8.2%) of the funding is for administrative costs.

The remaining $612,790 (4.8%) 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

Missouri is committed to meeting the mandated 4:3 ratio of federal to non-federal funds, based on actual FY 2026 federal expenditures. The state's maintenance of effort level from 1989 is $9,987,230, and the state's calculated non-federal match requirement for FY 2026 based on the planned budget total is $9,987,230. The total Federal and State MCH budget includes projected expenditures identified as benefitting the health of the maternal and child populations in Missouri and improving the state’s public health system for mothers, children, and families, including CYSHCN. These funds come from the Title V MCH Services Block Grant and state general revenue. Federal funds are legislatively appropriated to the DHSS, where MCH Leadership and the Title V MCH Program reside. Although not all programs are under the structural organizational authority of the MCH Director, the MCH Director maintains full oversight and authority for all Title V MCH Block Grant funding and supported programming. The majority of State Funds are for maternal mortality prevention, fetal and infant mortality review, newborn screening through the DHSS State Public Health Laboratory, direct care for CYSHCN, health promotion, 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, combined Title V MCH Block Grant and State funding supports key programs within DHSS, the Office of Childhood at DESE, DOC, and local public health. Funding also supports maintenance for specific MCH data systems and providing women/maternal health services to incarcerated women. FY 2026 expenditures will assure programs and contracted partners have essential support to address priority MCH needs and plan and provide services and activities to promote optimal MCH outcomes, especially for at-risk communities and maternal-child populations. Title V financial resources will continue to be allocated to support the Maternal Health Action Network, the MCH WarmLine and MCH Navigators at ParentLink, and family and community partner engagement. The Maternal Health Action Network will continue to facilitate the Moms’ Advocacy Network, Leadership and Self-Advocacy Academy, and annual Summit. Family and community members will be actively engaged in the new MCH Alliance to inform state MCH leadership, decision-making, and policy recommendations.

DHSS	Federal Funds (Title V)	State Funds
Special Health Care Needs Programs	$1,535,629	$1,119,728
Community Health Services and Initiatives	$6,001,495	$110,304
Environmental Public Health	$28,000	
Epidemiology for Public Health Practice	$878,389	
Genetics & Healthy Childhood	$743,502	$673,433
Safe Cribs	$73,563	
Office for Women's Health	$151,365	
Office of Dental Health	$635,446	
State Public Health Laboratory		$4,910,693
DCPH Director’s Office (including Maternal Mortality Prevention)	$768,075	$442,667
Vital Records	$132,724	
Administrative	$1,060,397	663,523
DESE Office of Childhood		
Child Care Health Consultation	$330,561	
Child Care Inclusion Services	$456,320	
Contract Indirect	$28,249	
Office of Administration		
Information Technology Services Department	$111,082	
Department of Corrections		
Services for Incarcerated Women		$2,066,882
TOTAL	**$12,934,797**	**$9,987,230**

*Information about the structure and programming of DHSS can be found in discussions of Program Capacity included in other 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 (Optional)

State Action Plan Narrative Overview

Missouri's Title V MCH Services Block Grant efforts support critical infrastructure, workforce, and public health strategies to build a robust statewide system of care and services for children (with and without special health care needs) ages 0-21 years, pregnant women, and their families. To improve the health and well-being of all mothers, children, and families, particularly those with low incomes or limited access to care, MCH programs focus on promoting health and safety through preventive and primary care, care for children with special health care needs, and family-centered, community-based care. The FFY 2026-2030 MCH State Action Plan and State Action Plan Narratives by Domain highlight the planned activities for FFY 2026 and outcomes accomplished in FFY2024, either as a direct result of Title V funding and support or an outcome of leveraging Title V capacity.

Overarching Areas of Note
MCH Leadership works with a broad range of partners/stakeholders, including community health centers, health systems, community-based organizations, and social services agencies, and engages partners/stakeholders to identify priorities, align goals, share resources, coordinate efforts, improve access to care, enhance care coordination, and address disparities in MCH outcomes.

MCH Leadership engages in cross-sector partnerships and collaborations to design, implement, and evaluate quality improvement initiatives to increase access to family-centered, coordinated, comprehensive, and community-based health care services and supports.

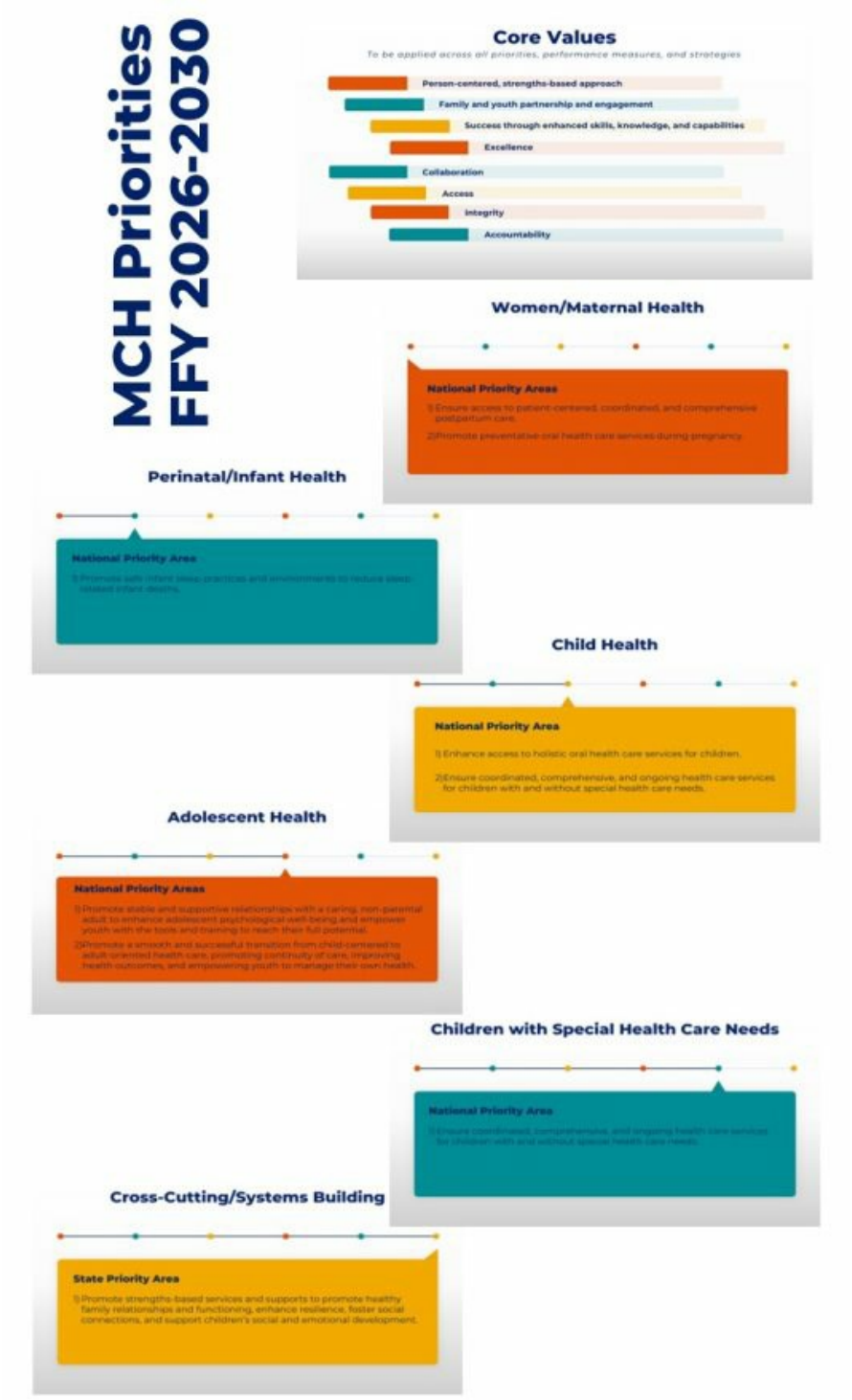
Efforts to advance access to family-centered, coordinated, comprehensive, and community-based health care services and supports for women, children and adolescents, including children and youth with special health care needs, and families are integrated throughout MCH State Action Plan strategies to provide opportunities to:

- Promote healthy lifestyles and effectively case manage obesity and other chronic conditions as part of a whole-person, person-centered approach;
- Promote the values of patient/family-centered shared care planning to operationalize core values of family-centered care and ensure families are full partners in their health care;
- Maximize opportunities to engage families in processes and initiatives, including development of resource materials, trainings/education, and program development, implementation, and evaluation; and
- Enhance health literacy skills by providing health information that is accessible, clear, and actionable.

Local Public Health MCH Contracts
In FFY 2026, LPHA contractors will complete year five contract work plan activities to achieve desired system outcomes outlined in their FFY 2022-2026 contract work plans. A contract outcomes report will be completed, evaluating performance trends and providing conclusions across the five-year contract work plan cycle. Contracting LPHAs will conduct a focused local MCH needs assessment, seeking input from MCH stakeholders, including families, consumers, providers, and other community partners, about local MCH issues and, based on local needs assessment findings, select at least one priority health issue from the Missouri Title V MCH Block Grant FFY 2026-2030 MCH Priorities and develop a five-year work plan (FFY 2027-2031) to address the selected priority health issue(s). The MCH Services Program will provide educational and technical assistance opportunities to increase LPHAs' knowledge and skills on utilizing the MCH Evidence *What Works Evidence Accelerators* to develop the FFY 2026-2030 contract work plans. Contracting LPHAs must also establish a five-year (FFY 2027-2031) evaluation plan for tracking and monitoring progress on the work plan and analyzing performance trends, including

identification of targeted outcome measure(s), evaluation questions, performance indicator measures, method(s) for tracking and monitoring progress, data sources(s), and methods for analyzing performance trends.

The picture below provides a bird’s eye view of the selected priorities and overarching core values to be addressed in the FFY 2026-2030 MCH State Action Plan.


MCH Priorities
FFY 2026-2030
Core Values
To be applied across all priorities, performance measures, and strategies
Person-centered, strengths-based approach
Family and youth partnership and engagement
Success through enhanced skills, knowledge, and capabilities
Excellence
Collaboration
Access
Integrity
Accountability
Women/Maternal Health
National Priority Areas
1) Ensure access to patient-centered, coordinated, and comprehensive postpartum care.
2)Promote preventative oral health care services during pregnancy.
Perinatal/Infant Health
National Priority Area
1) Promote safe infant sleep practices and environments to reduce sleep-related infant deaths.
Child Health
National Priority Area
1) Enhance access to holistic oral health care services for children.
2)Ensure coordinated, comprehensive, and ongoing health care services for children with and without special health care needs.
Adolescent Health
National Priority Areas
1) Promote stable and supportive relationships with a caring, non-parental adult to enhance adolescent psychological well-being and empower youth with the tools and training to reach their full potential.
2)Promote a smooth and successful transition from child-centered to adult-oriented health care, promoting continuity of care, improving health outcomes, and empowering youth to manage their own health.
Children with Special Health Care Needs
National Priority Area
1) Ensure coordinated, comprehensive, and ongoing health care services for children with and without special health care needs.
Cross-Cutting/Systems Building
State Priority Area
1) Promote strengths-based services and supports to promote healthy family relationships and functioning, enhance resilience, foster social connections, and support children's social and emotional development.

III.E.3 State Action Plan Narrative by Domain

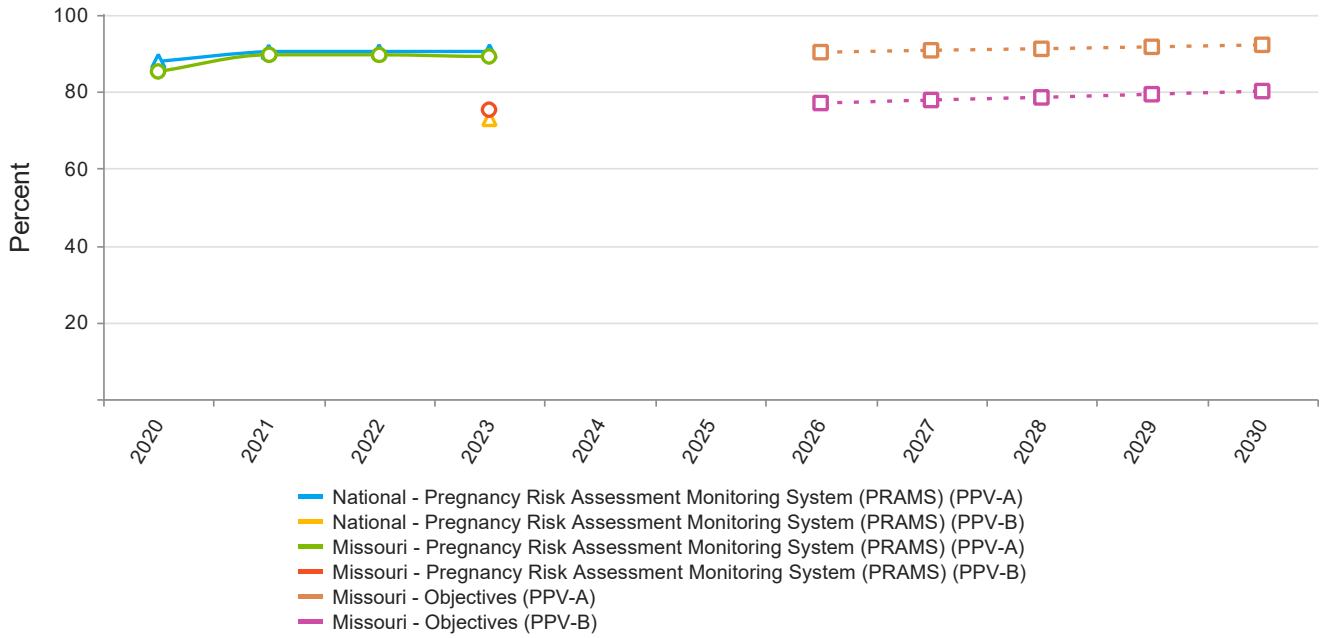
If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.

Women/Maternal Health

National Performance Measures

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	89.3	89.1
Numerator	56,979	53,527
Denominator	63,820	60,097
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	90.1	90.6	91.0	91.5	92.0

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	79.7	75.3
Numerator	45,011	39,863
Denominator	56,476	52,960
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	76.9	77.7	78.4	79.2	80.0

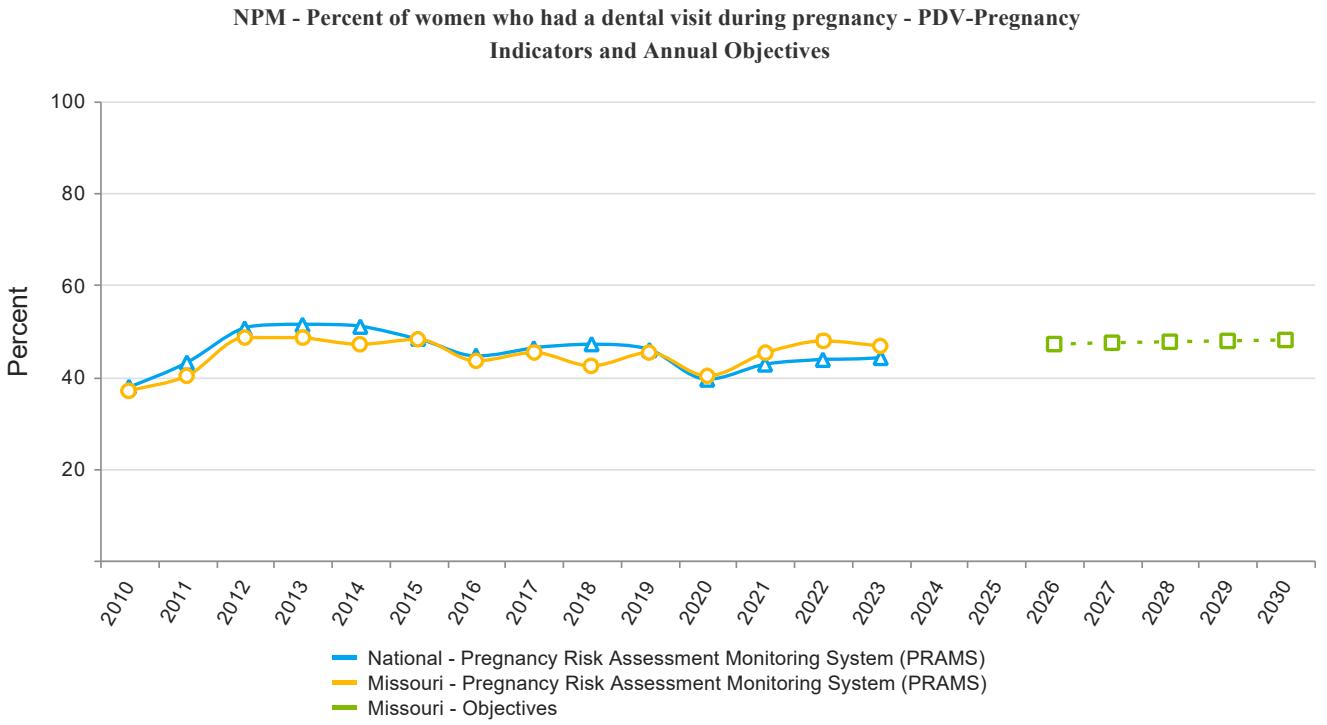
Evidence-Based or –Informed Strategy Measures

ESM PPV.1 - Number of postpartum care providers who participate in training through the Missouri PQC on implementing standardized and comprehensive postpartum care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	50.0	50.0	50.0	50.0



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	46.7
Numerator	28,824
Denominator	61,731
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	47.1	47.4	47.6	47.8	48.0

Evidence-Based or –Informed Strategy Measures

ESM PDV-Pregnancy.1 - Number of oral health care providers who participate in training on providing respectful, whole-person, and person-centered care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	50.0	50.0	50.0	50.0

State Action Plan Table

State Action Plan Table (Missouri) - Women/Maternal Health - Entry 1
Priority Need
Access to patient-centered, coordinated, and comprehensive postpartum care.
NPM
NPM - Postpartum Visit
Five-Year Objectives
By September 30, 2030, Missouri will increase the percent of women enrolled in Medicaid who attended a postpartum checkup within 12 weeks after giving birth from 83.25% to 86.5% (Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 9, 2023-Ongoing).
By September 30, 2030, Missouri will increase the percent of women who attended a postpartum checkup from 89.1% to 92.0% (PRAMS Phase 9, 2023-Ongoing).
By September 30, 2030, Missouri will increase the percent of women screened for depression and/or anxiety after giving birth from 82.7% to 86.0% (PRAMS Phase 9, 2023-Ongoing).

Strategies

Promote implementation of the comprehensive postpartum care guidelines recommended by the American College of Obstetricians and Gynecologists (ACOG) Committee Opinion No. 736: Optimizing Postpartum Care.
Examine the circumstances surrounding perinatal deaths to identify systemic issues and develop community-based action plans to prevent future deaths and improve perinatal health outcomes.
Engage in cross-sector partnerships and collaborations to design, implement, and evaluate QI initiatives to increase postpartum visit attendance.
Enhance cross-sector collaboration to promote whole person, person-centered, coordinated, and comprehensive postpartum care.
Provide training for all types of providers on respectful, person-centered care.
Implement the Maternal Mortality Prevention Plan.
Promote and support clinical-community integration and coordination of service delivery across the care continuum, including health/wellness and safety promotion and injury and disease prevention.
Improve clinical readiness, recognition, and response to obstetric emergencies.
Promote integration of screening and referral for mental health conditions into routine perinatal care, including postpartum visits.
Promote and support traditional and nontraditional provider roles and community-based models of perinatal care.
Promote comprehensive access to care, including adequate insurance coverage, for pregnant and postpartum women.

ESMs	Status
ESM PPV.1 - Number of postpartum care providers who participate in training through the Missouri PQC on implementing standardized and comprehensive postpartum care.	Active

NOMs

Maternal Mortality
Neonatal Abstinence Syndrome
Women's Health Status
Postpartum Depression
Postpartum Anxiety

State Action Plan Table (Missouri) - Women/Maternal Health - Entry 2

Priority Need

Preventive oral health care services during pregnancy.

NPM

NPM - Preventive Dental Visit - Pregnancy

Five-Year Objectives

By September 30, 2030, Missouri will increase the percent of pregnant women who had their teeth cleaned by a dentist or dental hygienist from 46.7% to 48% (PRAMS Phase 9, 2023-Ongoing).

Strategies

Enhance cross-sector collaboration to promote whole person, person-centered, coordinated, and comprehensive perinatal care, inclusive of oral health care.

Provide education to healthcare providers, community-based organizations, community partners, community members, pregnant women, and families on the importance and safety of dental care during pregnancy and the connection between good oral health and a healthy pregnancy.

Promote and support Local Public Health Agencies to implement the Preventive Services Program with pregnant women, including an oral health review, oral health education, application of fluoride varnish, oral health supplies, and referral to an oral health provider, as indicated.

Promote and support clinical-community integration and coordination of service delivery across the care continuum to assure preventive oral health care services during the perinatal period.

Promote comprehensive access to care, including adequate insurance coverage, for pregnant and postpartum women.

Provide education/training to oral health care providers on respectful, whole person, person-centered care for pregnant and postpartum women.

Promote a whole person, integrated approach to oral health care during the perinatal period, including the patient's lifestyle, nutrition, safety, systemic health conditions, and breastfeeding education and support.

ESMs	Status
ESM PDV-Pregnancy.1 - Number of oral health care providers who participate in training on providing respectful, whole-person, and person-centered care.	Active

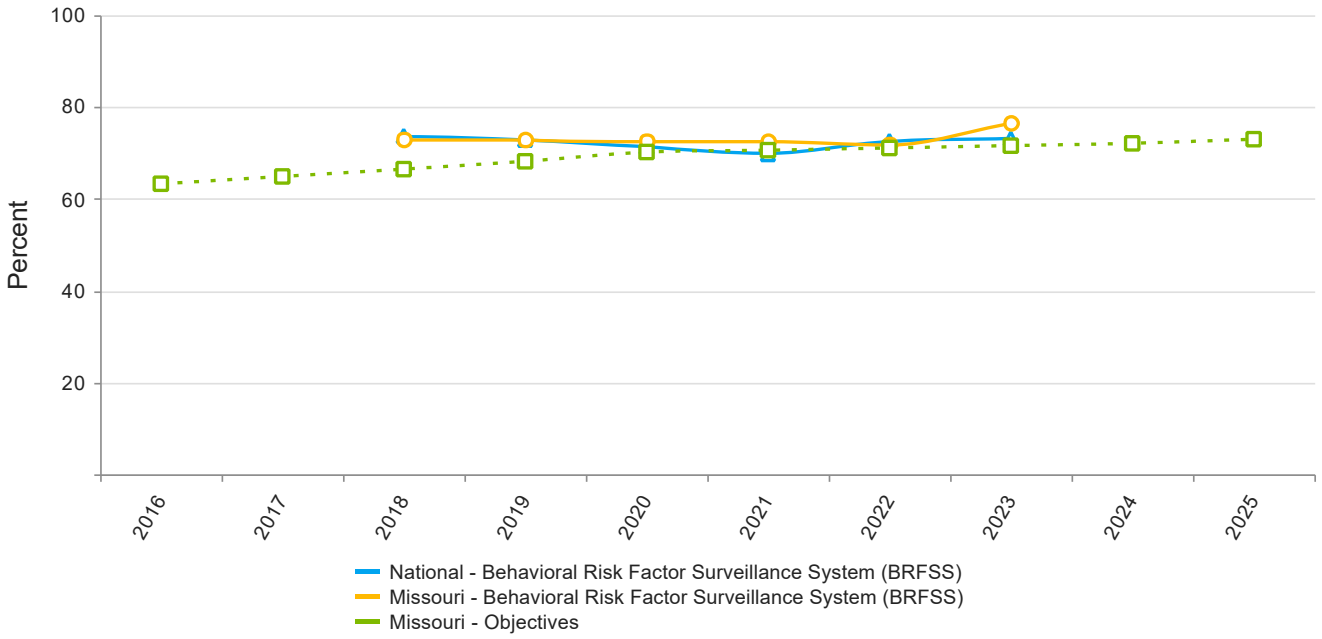
NOMs

Women's Health Status

Children's Health Status

2021-2025: National Performance Measures

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV Indicators



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	70.1	70.5	71	71.5	72
Annual Indicator	72.6	72.5	72.4	71.8	76.3
Numerator	754,373	755,016	751,551	751,176	814,079
Denominator	1,039,355	1,041,255	1,038,345	1,046,558	1,066,748
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

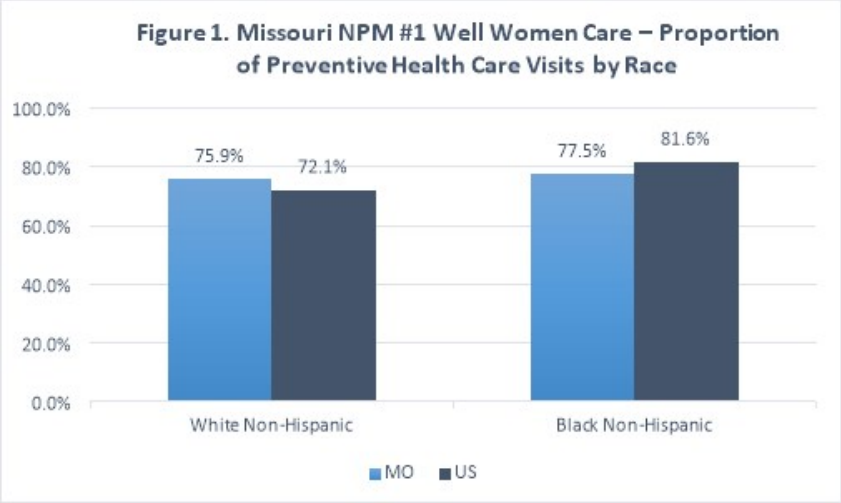
2021-2025: ESM WWV.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		85.8	86.2	86.8	87.2
Annual Indicator	83.7	86.7	86.6	85.4	87.6
Numerator	1,001	1,204	1,573	1,014	969
Denominator	1,196	1,388	1,816	1,187	1,106
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

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

The health and well-being of a woman before, during, and after pregnancy is important not only for the woman but also for the newborn. Women who maintain a healthy lifestyle, characterized by behaviors that promote well-being and reduce disease prevalence, during the preconception period are less likely to experience adverse pregnancy and obstetric outcomes and are also more likely to experience better postpartum health extending across their life span.

According to the 2023 BRFSS, 76.3% of Missouri women between 18 and 44 years reported having a preventive health care visit within the past year. This is higher than the national proportion of 73.0% for 2023. There were differences in racial/ethnic backgrounds in the proportion of women who had a preventive health care visit, with Missouri being similar to national levels and more non-Hispanic Black women (77.5%) than non-Hispanic White women (75.9%) receiving a preventive visit in the past year (Figure 1). A higher percentage of insured women (78.8%) than uninsured women (42.0%) received a preventive visit. A lower percentage of those with a high school education (50.5%) received a preventive visit in the past year than those with some college (79.2%) or college graduates (78.8%). The proportion of Missouri women with an education of some college or college graduate who received a preventive medical visit in the past year was higher than the national level respectively (74.1%, 76.7%). In Missouri, 68.1% of those with a household income less than $25,000 had a preventive visit in the past year, compared to 74.0% among those with a household income greater than $75,000. A higher percentage of married women (80.3%) had a preventive visit in the past year than unmarried women (73.3%).



National Vital Statistics data for 2023 indicate 75.6% of women began prenatal care in the first trimester, slightly lower than the 76.1% observed in 2022. First trimester initiation was also lower in Missouri compared to the national level (76.1%) in 2023. There was a disparity(ies) between different racial/ethnic backgrounds in first trimester care initiation in Missouri between non-Hispanic White (80.7%) and non-Hispanic Black women (61.0%). First trimester prenatal care initiation decreased for both non-Hispanic White (80.9%) and non-Hispanic Black women (61.0%) from 2022.

According to the 2023 Missouri Pregnancy Risk Assessment Monitoring System (PRAMS), 89.1% of Missouri women received a postpartum checkup. This proportion is similar to the 89.3% reported for 2022. Privately insured women had a higher rate of receiving a postpartum checkup (94.2%) than their Medicaid-insured counterparts (83.5%). Non-Hispanic Black women had lower rates of receiving a postpartum checkup (82.5%) compared to non-Hispanic White women (89.7%). Women with less than a high school diploma had lower rates of receiving a postpartum checkup (76.0%) than women with a high school diploma (85.8%), some college (85.5%), and a college degree or higher (98.0%).

Initiatives to Promote Women and Maternal Health

The Office on Women's Health (OWH) provided education and resources to promote well woman care. To increase access and uptake of resources, OWH developed a new online order form for materials. This proved to be incredibly successful, and OWH distributed over 2,000 booklets of the *WOMEN: Take Charge of Your Health* publication and the *My Health Tracking Card,* shown below. 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 is 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. The *WOMEN: Take Charge of Your Health* publication is now available in English and Spanish and can be accessed online and in print. The most recent printing of the book included a QR survey code to collect data regarding participant learning and resource utilization. While no participants have completed the survey to date, OWH has contact information from the online ordering form and will follow up with community members using the resource to ask for their input. The My Health Tracking Card tracks blood pressure, cholesterol, and weight. Resources are provided to the public, 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 moved to a monthly format in 2024, in response to requests for fewer distributions with more information in each update. OWH continued sharing educational, funding, and resource opportunities with the Women's Health Network listserv.

The Missouri Women's Health Council met twice in 2024. The Council is an advisory group of thought leaders with expertise in women's health and the various factors affecting women's health outcomes and well-being. The DHSS Director appoints council members who reflect the geographic and demographic variation across Missouri. The council is charged with informing and advising DHSS regarding women's health risks, needs, and concerns and recommending potential strategies, programs, and legislation to improve the health and well-being of all women in Missouri. The council comprises women from various professions, including health care providers, researchers, healthcare administrators, social workers, and directors of crucial social services foundations serving women throughout Missouri.

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 during pregnancy and throughout the lifespan, including the promotion of dental visits during pregnancy. This information is shared through distribution of literature developed by the ODH to women through an ongoing successful collaboration with the Women, Infants, and Children (WIC) Program and the Title V funded Home Visiting programs. Materials are also distributed through LPHAs, Federally Qualified Health Centers (FQHCs), and dental offices and at community outreach events. Through Title V funding, ODH created 10,000 oral health kits for pregnant women. The kits contained oral care supplies for mom and her newborn baby, literature on the importance of oral health and the safety of a dental visit for the pregnant woman, and instructions on proper teeth brushing technique. The kits were disseminated through LPHAs and other organizations across the state who worked with pregnant women.

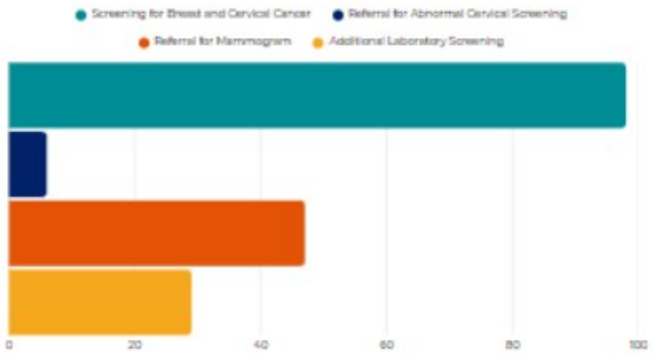
The ODH continued a program to fund five LPHAs through their WIC office to provide oral health education and supplies, fluoride varnish, and a warm hand off to a dental provider. The LPHA staff encouraged mothers to keep dental appointments by emphasizing the importance of oral care during pregnancy. The ODH provided technical assistance to Uzazi Village in Kansas City to provide dental care to pregnant and postpartum women. Uzazi Village is a non-profit organization offering perinatal health care to pregnant women who are medically underserved and eligible for MO HealthNet for Pregnant Women. ODH coordinated the donation of the larger dental equipment needed for the clinic and the purchase of smaller equipment and supplies and engaged a dental provider in the area to provide dental care two days a month, serving an average of eight women each day. Medicaid was billed for the dental services provided.

Community Health

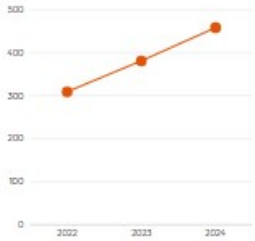
The MCH Services Program contracted with LPHAs to support a leadership role for LPHAs at the community level to build community-based systems and expand the resources those systems can use to respond to priority women and maternal health issues, while providing and assuring women of childbearing age and mothers have access to quality health services. Twenty LPHAs selected improving pre-conception, prenatal, and postpartum health care services for women of childbearing age as their priority health issue. The four examples below highlight some innovative strategies and achievements.

- The Atchison County Health Department increased breast and cervical cancer screenings and referrals among women 18-44 years. To increase knowledge around the importance of women's health screenings, the health department launched a social media campaign, sharing 508 women's health messages on their Facebook page. To increase awareness of women's health services provided at the health department, a monthly activity calendar was developed and shared each month in the local newspaper, with community service providers, the local food pantry, and in the waiting room of the health department. 47 women 18-44 years received a breast and cervical cancer screening, six women were referred for abnormal cervical screening results, and 29 women received additional laboratory testing to screen for sexually transmitted infections. In addition, 47 women (all ages) were referred for a mammogram.

- The Howell County Health Department increased breast and cervical cancer screenings among women aged 18-44 by 24.9%, as compared to FY 2022.

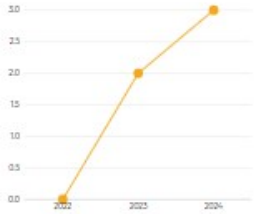


To increase the number who completed their scheduled appointment, a team of nurses called clients who missed and/or were due for an upcoming annual visit. A nurse, versus an office clerk, can inform the client of what screenings are needed and answer any medical-related questions. To increase access to women's health services, the health department began using its mobile unit to provide women's health services in outlying, rural areas with transportation barriers. The mobile unit alternated between two locations each month, using the parking lots of organizations in the middle of each town, so walking to the location was an option. Appointments were preferred, but walk-ins were welcome. A nurse practitioner was on-site and provided cervical and breast cancer screenings.



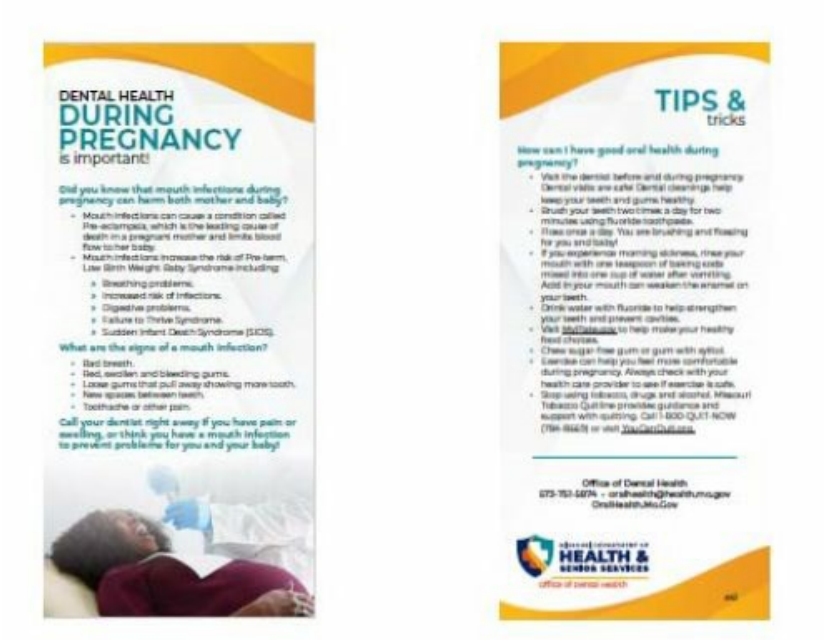
- The Phelps/Maries County Health Department increased knowledge among women of childbearing age and families regarding prenatal, postpartum, and newborn care from a baseline of zero in FY 2022 to 170 women at the end of FY 2024. The health department used the Growing Great Kids curriculum, an evidence-based home-visiting curriculum available in both English and Spanish. The courses can be provided both in-person and online with the goal of cultivating secure attachments, bolstering child development while building parenting, family strengthening, and other essential life skills with parents who themselves have experienced childhood adversity and other traumatic events, learning to balance risk and protective factors. To increase awareness and participation in classes, the health department partnered internally with the case management program and externally with Missouri Department of Social Services, Family Support Division (FSD). FSD accepts completion of the course as acceptable for families working with the court system.

- The Miller County Health Center increased the number of community- serving organizations for women of childbearing age who have policies addressing women receiving early prenatal care and wrap around services from a baseline of zero in FY 2022 to three at the end of FY 2024. The health department hosted an annual Community Pool Party, inviting all community-serving organizations to attend and host a table with information about services they provide. On average, 375-400 community members attend the pool party each year, and 15 organizations are in attendance. As a result, partnerships continued to form with the goal of identifying ways to better serve the community. In FY 2024, the health center partnered with the local Citizens Against Domestic Violence, a non-profit service organization, established in 1984, that provides crisis intervention, emergency shelter, legal advocacy, hospital advocacy, weekly empowerment groups, and support to victims of domestic violence, sexual assault, and human trafficking. The health department also partnered with the FQHC and local diaper bank to increase knowledge and skills regarding health and safety and access to services. The health department refers those without a medical home, especially pregnant women without an OB provider, to the FQHC. The monthly diaper bank distribution day was held in tandem with the health department providing on-site child passenger seat inspections and education about MCH services provided at the health department. The health department has not been tracking any correlation between the education regarding MCH services and the utilization of services but plans to track the correlation moving forward.



The MCH Services Program supported LPHA efforts to provide education on the importance of adequate dental care and overall oral health, collaborating with the ODH to share resources with LPHAs, including:

- *Dental Health During Pregnancy is important!* rack card. *(See infographics below.)*



- LPHAs collaborated 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.

The TEL-LINK Program provided over 3,500 health care service referrals to increase access to care. The program promotes this service through search engine campaigns to provide outreach to underserved populations. TEL-LINK collaborated with DSS, DMH, LPHAs, ParentLink, ODH, the Injury Prevention Program, Home Visiting, Safe Cribs for Missouri Program, Special Health Care Needs programs, Tobacco Quitline, WIC Program, and more to provide referrals on various services, such as smoking cessation, WIC clinics, dental care, and many more. Over 8,000 individuals clicked on the ad through this campaign to learn more about TEL-LINK's services. The search engine strategy utilizes geographic and demographic targeting, which directs individuals to TEL-LINK, where operators connect them to the closest resources. The program collaborated with ParentLink, WIC, and DSS to promote TEL-LINK.

The Newborn Health Program (NHP) continued to partner with a variety of community health providers to raise awareness and 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 accomplished this through the free distribution of the *Pregnancy and Beyond* books and a wide variety of educational materials. All resources contain information to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age. The NHP distributed 260,000 resources to Missourians and obtained the following feedback from partners:

- "Thank you for supplying this wonderful information. We have this at the bedside, this helps our patients make informative decisions based on facts."
- "So appreciate having these resources guides. Also like that the presentation as far as format, pictures, color, etc. are well done. This makes them eye-catching and more appealing to the client so are more apt to read them."
- "Patients are always happy to receive this book. We do pregnancy testing in our clinic and see a lot of first-time moms-to-be. This book is very well done and easy to understand."

The Healthy Births and Babies Unit utilized and promoted an informal MCH internal work group to 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 WIC Program promoted the importance of depression screening by 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 continued referring families to Home Visiting programs, TEL-LINK Program, the Missouri Primary Care Association, and other support programs. WIC also continued outreach efforts to enroll women in the WIC Program in their first trimester.

Home Visiting

The Title V funded Home Visiting programs at DESE shared information with all contracted local implementing agencies (LIA) to help home visitors link families with resources for accessing health care insurance, including Missouri Medicaid. Home visiting staff assisted enrolled clients in accessing insurance for prenatal, postnatal, and well-woman care through emails and postings within the monthly Office of Childhood (OOC) Home Visiting Section Newsletter, reaching 516 school district Parent Education Programs and 11 supervisors of the Home Visiting Programs. Through a standard agenda topic on the monthly sub-recipient monitoring and support calls with each LIA supervisor, Home Visiting Program Specialists continued to address the need for updated resources for accessing a regular and ongoing source of healthcare, including current guidelines for accessing and maintaining insurance coverage. 91% (71/78) of mothers enrolled in home visiting prenatally or within 30 days after delivery received a postpartum visit with a health care provider within eight weeks of delivery.

Additional Title V funded Home Visiting program services included:

- Promoted smoking cessation for all primary caregivers who reported smoking at enrollment and/or the subsequent 6-month visit. 53% (9/17) of primary caregivers who reported smoking, tobacco use or other forms of nicotine delivery, including e-cigarettes, at enrollment were referred to tobacco cessation counseling or services within three months. In addition, home visitors provided tobacco cessation information and resources, such as the Baby and Me Tobacco Free (BMTF) Program, Tobacco Quitline, and TEL-LINK, to enrolled participants. Home visitors also educated families about the risks and effects of child exposure to second hand smoke;
- Provided information and resources to all enrolled pregnant women promoting the benefits of continuing healthy pregnancies to the full 40 weeks. These resources included DHSS and March of Dimes educational materials. Title V funded Home Visiting Program Specialists assessed the distribution and use of these resources during monthly sub-recipient monitoring calls and annual monitoring visits with the LIAs;
- Screened all clients enrolled prenatally for symptoms of 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 during prescribed timeframes and anytime home visitors recognized potential symptoms of depression, and individuals who screened positive were referred to appropriate services. 53% (64/121) of primary caregivers enrolled in home visiting were screened for depression. Additionally, 21% (6/29) of individuals who screened positive for depression were referred. Current resources on mental health were shared with contracting LIAs through the monthly newsletter, including a new resource, the University of Missouri Maternal Health Access Project (MHAP), which provides perinatal psychiatry consultation for providers seeking assistance with finding resources for enrolled individuals; and
- Provided contracted home visitors with oral health resources from the ODH, promoting the importance of receiving preventive dental care during pregnancy and at all stages of life for primary caregivers and their families, to share with enrolled primary caregivers.

Environmental Health

Lead exposure can pose a risk for women of childbearing age as well as the developing fetus or nursing infant. The most severe effects of high levels of lead during pregnancy are miscarriage and stillbirth. Other problems during pregnancy, 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.

Lead poisoning prevention team members continued to perform the following activities to prevent or decrease blood lead poisoning among pregnant women and their babies:

- Provided community lead education through various outreach events, such as the Man Show, the Randolph County Bike Rodeo, the Missouri Chiropractic Physicians Association Conference, the Conference on the Young Years, the Coordinated School Health Conference, and 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;
- Contacted pregnant women and their health care providers when a woman's blood lead level was 5 mcg/dL or higher (tracked by the Adult Blood Lead Epidemiology and Surveillance staff); and
- Provided lead education and resource materials to health care providers, LPHA and health plan lead case managers, and 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 childbirth. The program partnered with statewide community-based partners to house substance-exposed infant manikins to demonstrate the effects of drugs and alcohol during pregnancy. In the 2024 calendar year, 214 sessions were held at community placement sites. 4,913 participants attended these sessions, including expectant parents, grandparents, substance use disorder treatment clinics, WIC clients, educators, students, health care providers, and Parents as Teacher clients. Participants examined three newborn infants (drug-affected, fetal alcohol syndrome, and healthy) together to compare the effects of substance use during pregnancy. Visualizing the possible outcomes of an individual's behavior can help empower them to succeed and strive for a healthy newborn infant. During the program evaluation, it was reported that after four months of being educated with the substance-exposed manikin project, a pregnant woman using methamphetamines, marijuana, and alcohol ended up having a healthy substance-free newborn. Also, two pregnant individuals (three and five months along) had been using many substances during their pregnancy. With their work with the Family Counseling Center and the substance-exposed manikin project, they have both been substance-free for two months. The program also had awareness campaigns to promote healthy pregnancy and abstaining from all substances before, during, and after pregnancy. Campaign ads were run for one month and displayed to 511,239 individuals. The campaign utilized geographic, demographic, and life stage targeting.

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

Maternal Mortality

OWH continued to abstract and review all pregnancy-associated mortalities in Missouri. These reviews led to the identification of strategies to prevent maternal mortalities. Strategies include training, following standards of care, funding health insurance programs like MO HealthNet for postpartum extension, collaborating across agencies to deliver comprehensive care, and improving community safety. DHSS reported findings from the Pregnancy-Associated Mortality Review (PAMR) and collaborated with partners and other key stakeholders to implement PAMR recommendations.

DHSS received continued funding through a five-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. OWH continued to refine and 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, with deaths at the beginning of the year abstracted first, if possible, and brought to the PAMR Board. 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. OWH contracts with the MHA through the ERASE MM grant to implement patient safety bundles in Missouri birthing facilities, clinics, and critical access hospitals. MHA continued implementing the "Care for Pregnant and Postpartum [Women] with Substance Use Disorder" (CPPSUD) bundle. According to the 2019-2022 PAMR reports (published between 2022 to 2025), mental health conditions were the leading underlying cause of pregnancy-related deaths, followed by cardiovascular disease, every year except 2021, when they were the second leading underlying cause - highlighting the need for this work. The Maternal/Infant Mortality Coordinator worked 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 leads the implementation of maternal safety bundles in Missouri's birthing facilities. As the first initiative, Missouri implemented 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. MCH Leadership and OWH continued collaborating with MHA and other critical 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 provided strategic guidance, focused on high-value opportunities to improve clinical, operational, and outcome performance, and developed collaborative partnerships to achieve these aims. In addition, the committee partnered 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 met three times with additional virtual meetings as needed. 53 of 59 Missouri birthing facilities, representing 94% of Missouri births, are participating in the MO PQC and reporting data metrics into the AIM data portal. DHSS and MHA assisted birthing facilities with data submission to minimize burden on the facilities and leverage key stakeholders to assist with AIM bundle implementation.

Discussions with key partners identified the need for a comprehensive plan for maternal mortality prevention, with targeted funding and initiatives. DHSS leveraged Title V funding to propose a new state-funded budget initiative to implement a Maternal Mortality Prevention Plan (MMPP). The Governor's final approved state fiscal year 2024 budget included $4.35 million to implement the Plan and effect simultaneous transformation through five domains of action affecting maternal health, with the community and population-level factors that influence MCH outcomes interwoven throughout all five domains. Implementation of the Plan, including a robust evaluation plan to monitor progress, measure success, ensure accountability, and inform ongoing maternal mortality prevention efforts, was launched through partnerships with internal and external maternal health partners. Improved maternal health data collection, standardization, harmonization, transparency, and support will enhance data quality and access, identify poor outcomes during pregnancy and make improvements to support healthy pregnancy, delivery and postpartum outcomes. The Plan included the development of a MCH Dashboard, published in June 2024, along with a new MCH Data Sources webpage. DHSS contracted with the University of Missouri to establish a collaborative hub and spoke model Maternal Health Access Project (MHAP), inclusive of perinatal mental health, with a single point-of-entry system for referrals to prenatal care providers and community-based agencies, resources, programs, and services for prenatal women. Through a contract with MHA, DHSS initiated implementation of three of the domains: 1) standardized, evidence-based maternal quality care protocols; 2) 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; and 3) a Postpartum Plan of Care to plan for and optimize comprehensive postpartum care.

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

OWH supported several initiatives to assist women of childbearing age. Through the Uninsured Women's Health Services Program, a collaboration with DSS, OWH reimbursed medical providers for women's health services.

These included approved methods of contraception; sexually transmitted disease testing and treatment, including pap tests and pelvic exams; family planning, counseling, and education on various methods of birth control; and drugs, supplies or devices related to the women's health services described above, when a physician or advanced practice nurse prescribed them. OWH continued to work with DSS and the Women's Health Council to identify areas for improvement in the program, such as application processes and eligibility. OWH maintained a public listing, indexed geographically and available online, of pregnancy assistance information and ultrasound providers. OWH supported a prenatal care program in Kansas City to provide free, demographically congruent group prenatal care to 38 women. OWH supported tobacco cessation for pregnant and postpartum women and their households through telehealth with the BMTF Program. OWH worked with BMTF to publicize the program and offer it at no cost to participants across the state. OWH led a doula training program to increase the number of doulas and doula training organizations across the state. OWH also represented DHSS on several statewide task forces and commissions, including the Missouri Sexual Assault Response Team and the Combatting Human Trafficking and Domestic Violence Commission. Finally, OWH supported the statewide Sexual Assault Nurse Examiner Telehealth Network, which launched to expand access to forensic exams across the state. The following services were provided through these efforts: 516 free tobacco cessation sessions, 446 free prenatal and postpartum visits, 222 women received a total of 4,272 doula service appointments, 142 medical providers received training about doula care and services, and 15 people received training as doula trainers.

The Missouri Maternal Health Multisector Action Network (the Network) continued efforts to connect stakeholders with existing resources and toolkits and foster partnerships amongst stakeholders. The Network worked closely with 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 assure the Network is positioned to address identified gaps. The Network continued to engage and connect stakeholders to increase collaborations and decrease siloes. The Network workgroups focused on actions to address the evolving needs of the mothers and their children and recruit mothers to participate in the Moms' Advocacy Network, launched in FY 2024, to prepare mothers to participate in and lead discussions where service delivery, policy and support decisions are explored. The collective voice, experiences, perspectives, and knowledge of the participating mothers guide the direction of the Action Network.

The MCH Director led Missouri's participation in the National Governors Association (NGA) Center for Best Practices *Improving Maternal and Child Health in Rural America: State and Territory Policy Learning Collaborative* to address the priority area, "Build Infrastructure for Sustained Success: State-level strategic planning, reporting, supportive platforms, collaboratives and centers contribute to improved, sustained outcomes for mothers, infants and their families, and increased accountability." The Core Team, comprised of the MCH Director, DHSS Chief Medical Officer, Senior Policy Advisor from the Governor's Office, Director of MO HealthNet, MHA Senior Vice President of Quality, Safety and Research, and Executive Director of the MHAP at the University of Missouri, partnered with SSM Health St. Louis - Women's Services to submit a proposal for the state Maternal Health Innovation Program through HRSA, with the plan leverage and expand the existing Maternal-Child Learning Action Network at MHA to serve as a maternal health task force and develop a statewide maternal health strategic plan.

As the state's chief maternal child health strategist, the MCH Director continued efforts 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 varied partnerships, DHSS brings MCH partners and programs together across programmatic silos and organizational boundaries to promote the health of the MCH population and address community factors that influence health outcomes. The MCH Director actively engaged in statewide collaborative efforts to promote the health of women of childbearing age, including but not limited to engagement in the 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 continued 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.

Additional Performance Analysis

To increase program efficiency and effectiveness and improve pre-conception, prenatal and postpartum health care services for women of childbearing age, OWH goals include reducing the amount of time it takes to abstract cases of maternal mortality, the amount of time to review cases, and the amount of time to prepare and publish the annual report for maternal mortality; updating the Women's Health Council to the Women's Health Advisory Committee and returning to the original authorizing legislation; and hosting two meetings of the Women's Health Advisory Committee in 2026.

The Pregnant Women Need Dental Care Too contracts with three LPHAs have demonstrated success, with the number of pregnant women covered by MO HealthNet for Pregnant Women who received dental services increasing in those jurisdictions. ODH also received extremely favorable feedback on the pregnant mom oral health kits and received requests for more kits than were available.

Challenges

Home Visiting had difficulty maintaining current resources for health care coverage and accessing affordable dental supplies for families. Home visitors encouraged taking young children to the dentist; however, recommendations by oral health care providers vary across the state regarding when a young child should be seen by a dentist. The conflicting information regarding when young children need to begin dental care created challenges for home visitors.

OWH was challenged to abstract and report on the number of maternal mortality cases in a timely manner, given the need for team members to address all the emerging maternal health initiatives in Missouri.

Limited funding creates barriers to providing the full scope of services, including oral health care services, for pregnant women.

Opportunities

Home Visiting Program Specialists partnered with DHSS to provide an informational webinar to promote the Baby and Me Tobacco Free program and continue to search for current resources to share with families. OOC is planning to provide training for LIA staff on performing an annual functional assessment of hearing, vision, and health (including oral health) on all enrolled children. Performance measures indicating need for improvement will be discussed during annual professional development events.

NPM: Postpartum Visit – Increase the incidence of women attending a postpartum checkup within 12 weeks after giving birth and receiving the recommended postpartum care components.

DHSS will promote implementation of the comprehensive postpartum care guidelines recommended by the American College of Obstetricians and Gynecologists (ACOG) "Committee Opinion No. 736: Optimizing Postpartum Care" across all efforts led and participated in to promote access to patient-centered, coordinated, and comprehensive postpartum care. As stated in the Committee Opinion, "The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs."

Pregnancy-Associated Mortality Review (PAMR)
The Office on Women's Health (OWH) manages PAMR pursuant to 192.990 RSMo. As directed in the law, the Director of DHSS appoints members to serve on the PAMR board. The board meets regularly in a closed meeting to examine summaries put together by a trained nurse abstractor. The summaries are compilations of de-identified information abstracted from medical encounters, vital statistics, autopsy reports, newspaper articles, social media postings, and/or other relevant records. The board completes a Committee Decision Form for each maternal mortality case to assist with data entry and analysis. Documents and data collected for the maternal mortality review process are confidential; the board is prohibited from releasing any information that could identify individuals. The PAMR Board is comprised of approximately 18 members representing varied geographic regions of the state and various domains intersecting maternal health. The board identifies potential solutions to address the contributing factors for each death.

Maternal Mortality Prevention Plan (MMPP)
With MCH Leadership oversight, OWH manages the contracts with MHA and the University of Missouri to accomplish the deliverables of the MMPP. OWH is responsible for ensuring contractors report on their progress in a timely fashion, contract deliverables are met, challenges encountered are addressed early and swiftly, and the work is done in accordance with the overarching plan to address maternal mortality in Missouri. OWH will meet with MCH Leadership regularly to share progress reports, spending updates, and contractor feedback. MCH Leadership will provide guidance to OWH on future contract deliverables and spending plans to ensure the MMPP is implemented as intended and adapted as needed. Ongoing implementation of the MMPP will include further development and maintenance of a dashboard/public-access web portal to disseminate state MCH data; promotion of maternal quality control protocols to standardize maternal care practices; continued expansion of the perinatal health access collaborative to allow general practitioners/primary care providers and community-based service providers to consult with medical specialists; statewide rollout of evidence-based recommendations for postpartum care, including care coordination, patient education and engagement, perinatal mental health, well-woman care and transition to primary care, management of chronic conditions, infant health, and addressing community and population-level factors influencing perinatal health outcomes; and relevant training for maternal care providers, including training on the provision of respectful, person-centered care.

As Missouri's recipient of HRSA's state Maternal Health Innovation Program grant, SSM Health St. Louis - Women's Services launched the Missouri Collaboration for Clinical Community Integration in Maternal Health (MO C3) to reduce maternal mortality and severe maternal morbidity (SMM) by improving access to comprehensive, high-quality, appropriate, ongoing care throughout the preconception, prenatal, labor and delivery, and postpartum periods; enhancing state maternal health surveillance/data capacity; and identifying and implementing innovative interventions to improve outcomes for populations disproportionately impacted by maternal mortality and SMM. The MCH Director and DHSS Chief Medical Officer serve on the MO C3 Core Advisory Panel to plan, implement, and evaluate MO C3 activities. The Maternal Health Task Force, a required component of MO C3 and formed around the PQC/Maternal-Child Learning and Action Network (MC LAN) at MHA, will develop a five-year state maternal health strategic plan, aligned with PAMR findings and recommendations, the statewide MCH Needs Assessment and State Action Plan, and the MIECHV Needs Assessment, to create and implement innovative strategies to address gaps in maternal

health care and social support services. Initial strategic directions will include enhancing patient experience and access to care; integrating and supporting the maternal workforce and partners; transforming care delivery and the systems that support care; and demonstrating value and driving sustainability through strategic storytelling.

Community Health
The MCH Services Program team is comprised of a program manager and four MCH District Nurse Consultants (DNCs) located throughout Missouri. The role of the MCH DNC is to provide consultation and technical assistance, serve as a liaison between DHSS and LPHAs, participate in coalitions, taskforces, and workgroups related to MCH outcomes, and provide other supports as needed. The East/Southeast DNC supports 28 LPHAs, the West Central DNC supports 28 LPHAs, the Northern DNC supports 29 LPHAs, and the Southwest DNC supports 27 LPHAs. Through the MCH Services Program, DHSS contracts with LPHAs to support LPHA local leadership roles 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. All LPHAs are eligible to participate after completion and approval of a five-year contract work plan and annual contract budget. Currently, the MCH Services Program contracts with 112 of the 115 LPHAs in Missouri. The three LPHAs not participating in the contract cite lack of workforce capacity as the determining factor. The program manager reaches out annually to LPHAs not participating to discuss possible participation.

In FY 2026, all LPHA contractors will complete planned activities to achieve desired system outcomes outlined in their FY 2022-2026 contract work plans. A contract outcomes report will be completed, evaluating performance trends and system outcomes. 20 LPHAs will continue work to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age.

- Callaway County Health Department will work with community-based organizations to increase the number of community-based organizations, including food pantries, diaper banks, and faith-based organizations, that adopt policies and practices to increase the number of women and families receiving education, resources, and support for postpartum depression.

- Howell County Health Department will work to increase the number of women of childbearing age who receive an annual preventive visit. The health department will use their mobile unit, staffed with a Nurse Practitioner and other clinical staff, to visit outlying rural areas that have transportation barriers and offer breast and cervical cancer screenings, lab testing, immunizations, and other wrap-around services. The mobile unit will alternate between two locations each month, using the parking lots of organizations located in the middle of each town to increase accessibility.

- Springfield-Greene County Health Department will use the Family Connects home visiting model to provide one to three nurse home visits after the birth of a newborn, incorporating the Mothers & Babies curriculum to support families. Mothers & Babies is an evidence-based intervention for pregnant [women] and new parents to help manage stress and prevent postpartum depression.

- Phelps/Maries County Health Department will work to increase knowledge among women of childbearing age and families regarding prenatal, postpartum, and newborn care using the Growing Great Kids curriculum. With courses provided both in person and online, the goal is to cultivate secure attachments and bolster child development while building parenting, family strengthening, and other essential life skills with parents who themselves have experienced childhood adversity and other traumatic events. The health department will partner with FSD (DSS). FSD has approved completion of the course as acceptable for families working with the court system.

All LPHA contractors will conduct a focused local MCH needs assessment, seeking input from MCH stakeholders, including families, consumers, providers, and other community partners, about local MCH issues. Based on those findings, LPHAs will select at least one priority health issue from the FY 2026-2030 MCH State Action Plan and develop a five-year work plan (FY 2027-2031) to address the selected priority health issue(s). The contract work plans will include a statement of the problem, goals for addressing the problem based on targeted national, state, and/or local outcome measures, evidence-based strategies to address the problem, activities and targeted system outcomes using the Spectrum of Prevention as a framework, and, based on the Life Course Perspective, identification of risk and protective factors that influence health disparities within families and the community. The MCH Services Program plans to provide educational and technical assistance opportunities to increase LPHA's knowledge and skills on utilizing the MCH Evidence *What Works Evidence Accelerators* to develop the five-year work plans. The *What Works Evidence Accelerators* include evidence-based strategies to increase the percentage of women who attend a postpartum checkup within 12 weeks after giving birth and increase the percentage of women who attend a postpartum checkup and received recommended care components. Strategies include:

- Appointment intervals;
- Community Health Workers;
- Group prenatal care;
- Mobile medical clinics;
- Mother-infant dyad programs;
- Provider training and education;
- Quality improvement initiatives;
- Workplace support;
- Postpartum care plans;
- Home visiting;
- Patient navigation; and
- Telehealth and remote monitoring.

The TEL-LINK Program will help improve women's and maternal health by providing health care service referrals to increase access to care for any childbearing woman, mother, community member, or provider needing assistance. The program promotes this service through search engine campaigns to reach the underserved population. Monthly usage reports by resource category will assist in finding ways to improve programmatic activities. TEL-LINK will partner with tobacco control programs, WIC clinics, and dental care providers to provide referrals to services such as smoking cessation, dental care providers, mental health treatment centers, health insurance providers, and many more.

The Tobacco Prevention and Control Program (TPCP) will continue to offer free cessation counseling and nicotine replacement therapy for Missourians through Missouri Tobacco Quit Services. Cash incentives are provided to perinatal and postpartum enrollees. TPCP will support efforts to implement and strengthen tobacco-free worksite policies, smoke-free multi-unit housing policies, and community policies. TPCP provides free technical assistance, support, and resources for implementing and strengthening smoke-free and tobacco-free policies.

The Newborn Health Program will partner with a variety of community health providers to raise awareness and provide education for the MCH population on MCH resources for women of childbearing age and their families. Providers will receive free copies of the *Pregnancy and Beyond* book, along with a wide variety of educational materials containing information to improve pre-conception, prenatal, and postpartum care and postpartum mood disorders, for dissemination to patients. *Pregnancy and Beyond* includes content regarding the importance of postpartum follow-up care. 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 Unit will work with an informal internal MCH work group to prepare comprehensive, current, and accurate outreach materials and maximize outreach opportunities at conference exhibits, webinars, virtual baby showers, and health fairs. Educational materials will also be distributed through Home Visiting programs and other service providers.

OWH will develop health materials for distribution digitally and at in-person events. Materials will be brief, specific,

and related to the health screenings needed based on age and health history. Postpartum visits and connection to primary care after pregnancy will be included.

The Adolescent and School Health Program will partner with LPHAs, school districts, and community partners to provide an evidence-based curriculum, made up of 13 lessons geared towards adolescent females ages 14-24 years, on making wise choices about relationships, pregnancy, partnering, and more. In addition to each of the planned 45–60-minute lessons, an additional 30-minute education/training will be incorporated into each class to facilitate guest presentations on a variety of topics related to pregnant and parenting teen mothers. One of the sessions will cover the importance of postpartum care for both mother and child and the supportive roles fathers can take in assisting with and supporting women in participating in these visits. Information will also be provided regarding access and enrollment in MO HealthNet and WIC services.

The State Breastfeeding Coordinator (SBC) will revise, update, develop, and make available resources for use in promoting breastfeeding and breastfeeding education. Lactation providers at hospitals, clinics, LPHAs, and local WIC agencies use these resources to reinforce direct patient education for prenatal and breastfeeding women, which improves breastfeeding outcomes by ensuring clear and accessible information is provided.

The SBC will work with the Missouri Breastfeeding Coalition (MBC) to add Missouri lactation providers at all levels to the provider directory on ZipMilk. ZipMilk is a lactation provider directory developed and maintained by the Massachusetts Breastfeeding Coalition and used by 18 states and Puerto Rico to help connect parents with various levels of lactation support, including free community support, breastfeeding counselors and educators, International Board Certified Lactation Consultants (IBCLCs), medical providers, support groups, and WIC breastfeeding support. Providers can list important details, such as specialty services provided, languages spoken, or cultural care provided. The MBC has agreed to pursue adding this resource to their website and to maintaining this resource in the future to promote comprehensive access to lactation care for postpartum women. The SBC will also work with the MBC Board on the coalition's 2026-2030 Strategic Plan to ensure continued MBC and DHSS collaboration on breastfeeding initiatives.

The SBC will serve as a subject matter expert on breastfeeding in Missouri, speaking to professionals and students about DHSS breastfeeding initiatives and, when available and requested, providing breastfeeding training for providers. The SBC will promote and support the delivery of high-quality perinatal care by providing technical assistance to hospitals that are trying to meet the Missouri "Show-Me 5" requirements, including virtual and on-site visits to educate hospital staff, and evaluation of hospitals that apply for recognition. (Additional information in the Perinatal/Infant Health domain.)

As funding permits, BCHW will offer and promote statewide trainings for health care providers throughout Missouri to increase the number of IBCLCs in the state, particularly in regions with low breastfeeding initiation rates. Collaboration will continue with statewide and regional partners to increase access to lactation support through a closed-loop referral platform to increase clinical-community integration and coordination of service delivery across the care continuum, encourage and support breastfeeding, and address low breastfeeding initiation rates.

The MCH Director will collaborate with DCR, Harm Reduction and Cannabis Grant programs, Office of Public Information, and other programs across DHSS to provide educational information and resources regarding the dangers of using marijuana during pregnancy and while breastfeeding.

Behavioral Health

BCHW plans to establish and maintain a Maternal Peer-based Recovery Support Technical Assistance Center to support DHSS-funded Maternal Peer-Based Recovery Support Programs and other organizations serving the maternal population with behavioral health conditions, including substance use disorder (SUD) and/or mental health (MH) conditions. Technical assistance will be provided on peer support and recovery support program development, expansion strategies, program sustainability, and evidence-based strategies for addressing the needs of the maternal population with MH and SUD. All services promote optimal health outcomes for the maternal population

impacted by SUD.

The Maternal Peer-Based Recovery Support Program, also referred to as the SUD Grant Program, will work with grantees to provide navigation services to refer and link individuals needing demographically congruent, evidence-based behavioral health and/or substance use treatment and resources. Grantees will assist program participants to:

- Reduce barriers to care through wrap-around services;
- Establish and implement a referral system for partner agencies to refer pregnant and postpartum women to the Maternal Peer-Based Recovery Support Program;
- Use an evidence-based screening tool to assess SUD treatment;
- Make referrals for program participants to access additional behavioral health and wrap-around services;
- Use warm referrals when possible;
- Provide maternal recovery support services for postpartum individuals;
- Ensure all program participants receive education on overdose prevention; and
- Ensure all program participants have access to overdose reversal methods and medically proven treatment.

OWH supports a person-centered, multi-disciplinary, coordinated, and integrated maternal care model for women with SUD. OWH leverages Title V-funded staff time to support two clinics funded by opioid settlement funds. The clinic teams include support specialists and experts in maternal-fetal medicine, psychiatry, substance use, nursing, and social work. The clinics will ensure women receive needed postpartum care and transfer to primary care, and, by bringing all these specialties together, moms and their babies will have a single point of access for support. OWH will measure the number of moms enrolled in the program each year.

The Prenatal Substance Use Prevention (PSUP) Program will support healthy pregnancy and childbirth by promoting the importance of prenatal substance use prevention. PSUP will partner with statewide community-based partners to house substance-exposed infant manikins to demonstrate the effects of drugs and alcohol during pregnancy and explain the importance of a healthy pregnancy and childbirth. The placement sites' biannual report will assist in finding ways to improve programmatic activities. The PSUP Program maintains 33 sets of substance-exposed infant manikins and reallocates the sets based on requests from community partners.

Partnerships and Collaborative Efforts
OWH contracts with multiple agencies to enrich Missouri's programs and initiatives to promote access to patient-centered, coordinated, and comprehensive care throughout the perinatal period. OWH leverages Title V-funded staff time to support implementation and monitoring of these efforts, including the PQC, implementation of Alliance for Innovation on Maternal Health (AIM) patient safety bundles, implementation of group prenatal care in a demographically congruent setting in Kansas City, and support of doula services in Southwest Missouri. Each of these initiatives is funded by either general revenue, other federal funds, or opioid settlement funds. This opportunity to collaborate across funding streams will allow OWH to ensure activities align with the statewide MCH State Action Plan.

MCH Leadership, OWH, and other DHSS programs participate in and lead many cross-sector collaborations for women's and maternal health, including the MC LAN, the PQC, the Missouri Interagency Maternal Health Consortium (IMHC), the Missouri Maternal Health Action Network (MHAN), the Women's Health Advisory Committee (WHAC), and the PAMR Board. These groups each meet on a consistent basis to discuss how to improve maternal health within their scope and membership. Together, these groups bring their collective impact to achieve improved health for women in Missouri.

The MC LAN has a broad membership that provides guidance, knowledge-sharing, and peer support in developing strategic quality initiatives based on the Triple Aim principles to support best practices that make birth safer, improve maternal health outcomes, and save lives. The PQC connects community, public health, and clinical leaders to improve the care and support systems that lead to better health and health outcomes before, during, and after a pregnancy. The PQC is currently supporting the implementation of several AIM bundles in Missouri hospitals. The purpose of the IMHC is to identify and foster solutions to address limitations in maternal health care availability,

capacity, trust, and utilization in Missouri. The goal is for Missouri mothers to have quality access to the entire continuum of pregnancy and postpartum care, thereby improving maternal health, mortality, and morbidity outcomes. This is accomplished by bringing together senior executives of partnering organizations to discuss how they can contribute to improving health outcomes in Missouri. MHAN comprises key stakeholders and strategic partners, including service providers, organizations, and mothers with experiential insight, from across the state. MHAN aims to develop strategic action plans and recommendations that foster effective cross-system collaborations to address barriers preventing mothers affected by perinatal substance use from accessing essential services. Ultimately, the goal is to improve behavioral health outcomes for mothers, children, and families impacted by perinatal substance use, as well as mental and behavioral health challenges. MCH Leadership, OWH, and other DHSS team members attend these meetings and provide insight based on team member subject matter expertise and insights gained from contractors and other partners.

The WHAC, led by OWH, supports DHSS leadership in identifying women's health issues and understanding policy opportunities to support women's health. This group will meet twice annually to support DHSS leadership with community perspectives to address emerging policy concerns.

The PAMR Board reviews maternal mortality cases to identify contributing factors and causes to prevent future maternal deaths. This group helps provide the data needed for identifying emerging health concerns. OWH leads this group and is responsible for all major components of the meetings.

The SUD Grant Program will work to enhance cross-sector collaboration and promote postpartum care through grantees, who will partner with health care organizations, community-based organizations, and local agencies to ensure the behavioral and health care needs of the maternal population are met.

MCH Leadership leads the statewide Fetal Infant Mortality Review (FIMR) Network and interfaces with the Missouri Child (0-17 years) Fatality Review Program (CFRP) to identify any trends in fetal and infant mortality related to postpartum health. The FIMR Network will include the promotion of whole-person follow-up postpartum care as a protective strategy in response to all fetal and infant loss.

MCH Leadership will collaborate with partners and stakeholders to promote postpartum checkups and whole-person postpartum follow-up care across the full 12-month postpartum period. MCH Leadership will work with the MHA and the Missouri MC-LAN/PQC to provide guidance, education, and programming to improve the health care experience and outcomes for pregnant and postpartum women and their babies. The MCH Director will work with MO HealthNet Maternal/Infant Health leadership to provide technical assistance and training for LPHAs, as needed, regarding Notification of Pregnancy, MO HealthNet for Pregnant Women, prenatal risk assessments, prenatal case management, postpartum benefits, and benefits available for perinatal substance use treatment and mental health services. MCH Leadership will partner across internal programs and with the University of Missouri, LPHAs, MHAN, home visiting programs, the full scope of women/maternal health care providers, pediatricians, family practitioners, provider organizations, and other partners working and interfacing with women during the postpartum period. Partnerships with community-based organizations and providers, including community health workers, doulas, midwives, community paramedics, peer support specialists, faith-based organizations, and more, will be leveraged to promote whole-person, patient-centered, coordinated, and comprehensive postpartum follow-up care.

DHSS will convene key organizational leaders in the IMHC to explore and improve maternal healthcare access across Missouri through exploration of 12 priority areas of action, identified based on interagency meetings and discussions with additional health advocates, providers, and provider organizations. The Consortium will explore initiatives to address the community and population-level factors that influence MCH outcomes and promote postpartum care and outcomes, such as remote telehealth for maternal-fetal-medicine visits, postpartum home visits, a 24/7 MCH call center, and increased utilization of community-based maternal care providers, such as doulas and community health workers. Additional priorities to promote maternal health include partnerships between maternal health care providers and birthing facilities, rural hospital and obstetric payment reform, malpractice liability coverage, modernization of birth center regulation, integrated nurse midwifery with obstetric care, EMS obstetric

readiness training, rural health workforce pipeline incentives, graduate medical education for obstetric providers, and a regionalized approach to assuring perinatal care and services.

Capacity Building
OWH supports the Cora Faith Walker Doula (CFW) Training program. OWH leverages Title V-funded staff capacity to support this state-funded training program and has sponsored training for the last three years. In state FY 2026, OWH will survey doulas to identify emerging and ongoing training needs and doula training organizations to identify training capacity, content, and needs. OWH will utilize survey findings to sponsor new training development, training provision, and continuing education for doulas in Missouri. To promote access to patient-centered, coordinated, and comprehensive postpartum care, OWH will ensure all doula trainings include information about the importance of postpartum visits and the transition to primary care after the postpartum period. OWH plans to evaluate the trainings using multiple strategies: doula training organizations will provide feedback to DHSS regarding the process of working with DHSS, promoting stronger community partnerships with community-based doula training organizations; OWH will measure the number of doulas trained; and, to learn about the economic impact of supporting doula training as an economic strengthener for Missouri, DHSS will review training logs and compare participant names to doula reimbursement information from DSS. This will show if doulas trained as a part of the CFW doula training program become employed and reimbursed as doulas through MO HealthNet.

To promote whole-person perinatal care, all patients should be screened for tobacco use, advised to quit, and connected with Missouri Tobacco Quit Services or another evidence-based cessation service, such as counseling with a Tobacco Treatment Specialist (TTS). TPCP will promote and support system changes within health care systems to screen and treat all clients for tobacco use and refer people who use tobacco to cessation services such as Missouri Tobacco Quit Services. In addition to cessation support, health system changes include tobacco-free facilities that promote quitting and eliminate exposure to secondhand smoke. Free TTS training and a Health Systems Change Community of Practice are available to providers and health systems. TPCP will offer and promote statewide technical assistance, support, and free resources for health care providers throughout Missouri to increase the number of providers in the state who screen all patients for tobacco use and refer them to evidence-based cessation using the Ask, Advise, Refer model.

Newly developing collaborative efforts across DHSS, MO HealthNet, MHA, the IMHC, the Mobile Integrated Healthcare Network, and other key partners will include strategies to improve clinical readiness, recognition, and response to obstetric/perinatal emergencies.

NPM: Preventative Dental Visit – Pregnancy - Preventive oral health care services during pregnancy.

Oral health plays an essential role in supporting healthy pregnancies. A recent study published in *Oral Health and Preventive Dentistry* showed when a pregnant woman receives treatment for a gum infection, it can reduce her risk of going into pre-term labor by 50%. The ODH team includes a dentist, dental hygienist, and several public health professionals and leads efforts to promote and educate on the importance of oral health. ODH will educate pregnant women, medical and dental providers, and other community partners on the importance of dental visits and oral health during pregnancy. Training for dental providers will include content on providing whole-person, patient-centered, coordinated, comprehensive, and respectful care. As funding is available, ODH will continue to create and distribute Brushing for Two kits, which include educational materials on proper oral care, tobacco cessation, and lead poisoning and prevention and oral care supplies for mom and baby.

To increase the number of pregnant women who receive a preventive dental visit and ensure preventive oral health care services during pregnancy, ODH will partner with the MCH Services Program to deliver oral health education to pregnant women through the MCH Services contract with LPHAs. LPHAs will facilitate dental appointments for pregnant women with their local dentist, FQHC, or dental clinic that accepts Medicaid and track subsequent dental visit attendance. LPHAs will provide education to the obstetric care providers on the importance and safety of a preventive dental visit for pregnant women. The MCH Services Program will encourage LPHAs to conduct an oral health review, provide oral health education and supplies, and make dental care referrals, as indicated, for pregnant

women receiving LPHA services. ODH will develop the Medical/Dental Home brochure to be provided to OB/GYNS and encourage warm hand-offs for oral care during pregnancy. To support LPHA outreach efforts, ODH will promote use of social media messages, created specifically for use by LPHA, highlighting the importance and safety of a preventive dental visit during pregnancy, with the family unit being considered in messaging.

In conjunction with other funding, ODH educates and provides guidance to promote the importance of oral health across the lifespan, with a focus on supporting families through education on topics such as water fluoridation, preventive oral care, access and workforce shortage challenges, and how oral health affects overall health. ODH will develop resources and provide water fluoridation education to towns and cities across Missouri, training to water operators and public and dental health professionals, and guidance on emerging water fluoridation issues. ODH will partner with dental clinics to conduct diabetes risk assessments, collect relevant data, and educate high-risk patients about ways to reduce the risk of developing diabetes.

ODH works with MO HealthNet to promote oral health at MHD's annual regional meetings to doulas, LPHAs, and other maternal service providers. ODH also maintains a partnership with the Missouri Primary Care Association, participating in their quarterly Oral Health Network meetings to educate on oral health initiatives, namely the importance of partnering with LPHAs to provide care to pregnant women. As funding allows, ODH will speak and exhibit at health promotion events, health fairs, conferences, and other educational opportunities to promote the importance of oral health during pregnancy. ODH will work closely with the MCOs and other funders to identify joint opportunities for expanding oral health education and resources and, in FY 2026, aims to partner with at least two MCOs on different events and programs to promote the importance of oral health during pregnancy. ODH is scheduled to exhibit and speak at Babypalooza events, which target pregnant women in rural areas . Information will be given on proper oral hygiene techniques for the parent and baby, the safety and importance of a dental visit, and general oral health information.

ODH works to build the oral health workforce and ensure oral care for the entire population. Recognizing the challenges of a strained oral health workforce, ODH will actively collaborate with Delta Dental of Missouri and community partners to explore strategies to develop a stronger oral health workforce. ODH will work in long-term care facilities to provide oral hygiene training to staff for providing dental services to facility residents. ODH will partner with dental education schools to expand dental assisting programs and with MPCA to enhance the dental assisting training program for high school students.

The MCH Services Program will work closely with ODH to increase educational and technical assistance opportunities to enhance knowledge and skills among LPHA contractors to develop five-year work plans utilizing the *What Works Evidence Accelerators.* Evidence-based strategies to increase the percentage of women who have a preventive dental visit during pregnancy include patient education and counseling, Quality Improvement Collaboratives, information about the use of teledentistry, and provider education, including for Early Head Start, Home Visiting, and WIC providers.

The Adolescent and School Health Program will partner with LPHAs, school districts, and community partners to deliver an evidence-based curriculum for adolescent females ages 14-24 focused on healthy decision-making about relationships, pregnancy, partnering, and more. Each lesson has a supplemental session to facilitate guest presentations on a variety of topics related to pregnant and parenting teen mothers. In collaboration with ODH, one featured session will cover the importance of proper oral health care for themselves and their child. Information on how to access and enroll in MO HealthNet will also be included.

The TEL-LINK Program will refer callers to community-based dental clinics, with the option to find low-cost or reduced dental services, to increase awareness of community resources and access to needed dental health services. The program will provide outreach to the underserved population through effective marketing strategies, such as search engine campaigns.

Other Activities to Promote Women and Maternal Health

The significant risks associated with lead exposure for women of childbearing age, developing fetuses, and breastfed infants are not generally well-known and understood. The most severe effects of high blood levels of lead during pregnancy are miscarriage and stillbirth. Other complications during pregnancy, 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 ability to reason and problem-solve, hearing impairment, and learning and behavioral challenges. The Childhood Lead Poisoning Prevention Program (CLPPP) will 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 *Pregnancy and Beyond* and other pamphlets and brochures, for distribution to expectant and new parents;
- Provide lead education and resource materials to health care providers, LPHAs, health plan lead case managers, and WIC staff regarding the need to discuss lead poisoning prevention and lead testing with clients; and
- Provide LeadCare Analyzers and lead test kits to LPHAs that do not have the capacity to provide accurate lead screenings, allowing them to routinely offer the service.

The MCH Director will actively engage in statewide collaborative efforts to promote the health of women of childbearing age, including but not limited to leading the State Health Improvement Plan (SHIP) Infant and Maternal Health priority area and continued engagement in PAMR, the MC-LAN, the Women's Health Committee, the Maternal Health Action Network, 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 the sharing of information and resources, shared learning, and identification of opportunities for alignment and collective impact. Efforts will continue to actively engage and leverage partnerships with a broad spectrum of partners across the state, such as LPHAs, MCOs, healthcare systems, the Women and Infant Substance Help (WISH) Center at SSM Health, MPCA, Generate Health, the Bootheel Perinatal Network, Bootheel Babies and Families, Uzazi Village, Jamaa Birth Village, the Missouri Foundation for Health, Health Forward Foundation, and many others. New opportunities for collaboration will be explored with the Children's Trust Fund, St. Louis Integrated Health Network, Mobile Integrated Health Network, Catholic Charities of Southern Missouri, and The Doula Foundation, as well as other partners yet to be identified. The MCH Director will participate in the Region 7 Maternal Health Alliance and collaborate with the Regional Public Health Analyst in the Office of the Assistant Secretary for Health (HHS) and other Region 7 states to advance maternal health initiatives across the region.

State Health Improvement Plan

Improving Infant and Maternal Health is one of the priorities identified by the State Health Assessment and addressed by the SHIP. The goals and objectives outlined under the Infant and Maternal Health priority area are set on a five-year project scale, with work ongoing through 2027. DHSS recognizes infant and maternal health are intrinsically linked and must be addressed within the framework of the mother-infant dyad to achieve the goal of advancing optimal health during the childbearing continuum and improve health outcomes for childbearing women and their infants. MCH Leadership will collaborate with a wide-ranging group of partners to implement activities to achieve three targeted objectives.

- Increasing the percentage of women of childbearing age who have received selected women/maternal preventive health services will be accomplished by:
    - Engagement of community health workers, doulas, and other community-based maternal health care providers.
    - Partnering with community-based organizations to provide prenatal care.
    - Implement community-based health promotion efforts.
    - Raising awareness of the importance of reproductive life planning.
    - Educating women on the importance of immunizations.

- Promoting comprehensive health care for pregnant women, postpartum women, and women of childbearing age.
- Supporting activities and facilitating partnerships to create environments that support healthy eating and active living.
- Partnering with tobacco control programs and community-based partners to assure delivery of effective tobacco cessation services.
- Participating 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 outcomes.
- Addressing underlying community and population-level factors that influence MCH outcomes.

- Increasing the percentage of women of childbearing age who self-report having received "respectful care" will be accomplished by:
  - Providing education to providers on the 12 domains of respectful care: being free from harm and mistreatment; maintaining privacy and confidentiality; preserving women's dignity; prospective provision of information and seeking of informed consent; ensuring continuous access to family and community support; enhancing quality of physical environment and resources; providing responsive maternal care; engaging with effective communication; respecting women's choices that strengthen their capabilities to give birth; availability of competent and motivated human resources; provision of efficient and effective care; and continuity of care.
  - Partner with academic institutions to include respectful care into the education curriculum for all health care professionals (physicians, nurses, social workers, APRNs, nutritionists, health care administrators) including facility related issues such as women's perception of incompetence or disrespect of professionals attending delivery, unhygienic facilities and unavailability of basic supplies.
  - Qualitative phenomenological study with focus group discussions (FGDs) with primipara and multipara women using a semi-structured discussion guide to elicit discussion and audio recording and transcribing interviews verbatim.
  - Analyze data using thematic analysis approach to describe the prevalence of various categories of mistreatment during admission, labor and delivery, and postpartum care (losing self-control, being overlooked, being informed of bad news without proper preparation, repeated examination without being properly communicated/informed, disallow companions and left unattended during labor).

- Reducing the percentage of preventable maternal deaths with underlying mental health issues, including SUD will be accomplished by:
  - Establishing a Perinatal Health Access Project.
  - Promote the use of validated screenings of mental health conditions and substance use disorder to be conducted at multiple intervals during pregnancy and the postpartum period.
  - Increasing provider knowledge of how to treat mental health conditions during pregnancy.
  - Promoting changes in systems, policies, and environments; fostering positive public dialogue; countering shame, prejudice, and silence; and building public support for suicide prevention.
  - Addressing the needs of vulnerable groups, tailoring strategies to match the cultural and situational contexts in which they are offered and seeking to eliminate disparities in health outcomes.
  - Collaborating with behavioral health agencies and partners to implement the Strengthening Families Protective Factors Framework.
  - Promoting efforts to reduce access to lethal means among individuals with identified suicide risks.
  - Implementing and spreading evidence-based suicide and self-harm prevention strategies and programs.
  - Strengthening collaboration across agencies, developing new tools and capacity, and implementing evidence-based change in suicide and self-harm prevention strategies.

DHSS will engage community-based organizations, community partners, and community members in developing, implementing, and maintaining programs and initiatives to promote access to health care, including preventive oral

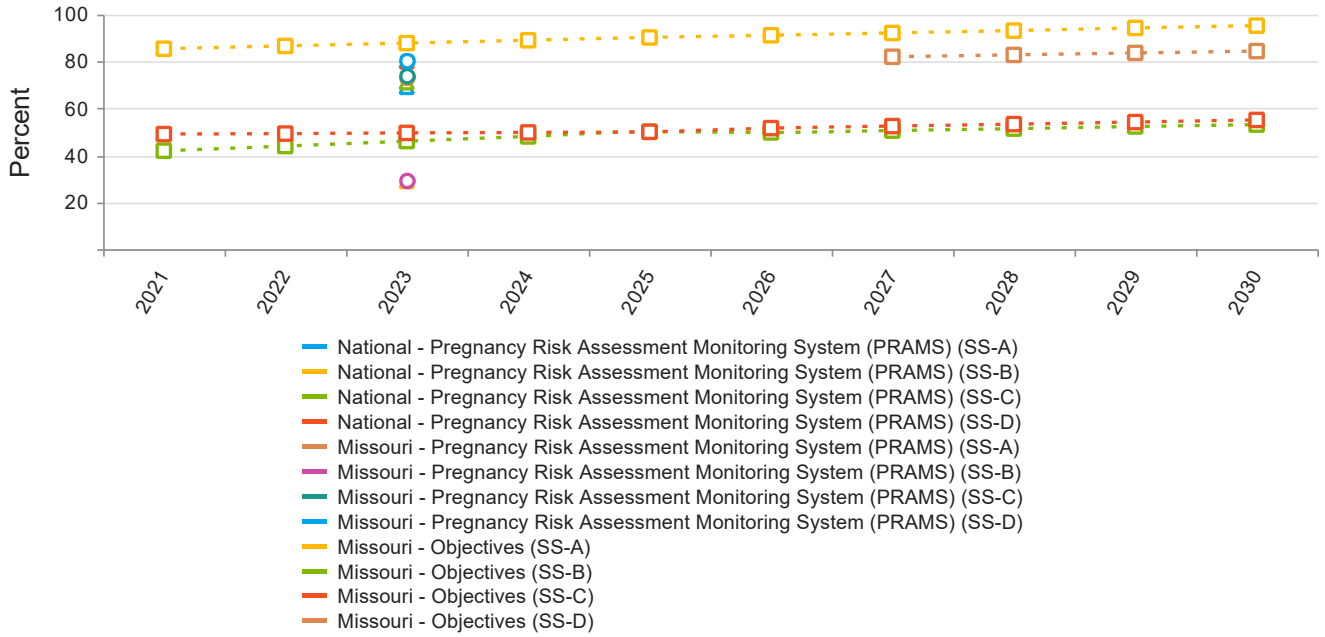
health care services, during the perinatal period. The values of patient/family-centered shared care planning will be promoted across all efforts led and participated in to operationalize core values of family-centered care and ensure families are full partners in assuring patient-centered, coordinated, and comprehensive perinatal care and optimal maternal health outcomes.

Perinatal/Infant Health

National Performance Measures

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 D) Percent of infants room-sharing with an adult during sleep - SS

Indicators and Annual Objectives



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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		85.2	86.4	87.6	88.8
Annual Indicator	83.1	84.8	82.9	82.8	72.9
Numerator	54,118	53,369	51,856	51,597	42,851
Denominator	65,137	62,925	62,533	62,314	58,773
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	90.9	91.9	92.9	94.0	95.0

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		41.9	43.9	46	48
Annual Indicator	40.3	37.1	36.6	35.5	28.9
Numerator	25,609	23,096	22,467	21,574	16,786
Denominator	63,599	62,314	61,451	60,782	58,181
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	49.7	50.5	51.3	52.2	53.0

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		49	49.2	49.5	49.7
Annual Indicator	55.0	54.6	58.9	60.1	73.7
Numerator	35,105	33,976	36,271	36,443	43,433
Denominator	63,808	62,273	61,579	60,621	58,900
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	51.5	52.4	53.2	54.1	55.0

NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	80.2
Numerator	47,479
Denominator	59,177
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	81.8	82.6	83.4	84.2	85.0

Evidence-Based or –Informed Strategy Measures

ESM SS.1 - Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bedsharing or soft bedding (aligned with MIECHV performance measure).

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		83.6	83.8	84	84.6
Annual Indicator		76.6	99.4	97.8	97.5
Numerator		108	166	264	427
Denominator		141	167	270	438
Data Source		MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program	MO DHSS DESE Safe Cribs Program	MO DHSS DESE Safe Cribs Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	80.3	82.0	83.7	85.3	87.0

State Action Plan Table

State Action Plan Table (Missouri) - Perinatal/Infant Health - Entry 1
Priority Need
Safe infant sleep practices and environments to promote safe infant sleep and reduce sleep-related infant deaths.
NPM
NPM - Safe Sleep
Five-Year Objectives
By September 30, 2030, Missouri will maintain at least 95% percent of infants placed to sleep on their backs (PRAMS Phase 9, 2023-Ongoing).
By September 30, 2030, Missouri will increase the percent of infants who are placed to sleep in a crib, portable crib, or bassinet from 92.8% to 94.5% (PRAMS Phase 9 Q50A, 2023-Ongoing).

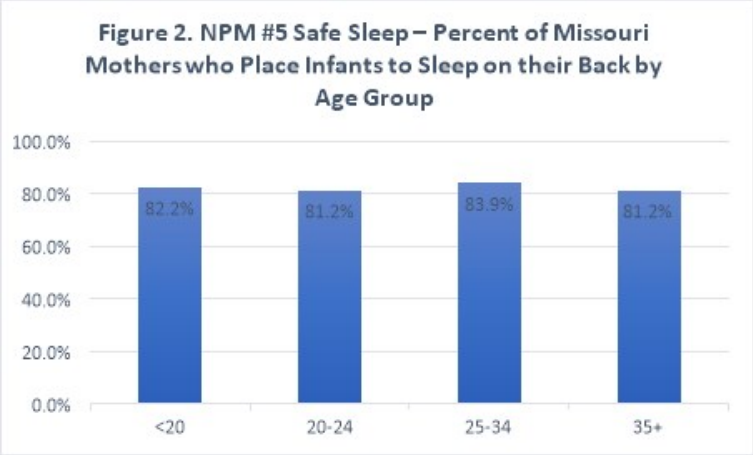
Strategies
Promote whole-person infant care, within the broader framework of the maternal-infant dyad and family.
Implement targeted initiatives that support breastfeeding initiation and duration, particularly in counties with low breastfeeding rates, to promote breastfeeding as part of safe infant sleep practices, consistent with AAP guidance.
Examine the circumstances surrounding infant deaths to identify systemic contributing factors and develop community-based action plans to prevent future deaths and improve infant health outcomes.
Identify and collaborate with partners to implement strategies to address community factors contributing to infant health risks and outcomes.
Engage in cross-sector partnerships and collaborations to design, implement, and evaluate QI initiatives to promote safe infant sleep practices and environments.
Enhance cross-sector collaboration to promote safe infant sleep practices and environments to promote safe infant sleep and reduce sleep-related infant deaths.
Provide training, emphasizing a nuanced approach to take family needs, beliefs, and contexts into account when talking about safe infant sleep practices and environments, to all types of providers and community members who interact with expectant and new mothers and families regarding safe infant sleep practices and environments.
Partner and collaborate with cross-sector stakeholders to provide person-centered guidance related to protective factors and implement and spread community-based safe infant sleep educational campaigns and evidence-based infant health promotion programs.
Partner and collaborate with cross-sector stakeholders to distribute safe sleep resources to families with limited resources and access.
Promote implementation and spread of evidence-based prevention and emergency perinatal mental health programs and services.
Promote and support traditional and nontraditional provider roles and community-based models of perinatal and infant care.

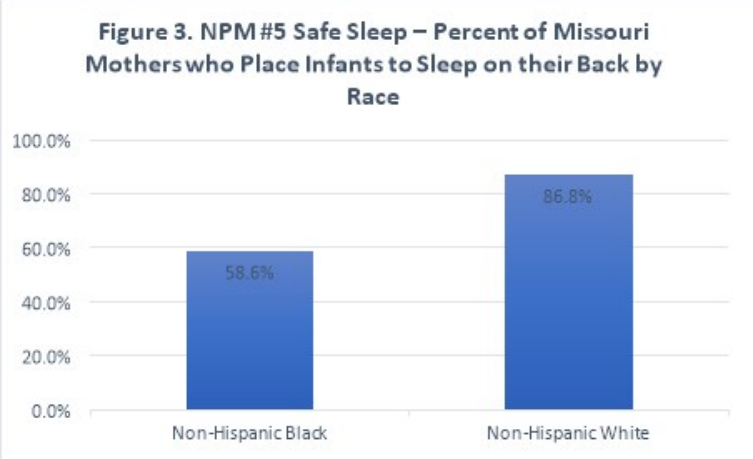
ESMs	Status
ESM SS.1 - Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bedsharing or soft bedding (aligned with MIECHV performance measure).	Active

NOMs
Infant Mortality
Postneonatal Mortality
SUID Mortality

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 percentage of infants placed to sleep on their backs as a State Performance Measure. According to the 2023 Pregnancy Risk Assessment Monitoring System (PRAMS), 72.9% of Missouri mothers placed infants to sleep on their backs. This is higher than the national proportion of 69.0% of women who placed infants to sleep on their backs. PRAMS data indicate mothers aged 25 and older are more likely to place babies to sleep on their backs (Figure 2). 2023 PRAMS data showed a difference, both in Missouri and nationally, between the percent of Non-Hispanic White and Non-Hispanic Black mothers who placed infants to sleep on their backs (Figure 3). College graduates were the highest proportion of mothers who laid infants to sleep on their backs (79.7%). Those with private insurance had a higher percentage of infants placed to sleep on their backs (76.6%) than those on Medicaid (71.0%). Continued education, outreach and collaboration with partners are needed to decrease these disparities and increase awareness among mothers, caregivers and community members about safe sleep practices.





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 also funded 10 Safe Kids (SK) coalitions, serving 53 counties in Missouri. All 10 coalitions provided 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 addressed injury prevention priorities such as crib safety and safe sleep based on community needs. The coalitions provided cribs, safe sleep education and resources to parents/caretakers, conducted media campaigns with safe sleep promotion messages, and worked with policymakers to address gaps in policies that could prevent safe sleep injuries. The SK coalitions worked closely with law enforcement officers, firefighters, paramedics, medical professionals, educators, community agencies, businesses, public policymakers, and, most importantly, parents, children, and adolescents. More than 700 pack-n-plays, along with AAP safe sleep education and training, were distributed through SK activities. In addition, 84 safe sleep events and trainings were held to increase participants' knowledge on ways to reduce the risk of infant death due to unsafe sleep environments. These events and training included more than 2,700 participants, such as expectant parents, new parents/caregivers, grandparents, first parents, first responders, and public safety officers.

SSM Health Cardinal Glennon Children's Hospital, the site of the SK Coalition in St. Louis, provided the one-hour safe sleep training developed by the SSM Health Safe Sleep Champion committee co-chairs. The training, based on evidence-based infant safe sleep recommendations, was provided to more than 550 first responders, including law enforcement, health care providers, emergency medical services personnel, firefighters, and other public safety professionals. The goal of the training was for first responders to understand the importance of infant safe sleep, have the requisite knowledge to identify an unsafe sleep environment, and be able to provide evidence-based safe sleep education to caregivers in the communities they serve. Pediatric residents, advanced practice nurses, and all new SSM Health Cardinal Glennon Children's Hospital employees were also trained as safe sleep champions.

The SSM Health Cardinal Glennon Safety Program also assessed the infant's current sleeping environment when parents or grandparents of a child under the age of one came in for a car seat appointment. If the team determined the child was sleeping in an unsafe sleep environment, the caregivers received safe sleep education and a safe sleep environment (portable play yard and bedding). The SSM Health Cardinal Glennon Safety Program provided safe sleep education at monthly Baby Safety 101 and virtual infant and child cardiopulmonary resuscitation (CPR) classes. Cardinal Glennon partnered with new and existing community agencies to provide the Baby Safety 101 classes to over 400 participants within the community to reduce barriers for the populations at greater risks for poor outcomes. Baby Safety 101 classes covered various topics for new and expecting parents and grandparents, such as the importance of prenatal and well-baby care, immunizations, poison prevention, oral health, home, fire, firearm, and medication safety. Upon completing the class, caregivers received a free safe sleep environment if they lacked the means to purchase one. The virtual infant child CPR classes had over 100 participants.

All Title V 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 coordinated with the Safe Cribs for Missouri Program and/or other local partners to obtain portable cribs for families who could not afford one. Based on data collected from birth through twelve months of age, 63% (142/225) of infants enrolled in home visiting were always placed to sleep on their backs, without bedsharing and without soft bedding. The Home Visiting Program updated and provided information to all contracted home visitors 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 methods, including the monthly home visiting newsletter with LIAs and during annual home visiting professional development events.

The Safe Cribs for Missouri Program in the Office of Childhood (OOC) at DESE provided portable cribs and safe sleep education resources to participating agencies. The Program utilized MCH funds to serve 86 counties, including five counties added during FY 2024.

The program continued to partner with DHSS and Safe Sleep Coalition partners to provide current educational resources that promoted SIDS risk reduction and safe sleep environments and practices. Updated DHSS warehouse ordering information was provided to agencies contracting with the Safe Cribs for Missouri Program. All education programs and resources comply with the evidence-based AAP safe sleep recommendations. The Safe Cribs for Missouri Program provided resources to all counties participating in the safe cribs program. Resources included the safe sleep video, the "This Side Up" t-shirt, and other educational materials available from DHSS at no charge. As facilitator of the statewide Safe Sleep Coalition, the Safe Cribs Program facilitated two coalition meetings. The Safe Sleep Coalition worked towards re-organizing and re-aligning the goals of the coalition to move

forward in the future. Updated resources, including a brochure and training videos, were made available on the Home Visiting webpage. The Safe Cribs for Missouri Program attended one health fair and two community baby showers to promote safe sleep education. The program also expanded into five additional counties in Missouri.

TEL-LINK is Missouri's toll-free MCH hotline and provides confidential information and referrals on maternal and child health services. The TEL-LINK Program continued to provide health care service referrals to increase access to care for. TEL-LINK was promoted through search engine campaign outreach to at risk populations. TEL-LINK supported and collaborated with community-based programs that provide cribs for low-income families.

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

- The Crawford County Health Department increased provider knowledge related to safe sleep among child care providers in Crawford County from a baseline of zero child care providers in FY 2022 to ten at the end of FY 2024. The health department paired providing safe sleep education with the annual sanitation and health inspection the child care provider is required to complete as part of the State of Missouri child care operating requirements. The health department provided resources from Safe Sleep Missouri, including the video, "ABC's of Safe Sleep."

- The Pike County Health Department increased knowledge around safe sleep among families, including families within the Amish community, from a baseline of one family in FY 2022 to a total of 60 at the end of FY 2024. The health department has a great partnership with a local physician assistant and together make home visits to Amish families per request after birth, providing newborn screening. In FY 2024, health department staff began leveraging these visits and, in addition to screening, provided safe sleep education and materials. Recognizing cellular devices and videos are not preferred by the Amish community, the health department provided verbal and written education followed by a live demonstration of a safe sleep environment. The Safe Sleep ABC's door hanger and Safe Sleep brochure were provided. If the family did not have a safe sleep environment, they were screened and enrolled into the Safe Cribs for Missouri Program or the Pike County Safe Cribs Program and provided with a pack-n-play.

- The Vernon County Health Department increased knowledge and skills regarding safe sleep best practices from a baseline of zero in FY 2022 to 38 at the end of FY 2024. The evidence-based Safe Sitter® program was used to teach babysitting skills to students in grades 6-8, introducing them to child care and child development, including safe sleep practices for infants. The health department hosted two courses in FY 2024, increasing knowledge and skills among 18 students.

DHSS continued to support and participate in the Maternal and Child Learning and Action Network (MC LAN) and Perinatal Quality Collaborative (PQC), facilitated by the Missouri Hospital Association (MHA), to support the reduction of severe maternal and infant morbidity and mortality throughout the state. A broad clinical and community network of maternal-child stakeholders, the MC LAN/PQC provides guidance and subject matter expertise, facilitates the exchange of knowledge, and provides peer support for the creation of effective quality initiatives, centered around the Quadruple Aim principles of enhancing patient experience, improving population health, reducing costs, and improving the work life of health care providers. The PQC includes access to evidence-based initiatives, technical support, education and resources. Quality improvement collaboratives, designed to result in highly reliable processes and improved care outcomes, are deployed for more complex topics. PQC QI initiatives include severe hypertension in pregnancy; obstetric hemorrhage; perinatal mental health; maternal substance use disorder; and cardiac conditions of obstetric care. In addition, the PQC prioritizes improving health outcomes for counties lacking OB providers and defined as maternal-infant deserts. The PQC, in partnership with MHA, awarded two series of stipends to Missouri hospitals and community-based organizations to support implementation of universal SUD, Mental Health, and Postpartum screening and brief intervention and referrals to treatment and Eat, Sleep, Console models for pregnant and postpartum women with substance use disorders and/or mental health conditions and infants born with neonatal abstinence syndrome.

The Mothers, Infants, and NAS ECHO (Extension for Community Healthcare Outcomes), sponsored by the University of Missouri's Telehealth Network, supported rural health care providers in caring for the mother-infant dyad with substance exposure. The MCH Director and Maternal/Infant Mortality Coordinator participated 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 on the use of pharmacologic interventions for infants with in-utero exposure from maternal substance use;
- 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 continued to participate in, as well as be a resource for, the local and regional infant mortality initiatives, including Generate Health in St. Louis, Nurture KC in Kansas City, the Missouri Bootheel Regional Consortium, and the Bootheel Network for Health Improvement Bootheel Babies & Families initiative in the southeast region of the state. Nurture KC and the Missouri Bootheel Regional Consortium are also Missouri's Healthy Start grantees.

- St. Louis: Generate Health's initiatives include advocacy, the Bloom Network, a collaborative effort to provide quality care to families through home visitation, perinatal behavioral health, and safe sleep, and FLOURISH. FLOURISH offers programs and services aimed at equipping under-resourced communities to foster environments where children and families are optimally positioned to flourish.
- Kansas City: Nurture KC's focus is on traditionally low-income families who reside in hard-to-reach neighborhoods in Missouri and Kansas. They emphasize meeting everyone's unique needs and strive to help people of all demographics. 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 is a comprehensive community-led initiative to reduce infant mortality rates in the six-county (Scott, New Madrid, Mississippi, Pemiscot, Dunklin, and Stoddard) Bootheel region and has three key focus areas including healthcare, safe sleep habits, and substance misuse.

Child Care Providers

The DESE OOC Compliance Section licenses and regulates child care programs. Through ongoing regulatory inspections, OOC verifies compliance with licensing rules regarding infant safe sleep. OOC educates 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 before initial licensure or within their first 30 days of employment, and every three years thereafter. OOC reviews and approves safe sleep training, and ensures training is available in a variety of formats to increase licensed child care providers' knowledge of infant safe sleep practices. During child care inspections, OOC staff 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 approved safe sleep plans that meet the AAP guidelines with families upon enrollment, advancing outreach to families.

The Child Care Health Consultation (CCHC) Program assisted licensed child care providers in meeting the safe sleep training requirement set forth in Section 210.223.4, RSMo. Contracted LPHAs provided consultation and training on safe sleep practices to child care providers at licensed and license-exempt child care facilities. Consultants evaluated the implementation of safe sleep policies and procedures and identified areas for continued evaluation and improvement. The safe sleep trainings for child care providers addressed 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 increased provider knowledge on which infants are at highest risk for experiencing a sleep-related death, and which home environments place infants at the highest risk for unsafe sleep environments and/or sleep-related deaths. Consultants provided 66 hours of safe sleep training and consultation related to safe sleep practices, policies, and procedures. Trainings also continued 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 provided safe sleep guidance in alignment with the most recent safe sleep guidelines published by the AAP "Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment." Family attendance during CCHC Program services was encouraged, and evidence-based information and resources regarding safe sleep practices, including organizations to contact for access to free safe-sleep resources, were provided to families.

Breastfeeding

Child Care Health Consultation

The CCHC Program supported child care and early care and education programs through consultations and trainings provided by LPHA staff to promote breastfeeding practices in the child care setting. Consultants provided 12 hours of consultation and training for child care providers on the importance of supporting breastfeeding in the child care setting, its benefits to mothers and infants, how to safely and effectively support breastfeeding in the child care setting, and referring child care providers, children in their care, and their families to WIC. LPHA staff provided consultations and trainings for child care providers to assist in the development and implementation of policies and procedures that encourage and support breastfeeding, are welcoming to all mothers, including employees who breastfeed, provide referrals to outside resources such as WIC, and provide education about the important role breastfeeding plays in the health of both mother and child. In addition, trainings included guidance on safe handling and storage of breastmilk. Parent/guardian attendance during all program services was encouraged, and evidence-based information and educational resources on breastfeeding were provided to child care providers and families.

Hospitals

The State Breastfeeding Coordinator (SBC) collaborated 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 hosted 10 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 alternated between a topical presentation and a networking session every other month, allowing hospitals working on improving maternity care practices to benefit from mentorship from staff at designated Baby Friendly hospitals. In FY 2024, three hospitals were redesignated as Baby Friendly, one hospital was designated as Baby Friendly, one hospital received the "Show-Me 5" recognition, and one hospital became a CHAMPS hospital, leading them to apply for the "Show-Me 5" recognition in FY 2025. Funds from the Centers for Disease Control and Prevention (CDC) State Physical Activity and Nutrition (SPAN) grant were leveraged to support the webinars and address breastfeeding continuity of care. Guest speakers presented on a range of breastfeeding-focused topics, including findings from the Breastfeeding Learning Collaborative—a Southeast Region collaborative geared toward identifying and addressing barriers to continuity of care of breastfeeding in the region, the rise in breastfeeding rates during the formula shortage, findings from the Breastfeeding in Rural Missouri survey conducted by the Maternal Health Specialist from the University of Missouri Extension, and an overview of the Missouri "Show-Me 5" Breastfeeding Recognition Award.

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 was provided with the goal of increasing the number of International Board Certified Lactation Consultants (IBCLCs) in the state. SPAN funding was leveraged to support the IBCLC training. Basic and advanced lactation training are offered in alternating years at no cost to WIC local agency staff, hospital nurses working with new mothers and infants, and community partners working with breastfeeding mothers who are working toward IBCLC status or maintaining credentials. In FY 2024, 44 people from 31 unique sites completed the advanced level 45-hour course. Sites included 20 WIC clinics, six hospitals, two other clinics, two community sites, and one family-nurse partnership. To avoid potential count duplication due to dyads receiving services at multiple locations, the calculation of total potential population reach was based on WIC caseload data only, with 61,686 people potentially impacted by the lactation education training.

Local Public Health Agencies (LPHAs)

The Missouri WIC Program provided additional funding through the Breastfeeding Friendly WIC Clinic program to local WIC agencies that provided breastfeeding support beyond what is federally required through the WIC program. The additional support included participating in the Breastfeeding Peer Counseling (BFPC) program for at least a year, providing after-hours support, classes, support groups, and breast pumps, and working with other community partners to increase breastfeeding awareness. In FY 2024, 53 WIC local agencies (LAs) received extra funding for personnel time through this program, an increase of two LAs from FY 2023. WIC also provided education on breastfeeding to local WIC agencies and health department professionals and worked to increase the number of IBCLCs in these facilities. Additionally, WIC worked to increase the number of trained peer counselors who provide mother-to-mother support and encouraged partnerships with health care providers and other community organizations. In addition to this program, 81 WIC LAs provided BFPC services. Approximately 80 peer counselors attended the biennial Breastfeeding Peer Counseling Conference to network, learn about program updates, and receive training.

Breastfeeding initiation decreased slightly in the WIC program from state FY 2023 (July 1, 2022 to June 30, 2023) to state FY 2024 (July 1, 2023 to June 30, 2024), from 75.9 percent to 74.0 percent, respectively. The initiation rate in state FY 2023 was a historical high for Missouri WIC and likely due to the formula shortage during the same time. Breastfeeding duration at 12 months in state FY 23 was 15.5 percent, with an increase to 16.6 percent in state FY 2024. These duration rates are also historic highs, showing mothers who began breastfeeding were supported to continue breastfeeding. 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 SBC incorporated information about DHSS breastfeeding initiatives into breastfeeding training provided to WIC staff throughout the year. In FY 2024, 75 new WIC staff were introduced to these initiatives in the Breastfeeding Basics training for new staff, and 95 breastfeeding coordinators, breastfeeding peer counseling program coordinators, and BFPCs received more in-depth training on these initiatives at either the Breastfeeding Coordinator training or the BFPC Conference. WIC LA staff used the DHSS breastfeeding recognition programs to improve support for WIC breastfeeding mothers in their community. LA staff were trained to provide technical assistance to local businesses, child care providers, employers and other stakeholders to help improve policies, systems, and the environments in which Missouri mothers work and live. WIC LA staff participated in local breastfeeding coalitions and worked with hospital staff throughout the state to improve continuity of care for breastfeeding dyads. The SBC facilitated connections between hospital and WIC LA staff and recommended hospitals pursuing Baby Friendly designation or Show-Me 5 recognition have WIC LA or LPHA staff on their committees.

The SBC spoke with various other groups to promote the DHSS breastfeeding initiatives and/or educate about breastfeeding. The SBC spoke with a group of dietetic interns from Northwest Missouri State University about the history and importance of breastfeeding in public health, DHSS breastfeeding initiatives, and getting breastfeeding off to a good start in the first weeks after delivery.

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, as well as continuation of breastfeeding as long thereafter as the mother and child desire. Planned efforts included:

- Provision of breastfeeding peer counseling;
- Breastfeeding support groups;
- Individual, community, and provider education;
- Promotion of breastfeeding friendly worksites and child care centers; and
- Fostering coalitions and networking with the Missouri Breastfeeding Coalition.

The Southwest Region MCH District Nurse Consultant attended Missouri Breastfeeding Coalition meetings. The Missouri Breastfeeding Coalition works to protect, promote, and support breastfeeding for all Missouri residents. The East/Southeast Region MCH District Nurse Consultant serves on the Board of Directors for Bootheel Babies & Families (BBF) to support, educate, and empower families and community partners to improve maternal and child outcomes, enabling families to thrive. Each of the six Bootheel counties host monthly meetings within their communities.

Breastfeeding Friendly Sites

The BCHW partnered 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 provision for employers to provide workplace accommodations that enable breastfeeding employees to express breast milk and the Providing Urgent Maternal Protections or Nursing Mothers (PUMP) Act requirements for 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 SBC continued 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. The "Breastfeeding Friendly Worksite Award" evaluates employers on criteria for three levels of support: Gold, Silver, and Bronze. Businesses that met one of the three levels were recognized in their community and statewide. In FY 2024, three worksites earned recognition as a Breastfeeding Friendly Worksite at the Gold level, with a potential population reach of 264 employees. Many local breastfeeding coalitions and LPHA WIC peer counselors continued 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 promoted the toolkit and partnered with other organizations assisting businesses in the state to enhance employee health.

Similar to the "Breastfeeding Friendly Worksite Award," the "Breastfeeding Friendly Child Care" award recognizes early care and education (ECE) providers who meet advanced criteria for breastfeeding support. Criteria include having a written policy that reflects breastfeeding support, 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 continued with the Missouri Breastfeeding Coalition and local breastfeeding coalitions to promote the Breastfeeding Friendly Child Care Program. Partnering with Child Care Aware of Missouri, the "Breastfeeding Friendly Child Care" award and corresponding online training were promoted, and those who meet the criteria to earn the distinction were publicly recognized. Plans to further promote the award to parents and providers continued to be implemented. DHSS, DESE, and MOCAN ensured the "Breastfeeding Friendly Worksite" and the "Breastfeeding Friendly Child Care" awards were highlighted throughout worksite wellness and ECE outreach efforts.

The CCHC Program continued training child care providers to promote child care facilities as "Breastfeeding Friendly Child Care Facilities" and "Breastfeeding Friendly Worksites" for parents of enrolled, breastfed children and breastfeeding employees. LPHAs utilized the CCHC Program as a partner to promote the awards, as well as provide training. In-person and online trainings were available to meet the high provider demand. These award programs are low-cost, efficient, and provide realistic means to sustain support for breastfeeding families.

The Breastfeeding Program also promoted the new "Breastfeeding Welcome Here" initiative to recognize businesses that agree to train staff to be welcoming to breastfeeding families and display a "Breastfeeding Welcome Here" sticker on a door or window. Businesses that sign the Breastfeeding Welcome Here pledge agree to provide a welcoming environment where breastfeeding mothers can sit anywhere and enjoy a welcoming attitude from staff, management and, to the fullest extent possible, other customers. This initiative requires little effort on the part of businesses and helps expand community support for breastfeeding. In FY 2024, 21 sites pledged to welcome breastfeeding at their establishment, with a potential population reach of 11,717 people.

Resources for Parents

The Newborn Health Program (NHP) participated in statewide educational activities to increase awareness and promote recommended and evidence-based MCH practices, including breastfeeding. The NHP also provided 24,000 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 and the NHP's webpage that provides electronic access to similar breastfeeding information/resources, the NHP also hosted a virtual baby shower in collaboration with Healthy Birth Day, Inc. and worked with the Office of Dental Health (ODH) to

promote the importance of dental visits and counting fetal kicks.

Title V funded Home Visiting Program contracted home visitors provided education, resources, and support to enrolled prenatal participants to promote breastfeeding initiation and continuation through at least 6 months of age. 29% (32/112) of infants were breastfed any amount during the first six months among mothers who enrolled in home visiting prenatally. The Home Visiting Program assessed home visitors' technical assistance needs for breastfeeding through monthly subrecipient monitoring calls and provided resources and training opportunities through ongoing communication. Collaboration with the SBC continued to be encouraged to assure up-to-date information, promote training opportunities, and provide support for all contracted home visitors.

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

Risk-appropriate Care
The OWH continued 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 birthing facilities through the CDC's Levels of Care Assessment Tool (LOCATe). LOCATe helps identify which facilities have no formal written transfer plan for high-risk deliveries. The OWH collaborates 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 ensures a more standardized approach for caring for high-risk patients and increases the likelihood of high-risk, very low birthweight babies being born at a level III+ facility, thereby reducing infant morbidity and mortality. SB50 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
According to the CDC, Missouri has the 18th highest stillbirth rate in the country. Missouri vital statistics show there are approximately 353 stillborn births each year. The NHP partnered with Healthy Birth Day, Inc. to implement and operate a *Count the Kicks* Public Awareness Campaign to support pregnant women and reduce Missouri's stillbirth rates. *Count the Kicks* teaches the importance of and method for counting a baby's kicks in the third trimester of pregnancy. A FREE *Count the Kicks* pregnancy app and free educational materials are available from *Count the Kicks*. The NHP continued to partner with a wide range of community health partners to promote *Count the Kicks* resources.

Newborn Screening
The Newborn Screening Program worked to increase awareness of newborn screening and ensure 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 worked with birth providers in both inpatient settings and the homebirth community to provide education and technical assistance. In addition, the program networked 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) continued working to ensure newborns were 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 continued to pursue a reduction in loss due to follow-up/loss to documentation to ensure newborns do not miss the opportunity to develop adequate language skills. Activities included family support, referrals to EI, and education of health professionals and service providers.

Oral Health
In the summer of 2024, the ODH created 10,000 "Brushing 4 Two" Kits that were distributed to organizations, such as LPHAs, who worked closely with pregnant women. The kits included instructions on proper oral health for pregnant women and newborn infants. The kits contained items such as a finger swipe made to gently clean newborn babies' gums and other items for caregivers' use to clean the small mouths of newborns and toddlers. ODH also collaborated with MHA on their pregnancy book and scheduled a webinar to talk about oral health and pregnancy to the MHA members and other interested parties. ODH also provided education about the importance of oral care during pregnancy and starting oral care at an early age during numerous events.

Maternal Health Multisector Action Network
DHSS continued its partnership with the University of Missouri Kansas City Institute for Human Development (UMKC-IHD) to

support and facilitate the statewide Maternal Health Action Network (MHAN). MHAN worked closely with partners to develop strategic action plans and recommendations, foster effective cross-system collaborations to address barriers preventing mothers affected by perinatal substance use from accessing essential services, and improve behavioral health outcomes for mothers, children, and families impacted by maternal substance use and mental health challenges. During FY 2024, MHAN restructured the core priority workgroups, launched the Moms' Advocacy Network, developed and launched the Leadership and Self-Advocacy Academy, provided education and training, including poster and oral presentations, and hosted an in-person convening of partners and stakeholders. To connect stakeholders with related initiatives and resources, the MHAN project team released three issues of the MHAN Quarterly Newsletter, regularly shared news items, opportunities, and program highlights, and updated the MHAN website. The Mothers' Advocacy Network and Leadership and Self-Advocacy Academy prepare mothers to advocate with decision makers on behalf of mothers with SUD and mental health challenges. Full details regarding MHAN are included in the FY 2024 MHAN Annual Report.

Additional Performance Analysis

The Newborn Screening Program collaborated with the education department at Mercy St. Louis to provide a newborn screening in-service to nearly 200 NICU and nursery nurses. The program also presented newborn screening information at the Statewide Community Health Worker (CHW) Advisory Meeting. The slide show used for this presentation is being designed as a future online tool for ongoing education for CHWs and doulas. The program visited an integrative medicine clinic in Springfield to provide education and support to the staff who collect blood spot samples for their patients who deliver at home or need a repeat sample collected. The program collaborated with the OWH, Office of Public Information, and University of Missouri Children's Hospital & Birthing Center to create a collection of photographs and a blood spot collection video for educating health care providers. The materials are still in the editing and finalization stages, with final products hopefully available later this year. Both the photos and video clips feature Missouri parents, newborns, and health care providers in the MU Health Care setting.

Challenges

The Newborn Screening Program faced challenges with limited staff, resources, and time for more extensive outreach efforts. Similarly, the Safe Kids Coalitions reported difficulties with staffing changes, funding, and a reduction in the number of counties covered by the coalitions. The CCHC Program experienced internal and external challenges, including limited LPHA workforce capacity, LPHA workforce turnover, and limited program services due to program funding limitations.

Finding new speakers to address topics related to the 10 steps of the Baby Friendly Hospital Initiative posed challenges for SBC. Participation in the Baby Friendly Collaborative was lower due to changes in funding and using GovDelivery to email participants instead of personal email. There were very few new Breastfeeding Friendly Worksites, likely due to WIC LAs and LPHAs having limited time to pursue the program and the lack of funding incentives for businesses to set up lactation rooms.

Although peer counseling is very successful, LA staff reported difficulty recruiting and retaining peer counselors due to several factors, primarily lower pay, increased difficulty finding child care for the peer counselor's children due to the part-time nature of the job, and the lack of remote work opportunities. LA administrators reported not applying for funding or not using funding due to the difficulty in hiring or the low amount of funding offered.

Home Visiting experienced challenges collecting consistent data regarding safe sleep practices (observation versus parent report) and variations in traditional beliefs and customs regarding co-sleeping adhered to by some populations. Additionally, mothers having to return to work sooner before breastfeeding is established and with employment agencies that do not support breastfeeding practices created challenges. Home visitors report areas where hospitals do not encourage and support breastfeeding during hospital stays after births. Mothers are also released from the hospital sooner after the birth, not allowing opportunities for breastfeeding support.

Assuming leadership of the Safe Sleep Coalition was challenging for the Safe Cribs of Missouri Program without historical knowledge of coalition operations. The program also experienced challenges gathering follow-up data from participants in the program.

Opportunities

The Newborn Screening Program restructured a vacant position to hire a follow-up nurse for more targeted focus on outreach and education.

The Missouri WIC program is changing the qualifications for the Certified Professional Authority (CPA) role. In addition to other changes, IBCLCs and breastfeeding peer counselors with at least four years of consecutive WIC service out of the last six years will now be eligible to be trained and promoted into the CPA role. This will open a career pathway for talented peer counselors and allow WIC to retain these valuable employees. This is expected to expand the pool of WIC professional staff and may improve participation in the peer counseling program.

The state FY 2026 budget removed funding for evidence-based home visiting from DESE's budget and reappropriated funding for the Missouri Parenting Partnership Program (MOPPP) and Maternal, Infant, & Early Childhood Home Visiting (MIECHV) to the Children's Trust Fund (CTF), within the state Office of Administration. The Safe Cribs of Missouri Program, including leadership of the Safe Sleep Coalition, and Title V funded home visiting programs are being administered by OOC through September 30, 2025, and will then return to DHSS. DHSS will collaborate with CTF to align statewide home visiting practices and performance measurement.

Perinatal/Infant Health - Application Year

NPM: Safe Sleep - Safe infant sleep practices and environments to promote safe infant sleep and reduce sleep-related infant deaths.

Perinatal health encompasses the period from conception through the first year of a child's life, including fetal development, the health and wellbeing of the newborn, and infant health and safety. Fetal health is influenced by factors like maternal health, nutrition, and lifestyle choices, as well as genetic, infectious, and environmental influences. Early identification and treatment for heritable disorders, proper nutrition, a safe environment, vaccination against communicable diseases, and normal growth and development are crucial to optimal infant health. The rate of infant mortality is a key indicator of a society's overall health, and death related to unsafe sleep practices is one of the leading causes of infant death. AAP recommendations for a safe sleep environment to reduce the risk of infant sleep-related deaths include supine positioning; use of a firm, non-inclined sleep surface; room sharing without bed sharing; and avoidance of soft bedding and overheating. Additional recommendations to reduce the risk of sudden infant death include human milk feeding; avoidance of exposure to nicotine, alcohol, marijuana, opioids, and illicit drugs; routine immunizations; and use of a pacifier.

Safe Sleep Initiatives
The Safe Cribs for Missouri Program provides portable cribs and safe sleep education to low-income families who have no other resources for obtaining a crib. Effective October 1, 2025, the Title V funded Safe Cribs for Missouri Program will transition from DESE back to DHSS. The program will be implemented through LPHAs, The Alliance for Southwest Missouri, and the Southeast Missouri Building Blocks home visiting program. Through a combination of Safe Cribs for Missouri and other crib assistance programs, all but three counties in Missouri are covered. MCH Leadership will work with GHC programs to sustain Safe Cribs for Missouri programming.

BCHW serves as the state lead for Sake Kids Worldwide to implement and facilitate the accomplishment of common goals and objectives concerning childhood injury prevention. BCHW also collaborates with ten Safe Kids (SK) coalitions that serve 53 counties across Missouri. The SK coalitions are led by LPHAs, non-profit entities, and local hospital systems. The coalitions, in collaboration with BCHW, will provide safe sleep environments, education, and resources to expectant and new parents/caretakers based on AAP guidelines; promote safe sleep through media campaigns; and work closely with law enforcement officers, firefighters, paramedics, medical professionals, educators, community agencies, businesses, and public policymakers to address gaps in policies that could prevent safe sleep injuries.

BCHW will promote the SSM Health Cardinal Glennon Safety Programs through Safe Kids St. Louis and the MIVPAC website. These programs include monthly Baby Safety 101 classes and virtual infant and child cardiopulmonary resuscitation (CPR) classes. A variety of topics are covered, such as the importance of prenatal and well-baby care, safe sleep, immunizations, oral health, and safety, for new and expecting parents, grandparents, and caregivers. A post-survey for the Baby Safety 101 classes will be provided to gauge increase in knowledge and obtain feedback.

The TEL-LINK Program will provide safe sleep referrals to increase safe sleep options for any Missourian who needs assistance. This service is promoted 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, WIC clinics, mental health treatment centers, health insurance providers, and many more.

LPHA contractors will complete year five contract work plan activities to achieve desired system outcomes outlined in FY 2022-2026 contract work plans. A contract outcomes report will be completed, evaluating performance trends and providing conclusions across the five-year contract work plan cycle. Seven LPHAs will promote safe sleep practices among newborns to reduce sleep-related infant deaths.

- Cole County Health Department will work to increase knowledge and skills and change organizational practices among childcare providers regarding safe sleep practices and resources for both staff and families served.

- Modeled after the national Cribs for Kids, Safe Sleep Ambassador program and trainings, Pike County

Health Department will work with community partners to adopt policies/procedures that include designating a Safe Sleep Champion. Community partners include but are not limited to Head Start, the local emergency room, a local pregnancy home, local childcare providers, faith-based organizations, and others who provide services to infants. There are currently 11 Safe Sleep Champions, defined by the health department as:

> *"An individual that is willing to take a safe sleep training and help bring a unified message on the most up to date safe sleep practices and recommendations. Champions will serve as advocates for promoting safe sleep and will provide families with education and available resources to ensure the establishment of a safe sleep environment. Anyone can become a Safe Sleep Champion!"*

- Crawford County Health Department will continue work to increase individual knowledge and skills among parents and families of infants regarding best safe sleep practices, utilizing the Safe Sleep Survival kit, modeled after the National Cribs for Kids, which includes a pack n play, fitted crib sheet, HALO sleep sack, Phillips soothie pacifier, and safe sleep education.

The MCH Services Program plans to provide educational and technical assistance opportunities to increase LPHA's knowledge and skills on utilizing the MCH Evidence *What Works Evidence Accelerators* to develop the five-year work plans. The *What Works Evidence Accelerators* include evidence-based strategies to increase the percentage of infants placed to sleep on their backs, percentage of infants placed to sleep on a separate approved sleep surface, percentage of infants placed to sleep without soft objects or loose bedding, and percentage of infants room-sharing with an adult. Strategies include:

- Caregiver/parent education;
- Child care provider education;
- Health care and social service provider education;
- Building on Campaigns with Conversations;
- Community-based crib distribution and safe sleep education;
- Hospital-based safe sleep training;
- Mass media campaigns; and
- Multidisciplinary hospital quality improvement initiatives.

The MCH Services Program East/Southeast Region District Nurse Consultant will continue attending Missouri Bootheel Regional Consortium (MBRC) meetings, serving on the Board of Directors for Bootheel Babies & Families (BBF) and partnering with the Bootheel Perinatal Network (BPN). BBF supports, educates, and empowers families and community partners to improve MCH outcomes, enabling families to thrive. BBF is a community-led model comprised of six counties in the Bootheel region (Scott, New Madrid, Mississippi, Pemiscot, Dunklin, and Stoddard) working together to lower the infant mortality rate through the key focus areas of healthcare, safe sleep, and substance use. Each of the six counties hosts monthly meetings within their communities. BPN includes the same six counties and plans to continue work to develop a network approach, increase access to care before, during, and after pregnancy, enhance telehealth opportunities, and create a sustainable model using lived experience, asking pregnant or new mothers with an infant six months of age and younger to share what it is like to be pregnant or parenting in southeast Missouri. These shared stories will help drive change to improve the health and opportunities for mothers and families in the Bootheel.

Child Care Providers

The DESE Office of Childhood (OOC) Compliance Section licenses and regulates child care programs. Through ongoing regulatory inspections, OOC will verify compliance with licensing rules regarding safe sleep for infants. OOC will educate child care providers about safe sleep practices for infants through technical assistance, training, and Child Care Health Consultation (CCHC). Section 210.223.1 of the Revised Statutes of Missouri (RSMo) requires all licensed child care facilities that provide care for children less than one year of age to implement and maintain a written safe sleep policy in accordance with the most recent AAP safe sleep recommendations. Missouri child care licensing rules require licensed child care facilities to provide parent(s) and/or guardians(s) who have infants in care a copy of the facility's safe sleep policy. OOC will review and approve safe sleep training and ensure training is available in various formats to increase licensed child care providers' knowledge of infant safe sleep practices. During childcare inspections, OOC staff will review training records to ensure all required child care training on safe sleep for infants is completed within the required timeframes. The CCHC Program will assist licensed child care providers in meeting the safe sleep training requirement outlined in RSMo 210.223.4. CCHC consultants will provide consultation and training regarding safe sleep practices to child care providers. Consultations will focus on assessing the child care program's policies regarding safe sleep, reviewing

implementation of safe sleep policies and procedures, and evaluating opportunities for improvement. Consultants will provide safe sleep training that addresses the importance of placing infants to sleep on their backs and using separate approved sleep surfaces without soft objects or loose bedding in the same room with an adult. The trainings will also increase provider knowledge on infants at highest risk for sleep-related deaths and which environments place infants at the highest risk for unsafe sleep environments and/or sleep-related deaths. Trainings will also prepare child care providers to address parent/guardian concerns with safe sleep procedures implemented in the child care setting. Safe sleep trainings, consultations, and other resources utilized by consultants will adhere to the most recent AAP Policy Statement. As part of the new Missouri Professional Development (MOPD) System, child care providers will now complete evaluations of trainers and trainings.

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. Future program trajectory, activities, and focus will be steered with input from Child Care Health Consultants at LPHAs, child care program directors and staff, and identified needs of families and children enrolled in child care programs across the state. In addition, consultants will give input on Child Care Licensing Rule Revisions being completed by the Child Care Compliance and Regulation sections.

Collaborative Efforts

The MCH Director and other DHSS team members will participate in the Maternal and Child Learning and Action Network (MC LAN), facilitated by the Missouri Hospital Association (MHA), to assist with the implementation of infant morbidity/mortality reduction initiatives throughout the state. The MC LAN launched a Missouri Neonatal Abstinence Syndrome (NAS) collaborative in 2021, coinciding with the implementation of the Obstetric Care for Women with Opioid Use Disorder initiative. A family-centered approach acknowledges the mother's health needs and provides consistent access to robust systems of recovery treatment, behavioral health, and social support. Participating organizations 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 (ESC) into practice; establishing Safe Plans of Care for the mother and infant; and accessing training on promoting fair, impartial and respectful care. These approaches recognize the importance of the mother's presence and active involvement in the infant's care for managing infant withdrawal symptoms and promoting healing and emphasize non-pharmacologic interventions such as rooming-in, breastfeeding, skin-to-skin contact, swaddling, and infant consoling as the first line of treatment. Empowering mothers to be primary caregivers promotes mother-infant attachment and strengthens the mother-infant bond, supporting the infant's development and the mother's recovery journey.

The Mothers, Infants and NAS ECHO (Extension for Community Healthcare Outcomes) was created by the University of Missouri’s Telehealth Network and MHA to support rural healthcare providers in caring for the mother-infant dyad with substance exposure. The MCH Director and other DHSS team members will 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 ESC non-pharmacologic care model for optimal health and psychosocial outcomes.
- Provide guidance for the use of pharmacologic interventions for infants with in-utero exposure to maternal substance use.
- Identify a framework to connect hospitals with internal and external support/resources for the mother-infant dyad.
- Ensure mothers with SUD receive appropriate pain and withdrawal assessment and treatment after delivery to stabilize symptoms, promote recovery, and support optimal family function.

The MCH Director, MCH Services Program team, and OWH will participate in and be a resource for local and regional infant mortality initiatives, including, but not limited to, the Children’s Trust Fund (CTF), Generate Health and FLOURISH in St. Louis, Nurture KC and the Community Consortium in Kansas City, and the MBRC, BBF initiative, and Bootheel Perinatal Network in southeast Missouri. Nurture KC and Missouri Bootheel Regional Consortium are Missouri's two Healthy Start Grantees.

- Statewide: CTF, Missouri’s foundation for child abuse prevention, strengthens families and prevents child abuse and neglect (CA/N) through grant-making, public education and awareness, policy, and partnerships.

CTF funds CA/N prevention programs throughout the state that focus on responsive CA/N and child sexual abuse prevention, home visiting services, home visiting collective impact; and safe sleep.

- St. Louis: Generate Health's initiatives build collective power to advocate for policies and practices that center, support, and celebrate families throughout their pregnancy and parenthood journeys. FLOURISH St. Louis works in coordination with Generate Health and is a collective impact initiative that brings together maternal-child health partners, medical providers, epidemiologists, and community members to collect, analyze, and interpret infant and maternal mortality data. The Bloom Network is a collaborative effort to coordinate quality maternal and infant health services for families through home visitation, perinatal behavioral health, and safe sleep promotion. Inspired by the CDC Foundation's "Hear Her Campaign," the 2BHeard Initiative is an awareness campaign designed to ensure every pregnant woman, their support networks, and healthcare providers recognize urgent maternal warning signs of life-threatening complications during the perinatal period.

- Kansas City: Nurture KC i*s a community collaboration dedicated to reducing infant mortality and improving family health by working together to change policy for broad impact, transform systems to improve health outcomes at a local level, and provide one-on-one support to connect families.* Nurture KC focuses on traditionally low-income families who reside in hard-to-reach neighborhoods in Missouri and Kansas. They emphasize culturally and linguistically appropriate care and strive to help people of all backgrounds. Nurture KC's cornerstone programs include the Kansas City Healthy Start Initiative, the Mid-America Immunization Coalition, and the Safe Sleep Program and 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, and MCH Leadership partners with multiple community-based organizations to address the community and population-level factors contributing to unsafe sleep and infant mortality. Core programs of the MBRC provide outreach, education, training, targeted interventions, community events, and community mobilization services for mothers, fathers, children, and families in the Bootheel to address health disparities among underserved communities. BBF has three key focus areas: healthcare, safe sleep habits, and substance use. BPN leverages existing services to combine clinical and community resources and develop a sustainable coordination of care to improve maternal and infant outcomes in the Bootheel. MCH Leadership will continue to support the annual low birth weight conference in the Bootheel, which brings together community members, community leaders and partners.

MCH Leadership will work with programs and partners to promote training that emphasizes a nuanced approach to take family needs, beliefs, and contexts into account when talking about safe infant sleep practices and environments for all types of providers, professionals, and community members who interact with expecting and new mothers and families regarding safe infant sleep practices and environments.

Breastfeeding Promotion

Hospitals

The State Breastfeeding Coordinator (SBC) serves as a bridge between breastfeeding stakeholders in Missouri and facilitates discussion between hospital staff, WIC local agency staff, breastfeeding coalition members, employers, clinicians, and lactation providers. The SBC will collaborate with the Missouri Breastfeeding Coalition (MBC), WIC local agencies (LAs), and the Missouri Physical Activity and Nutrition (MPAN) program to coordinate efforts to promote, protect, and support breastfeeding statewide. The MBC holds bimonthly member meetings for local coalition members and other stakeholders to share information about breastfeeding promotion efforts, educational programs, and trends in breastfeeding support. The SBC participates in these meetings to share information with coalitions about state breastfeeding initiatives and to encourage local coalitions to use DHSS initiatives to promote breastfeeding throughout the state. The MBC also holds bimonthly board meetings, in which the SBC participates, to discuss coalition business and complete strategic planning for the coalition. The board is currently developing the 2026-2030 strategic plan .

BCHW will support the Missouri "Show-Me 5" and Baby-Friendly Hospital Collaborative efforts. The Collaborative provides an opportunity for maternity care providers to network and learn about the 10 steps to Baby-Friendly and how to integrate these steps into maternity care practices. The Collaborative includes a series of meetings, facilitated by the SBC, that alternate between a speaking topic and a networking session every other month to learn and discuss one or more of the 10 steps to Baby-Friendly, allowing hospitals working on improving maternity care practices to benefit from mentorship from staff at designated Baby-Friendly hospitals. Networking months are reserved for peer sharing and learning, asking questions, or other technical assistance needs. As funding permits, BCHW will seek out speakers who are representative of Missouri Baby-Friendly hospitals and state/national speakers to address topics relevant to the 10 steps and encourage Missouri hospitals to implement the Missouri "Show-Me 5" Hospital and Baby-Friendly Hospital practices to promote breastfeeding continuity of care.

The SBC will provide technical assistance to hospitals trying to meet the Missouri "Show-Me 5" requirements, including virtual and on-site visits to educate hospital staff, and will evaluate hospitals that apply for recognition. The "Show-Me 5" program and materials will be reviewed and revised to ensure the program is aligned with current Baby-Friendly practices and meets the needs of both hospitals and mothers.

Local Public Health Efforts

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) will provide additional funding through the Breastfeeding Friendly WIC Clinic Program to WIC LAs that offer breastfeeding support beyond what is federally required through the WIC Program. The extra 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 WIC LAs and health department professionals to increase the number of International Board Certified Lactation Consultants (IBCLCs) in these facilities. Additionally, supported by WIC expansion of the qualifications for the Competent Professional Authority, or CPA, in FY 2025, the state will work to increase the number of trained peer counselors providing mother-to-mother breastfeeding support and encourage partnerships with healthcare providers and other community organizations. IBCLCs with no other credentials or degree will now be qualified to serve as a professional in the WIC program after completing WIC-specific training. Another pathway allows peer counselors who have worked continuously in WIC for more than four years and have a recommendation from their Nutrition Coordinator to qualify for open CPA positions, with WIC-specific training. This creates a new career ladder for paraprofessionals in the WIC program. The paraprofessional positions (Clerk, Health Professional Assistant (HPA) and BFPC) are often filled with applicants from the community who have individual experiences in the communities that WIC serves. They may also have special skills, such as knowing a second language. Creating a career path to move these staff members from paraprofessional to professional rewards dedicated service and honors their knowledge and experience, while removing the barrier of requiring a four-year degree to enter the professional role at WIC.

The SBC will promote DHSS breastfeeding initiatives to WIC Breastfeeding Coordinators at LAs. All LA staff are required to take a basic breastfeeding training, where they are informed about the state's recognition programs for businesses, employers, hospitals, and child care facilities that support breastfeeding. Trained LA staff participate in local breastfeeding coalitions and other community organizations, where they are ideally positioned to promote DHSS breastfeeding initiatives. In addition to this basic training, the SBC will also promote these initiatives at the FY 2026 Breastfeeding Peer Counseling Conference and discuss them with WIC LAs throughout the year.

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

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

The CCHC Program will support child care and early care and education programs through consultations and training to promote breastfeeding practices in the child care setting. LPHA staff who provide CCHC services will provide consultations and trainings for child care providers to assist in the development and implementation of policies and procedures that encourage and support

breastfeeding; are welcoming to all mothers, including employees who breastfeed; provide referrals to outside resources, such as WIC; and provide education about the important role breastfeeding plays in the health of mother and child. Training and consultations 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. Future program trajectory, activities, and focus will be steered with input from Child Care Health Consultants at LPHAs, child care program directors and staff, and identified needs of families and children enrolled in child care programs across the state. Although not typically included in CCHC training and consultation content, as LPHA team members, Child Care Health Consultants are able to provide support to child care providers and mothers, including information about local milk banks, breast pump rental and use, and breastfeeding peer support.

Breastfeeding Friendly Sites

BCHW will partner with the SBC, the Missouri Council for Activity and Nutrition's (MOCAN) workgroups (Schools, Child Care, Physical Activity, Worksites, Food Systems, Health Care, and Healthy Aging), and other stakeholders. Collaborative efforts will educate employers on the Affordable Care Act 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. BCHW and the SBC will continue recognizing employers achieving the Missouri Breastfeeding Friendly Worksite criteria. To receive the award, employers must address policies for breastfeeding support, educate expecting mothers on their breastfeeding policies, provide a private place appropriate for expressing breast milk, offer flexible scheduling, and make breastfeeding resources available. Efforts will be further enhanced by the Breastfeeding Welcome Here campaign, recognizing businesses that agree to train staff to be welcoming to breastfeeding families and agree to display a "Breastfeeding Welcome Here" sticker on a door or window. This initiative requires little effort on the part of businesses and helps expand community support for breastfeeding.

The MOCAN Worksites workgroup encourages businesses to implement a wellness program for staff. The WorkWell Missouri Toolkit was developed to assist employers reduce 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 promote the toolkit and partner with other organizations to help businesses improve employee health.

The Breastfeeding Friendly Child Care Award recognizes child care facilities that meet advanced criteria on providing breastfeeding support. Criteria include having a written policy supporting 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 MBC and local breastfeeding coalitions to promote the Breastfeeding Friendly Child Care Award. Partnering with MOCAN and Child Care Aware of Missouri, 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, promoting the award to parents and providers.

The CCHC Program will train child care providers to promote child care facilities as Breastfeeding Friendly Child Care Facilities and Breastfeeding Friendly Worksites for parents of enrolled children and breastfeeding employees, respectively. LPHAs will leverage the CCHC Program to promote the awards as an essential resource for training. In-person and online trainings will be available to meet high provider demand. These award programs are low-cost, efficient, and provide realistic means to sustain support for breastfeeding families.

Resources for Parents

Maternal smoking, secondhand smoke, and thirdhand smoke are all known risk factors for sudden infant death. Young children are especially vulnerable to these exposures, and thirdhand smoke, the residue left on clothes and surfaces, can pose lingering dangers even in smoke-free environments. All members of the household should be screened and treated for tobacco use and advised to maintain a smoke-free living environment, including the absence of smoking, vaping, and the use of all tobacco products, including e-cigarettes, to help reduce these risks.

To support these efforts, the Tobacco Prevention and Control Program (TPCP) will partner with local coalitions and LPHAs to increase the number of workplaces and communities with comprehensive tobacco-free and smoke-free policies. Low-income workers are more likely to be exposed to secondhand smoke at work due to smoke-free exemptions for restaurants, casinos, and bowling alleys. Smoking at job sites is also more common in traditionally blue-collar jobs, such as construction sites. Perinatal and breastfeeding women and other parents in these positions may not be protected from secondhand and thirdhand smoke while working, and children of these parents may be exposed to thirdhand smoke through parents' clothing and belongings.

TPCP also partners with the American Lung Association to increase the number of multiunit housing properties with comprehensive smoke-free policies. Multiunit housing residents, including perinatal and postpartum women, are not protected from secondhand smoke in Missouri. Children in multiunit housing are more exposed to secondhand smoke even if living with someone who does not smoke. Parents living in smoke-free buildings and communities are more likely to make their own homes smoke-free and are also more likely to quit using tobacco. Additional TPCP efforts and resources around promoting and incentivizing Missouri Tobacco Quit Services, smoke-free communities, smoke-free multi-unit housing, and smoke-free homes and vehicles can be found in the Women and Maternal Health domain.

The Newborn Health Program (NHP) will participate in statewide educational activities to increase awareness and promote recommended and evidence-based MCH practices, including breastfeeding. NHP will provide the free prenatal and newborn health book, *Pregnancy and Beyond,* and other educational literature to 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, NHP will maintain electronic access to similar breastfeeding information and resources on the Newborn Health webpage.

Other Activities to Promote the Perinatal and Infant Health Domain

State Health Improvement Plan
Improving Infant and Maternal Health is one of the priorities identified by the State Health Assessment and addressed by the State Health Improvement Plan (SHIP). The goals and objectives outlined under the Infant and Maternal Health priority area are set on a five-year project scale, with work ongoing through 2027. Several different factors contribute to infant mortality and the goal to advance optimal infant health by decreasing infant mortality and improving overall infant health seeks to address the leading causes. To meet the priority objective of reducing the rate of non-Hispanic black and African American infant deaths per 1,000 black live births, MCH Leadership will collaborate with a wide-ranging group of over twenty partners to implement the following activities.

- Promote optimal perinatal health through the Perinatal Quality Collaborative (PQC) and implementation of the Maternal Mortality Prevention Plan. (Note: The Maternal Mortality Prevention Plan is discussed in detail in the Women/Maternal Health domain.)
- Analyze birth and death certificate data through the statewide Fetal and Infant Mortality Review (FIMR) Network with 7 regional FIMR teams to identify leading causes of infant death and related risk factors.
- Analyze Pregnancy Risk Assessment Monitoring System (PRAMS) data on topics that include timing of prenatal care, barriers to receiving prenatal care, experiencing stressful life events, attending postpartum visits, experiencing postpartum depression, breastfeeding, and bedsharing. Use PRAMS data to help inform efforts to reduce black infant mortality.
- Partner with MO HealthNet and traditional maternal care providers, such as doulas, midwives, and community health workers (CHWs), to increase access to and utilization of community-based maternal care services, especially for black families.
- Develop a MCH specialty curriculum for CHWs, with a focus on perinatal and infant health.
- Create a website directory of car safety training and child seat provision.
- Encourage safe sleep certification for hospitals.
- Use Child Fatality Review Panel data to inform efforts to reduce accidental infant death.
- Develop and coordinate a network of home visiting programs throughout the state to assess access to perinatal home visiting in high-risk communities.
- Promote inclusion of community-based programs and resources, including home visiting programs, as part of existing digitized resource and referral networks (i.e., Unite Us platform, Uplift Connection).
- Encourage collaborating agencies/organizations to partner with multi-sectored local partners to develop

innovative programs and policies that promote safe infant sleep, encourage smoking cessation, and promote breastfeeding, immunizations, and prenatal care.

As part of the SHIP, MCH Leadership will also work with BI and other programs across DHSS, statewide partners, and LPHAs to increase the percentage of 12-month-olds who are up to date on all vaccinations by implementing the following activities:

- Encourage well-child visits;
- Creation of a user-friendly reminder of vaccination timing for parents;
- Patient outreach and follow-up;
- Engagement of CHWs, doulas, home visitors, and other community-based maternal and infant health care providers; and
- Promote child, adolescent and adult immunizations, especially for those communicable diseases significantly impacting infant health, such as Pertussis, Measles, Pneumococcal disease, Influenza, and more.

Fetal and Infant Mortality Review

The Missouri Child (0-17 years) Fatality Review Program (CFRP) is a county-based initiative that encourages an improved community understanding and response to child fatalities from all causes. RSMo Section 210.192 requires any child death from any cause be reported to the coroner/medical examiner, who is required to follow specific procedures concerning child fatalities. If the child fatality meets certain criteria, the circumstances surrounding the death will be reviewed by the county CFRP panel. Missouri statute also requires a state-level CFRP panel be appointed by the DSS. The state CFRP panel is convened bi-annually to provide oversight, identify systemic problems, and bring concerns to the State Technical Assistance Team's (STAT) attention. STAT assists multidisciplinary teams and local law enforcement agencies in investigating and prosecuting child sexual abuse, child exploitation, and internet crimes against children.

The state FY 2026 DHSS budget includes $1.8+ million to support the statewide FIMR network of regional FIMR teams. Under the oversight of MCH Leadership, DHSS implements the Missouri FIMR Network through contracts with 7 LPHAs. The FIMR Network operates as a two-tiered system, with 7 regional Community Review Teams (CRT) and 7 separate regional Community Action Teams (CAT). Each regional CRT will review all fetal and infant deaths from 24 weeks gestation through the first 12 months of life. Each regional CAT will take the recommendations of the CRT and put them into action. The FIMR process will include case identification, medical records abstraction, home/family interviews, case reviews, and recommendations for action.

The MCH Director will continue to participate in the state CFRP panel, as appointed by DSS, and collaborate with the CFRP Program Manager and state CFRP panel and preexisting local FIMR teams in Kansas City and St. Louis to leverage state and local expertise, align efforts to reduce and prevent fetal and infant mortality, avoid redundancies, and bridge existing gaps in statewide FIMR efforts.

Risk-appropriate Care

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

Newborn Screening

The Newborn Screening Program will work towards increasing awareness of newborn screening to ensure 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 disorders, including hearing loss and critical congenital heart disease. The program will work with birth providers in the medical center and homebirth settings to provide education and technical assistance. The program will collaborate with a birthing hospital and the DHSS Office of Public Information to create an instructional video demonstrating the proper technique for blood spot collection. This

resource will assist in decreasing the number of poor-quality samples received by the Missouri State Public Health Laboratory and ensure timely screening results, which promote early intervention for newborns identified at higher risk for the disorders included in screening. The program will network with health care providers, midwives, community health workers, doulas, and other partners to disseminate accurate, up-to-date information about newborn screening during prenatal and postnatal visits.

The Newborn Hearing Screening Program (NHSP) will continue efforts to ensure newborns are screened by one month, diagnosed by three months, and enrolled in early intervention (EI) by six months. NHSP will continue pursuing a reduction in loss to follow-up or 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 MPCA, ODH will continue to educate mothers about the importance of oral health for their overall health and well-being, including during pregnancy. ODH will continue a pilot program with LPHAs to provide oral health education, fluoride varnish, and a warm handoff 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 complete the scheduled dental visit.

Home Visiting

In an effort to consolidate and coordinate evidence-based home visiting services, the TAFP state FY 2026 budget includes amended budget language to restructure DESE's Office of Childhood (OOC) Home Visiting section, effective July 1, 2025, and the following programs will transition from DESE to the Children's Trust Fund (CTF):

- The Missouri Parenting Partnership Program (MOPPP), which offers statewide, voluntary home visiting services, focusing on the prevention of child abuse and neglect; and
- The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, which offers home visiting services in select counties to ensure children can grow up healthy, safe, and ready to learn.

Also effective July 1, 2025, all MCOs will reimburse for home visiting services for a subset of high-risk members. The Children's Trust Fund (CTF) will be the fiscal intermediary for reimbursement from the MCOs, allowing home visiting agencies to seek reimbursement directly from CTF.

Effective October 1, 2025, Title V funded home visiting contracts with four LPHAs and one hospital will transition from DESE back to DHSS. Two contractors will implement the Healthy Families America home visiting model, and three contractors will implement the Nurse Family Partnership home visiting model. DHSS will execute a MOU with CTF to establish a framework for collaboration and coordination, outlining shared intentions, objectives, and responsibilities. MCH Leadership and the MCH Services Program will collaborate with CTF to align Title V funded home visiting contracts and evaluation metrics with other statewide home visiting services. MCH Leadership will convene a group of subject matter experts in home visiting, group care models, MCH, and curriculum development, along with CTF, to research group family visiting models and develop a curriculum for piloting implementation of group family visiting.

Title V funded home visitors will be trained to complete an annual functional hearing, vision, health and oral health assessment for all enrolled children.

Perinatal and Infant and Early Childhood Mental Health (IECMH)

The first few years of life are crucial for brain development and lay the foundation for lifelong health and well-being. IECMH is the growing ability of infants and young children to form secure and close relationships, experience, regulate, and express a wide range of emotions, and engage with their surroundings. IECMH is intricately linked to the mental health of mothers and caregivers, and maternal mental health significantly impacts maternal-infant bonding and a child's social-emotional development. The MCH Director serves as the DHSS ex-officio member on the Board of Directors for the Missouri Association for Infant and Early Childhood Mental Health (MOAIMH-EC), a collective of cross-sectored specialists whose work supports the developmental and emotional well-being of infants, toddlers, preschoolers and their parents. MOAIMH-EC works to optimize well-being in the early years by promoting first relationships and advancing effective IECMH practice through state-wide *Alliance for the Advancement of Infant Mental Health* credentialing for infant/early childhood professionals. The MCH Director also collaborates with the DESE IECMH statewide quality initiative to provide evidence based, multi-tiered systems of support and consultation to child care professionals caring for young

children with challenging behaviors. The MCH Director and CYSHCN Director participate in the Early Childhood Comprehensive Systems (ECCS) Advisory Council and ECCS collaborative efforts with DESE and DMH, including the quarterly Early Childhood Summit, facilitated by the Early Childhood Wellness Coordinator at DMH.

The MCH Director serves on the Maternal Health Access Project (MHAP) Advisory Council. To increase capacity of perinatal care providers across the state to diagnose and treat pregnant and postpartum women's mild to moderate behavioral health conditions, MHAP offers same-day provider-to-provider consultations with a team of perinatal psychiatrists and specialists, care coordination support for patients, and education and training materials on a wide range of topics related to perinatal health, especially focused on mental and behavioral health. All MHAP services are provided at no cost to providers or their patients.

MCH Leadership will encourage programs and partners to promote MHAP; promote maximizing extended Medicaid coverage for all conditions (including medical, mental health and SUD) during pregnancy and the full 12-month postpartum period; promote referral to the National Maternal Mental Health Hotline and the 988 Suicide & Crisis Lifeline for pregnant and postpartum women experiencing a mental health crisis; and implement and encourage partners to implement the following recommendations included in the 2025 PAMR Report.

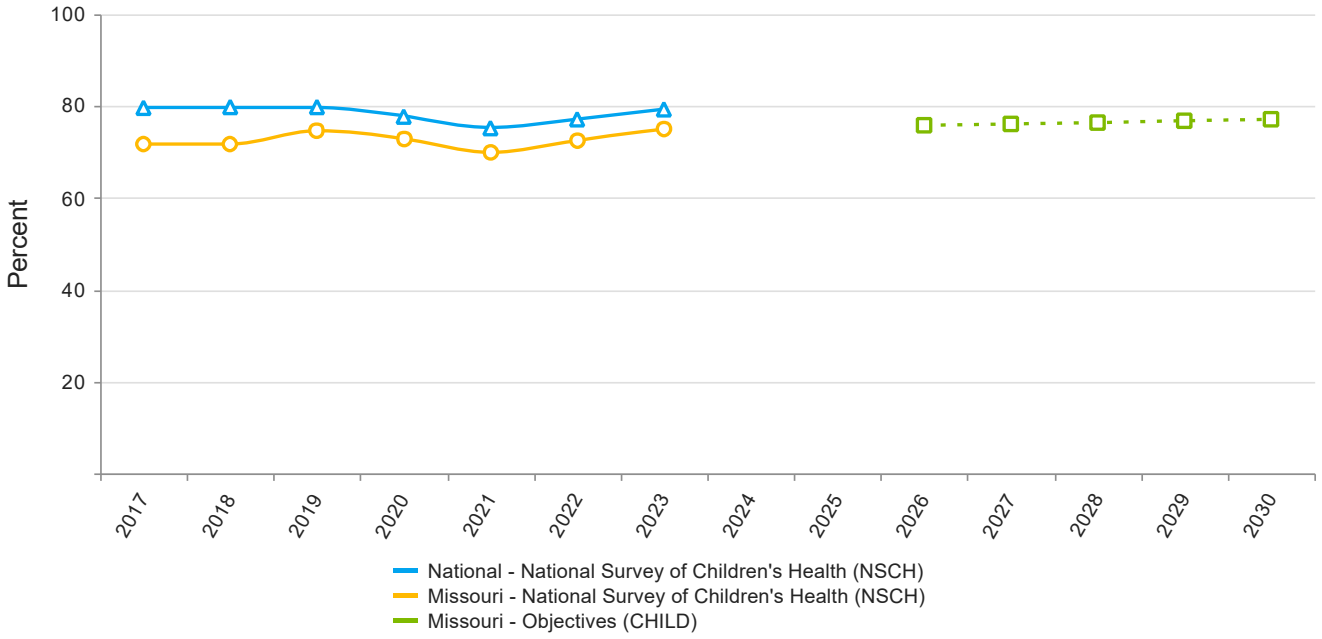
- State agencies, in partnership with community-based organizations, should implement community violence intervention programs, with a focus on reducing homicides among pregnant and postpartum women.
- Health care providers should implement SBIRT (Screening, Brief Intervention, and Referral to Treatment) for mental health concerns like depression, anxiety, and SUD for pregnant and postpartum women, as indicated; and collaborate with community-based organizations to educate women of childbearing age about preconception health to optimize a woman's health prior to pregnancy.
- Health care facilities should utilize social workers, community health workers, peer support specialists, and/or recovery coaches and doulas during pregnancy and postpartum, to increase continuity of care for referrals, care coordination, communication and addressing community and population-level factors that influence perinatal health outcomes.
- Community-based organizations should: collaborate with health care facilities and providers to reduce stigma surrounding maternal mental health and SUD, educate community members on intimate partner violence, and provide related assistance and connection to resources.

NOTE: The Women and Maternal Health domain also contains content relevant to perinatal and infant health, including discussion of clinical-community integration and coordination of service delivery across the care continuum.

Child Health

National Performance Measures

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child
Indicators and Annual Objectives



NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child - Child Health

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	75.0
Numerator	976,851
Denominator	1,303,086
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	75.7	76.0	76.3	76.7	77.0

Evidence-Based or –Informed Strategy Measures

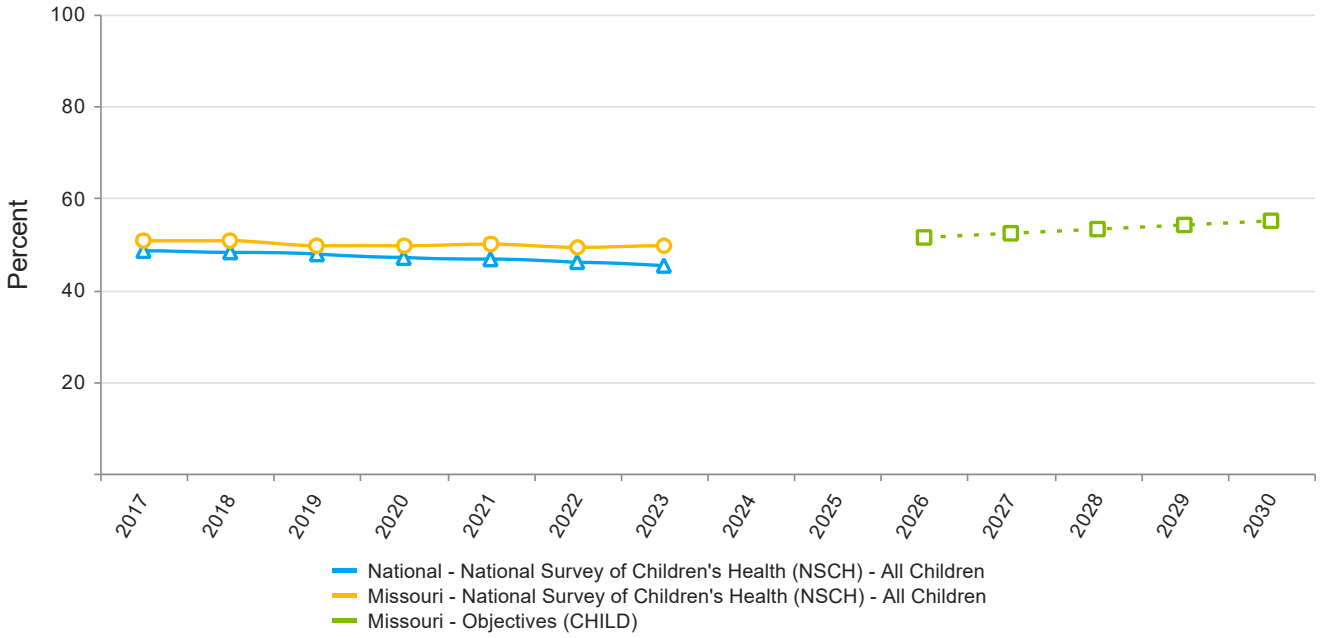
ESM PDV-Child.1 - Number of students referred to an oral health care provider as a result of participating in the Preventive Services Program (PSP).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	14,000.0	14,000.0	14,000.0	14,000.0	14,000.0

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



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	49.2	49.6
Numerator	675,506	678,140
Denominator	1,374,264	1,368,115
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	51.4	52.3	53.2	54.1	55.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of school health staff educated on the importance and benefits of a medical home for children with and without special health care needs.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		1,800	2,000		
Annual Indicator	1,822	1,057	637	193	193
Numerator					
Denominator					
Data Source	MO DHSS Programs	MO DHSS Programs	MO DSS Programs	MO SHCN Family Partnership	MO SHCN Family Partnership
Data Source Year	2020	2021	2022	2023	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	125.0	125.0	75.0	75.0	75.0

State Action Plan Table

State Action Plan Table (Missouri) - Child Health - Entry 1	
Priority Need	
Access to holistic oral health care services for children.	
NPM	
NPM - Preventive Dental Visit - Child	
Five-Year Objectives	
By September 30, 2030, Missouri will increase the percent of children, ages 1 through 17, who had a preventive dental visit in the past year from 75% to 77% (NSCH 2022-2023).	
Strategies	
Promote and support delivery of preventive oral health care by oral health professionals and implementation of the Preventive Services Program in schools, including an oral health review, oral health education, application of fluoride varnish, oral health supplies, and referral to an oral health provider, as indicated.	
Enhance cross-sector collaboration and promote whole person, person-centered, coordinated, and comprehensive health care for children, including oral health care.	
Facilitate collaborative relationships between oral health professionals and other health professionals to promote coordinated holistic care.	
Develop and distribute educational materials and implement community-based educational campaigns and health promotion/wellness programs, including oral health care.	
Provide training for oral health care providers on whole person, person-centered care.	
Promote comprehensive access to care, including adequate insurance coverage and oral health coverage, for children.	
ESMs	**Status**
ESM PDV-Child.1 - Number of students referred to an oral health care provider as a result of participating in the Preventive Services Program (PSP).	Active

NOMs

Tooth decay or cavities

Children's Health Status

CSHCN Systems of Care

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

Priority Need

Access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children with and without special health care needs.

NPM

NPM - Medical Home

Five-Year Objectives

By September 30, 2030, Missouri will increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home from 49.6% to 52.0% (NSCH 2022-2023).

By September 30, 2030, Missouri will increase the percent of children without special health care needs, ages 0 to 17, who have family centered care from 86.5% to 90.0% (NSCH 2022-2023).

Strategies

Promote coordinated systems across the child/family care continuum to assure evidence-based management of acute, chronic, and/or complex child and adolescent medical conditions by promoting the medical home approach to care.

Partner and collaborate with cross-sector stakeholders to integrate the medical home approach and promote care coordination and community referrals to facilitate the linkage of children and their families with appropriate services and resources.

Provide education and outreach on the importance of medical home for children to cross-sector stakeholders serving and engaging with children and their families.

Promote effective partnerships between families and integrated clinical-community health care teams to enhance access to a medical home for children and their families and coordination of service delivery across the care continuum.

Engage in cross-sector partnerships and collaborations to design, implement, and evaluate QI initiatives to increase access to whole person, person/family-centered, coordinated, comprehensive, and community-based health care services and supports for children and their families.

Provide training for all types of providers on whole person, person/family-centered, coordinated, comprehensive, and community-based health care services and supports for children and their families.

Promote person/family-centered shared care planning to operationalize core values of person/family-centered care and ensure families are full partners in their child's health.

Promote comprehensive access to care, including adequate insurance coverage, and support community-based models of care for children and their families.

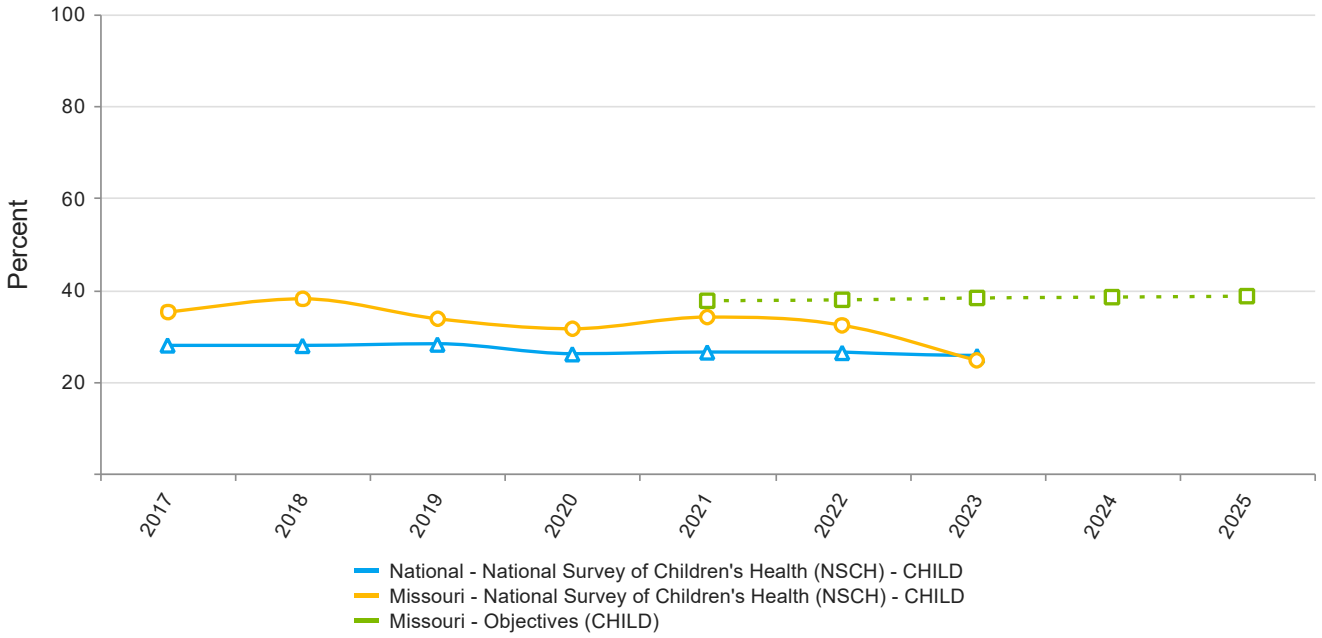
Collaborate with the Department of Elementary and Secondary Education and cross-sector stakeholders to promote healthy development of children and implement strategies to help children stay healthy.

ESMs	Status
ESM MH.1 - Number of school health staff educated on the importance and benefits of a medical home for children with and without special health care needs.	Active

NOMs
Children's Health Status
CSHCN Systems of Care
Flourishing - Young Child
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child Indicators



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		37.6	37.8	38.2	38.4
Annual Indicator	32.8	31.2	34.3	32.4	24.6
Numerator	156,884	145,507	154,430	147,004	110,011
Denominator	477,809	465,671	450,203	453,355	446,508
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM PA-Child.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	100	200	300
Annual Indicator	33	352	486	559	559
Numerator					
Denominator					
Data Source	MO DHSS Go NAPSACC data	MOPHIRS Report -CLPHS Service Log	MO DESE CCHC program	MO DESE CCHC program	MO DESE CCHC program
Data Source Year	2019	2021	2022	2023	2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: State Performance Measures

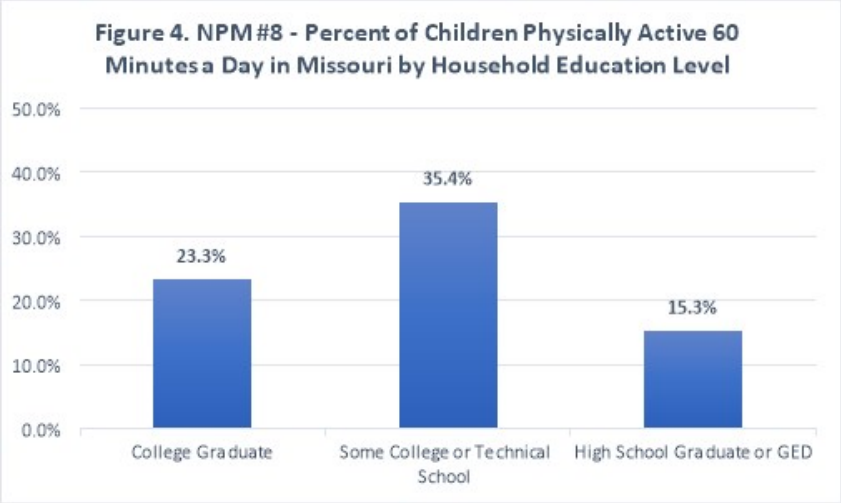
2021-2025: SPM 1 - Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	71.9	72.1	72.3	72.5	72.7
Annual Indicator	72.5	72.5	69.8	72.5	75
Numerator	928,942	928,942	905,262	948,407	976,851
Denominator	1,280,625	1,280,625	1,296,180	1,308,148	1,303,087
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2019_2020	2020_2021	2021_2022	2022_2023
Provisional or Final ?	Final	Final	Final	Final	Final

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

Please note that 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 more significant impact. Still, it should be noted that some strategies and activities may address a wider age range.

According to 2022-2023 National Survey of Children's Health (NSCH) data, 24.6% of Missouri children ages 6-11 were physically active for at least 60 minutes a day, compared to their national counterparts (25.6%). Girls (25.1%) were slightly more likely to meet the physical activity benchmark than boys (24.3%). Survey findings suggest lower physical activity levels for children from high school graduate or GED households (Figure 4, *interpret with caution, may not be reliable*). Children with public insurance only (25.1%) were less frequently physically active for one hour daily than their national counterparts (27.2%).



Obesity is complex, and environmental and behavioral factors play a critical role. Healthy eating and regular physical activity are essential to achieving and maintaining good health. Missouri works to implement best practices to ensure all Missourians live in communities that support healthy eating and active living habits. The 2023 BRFSS reports that more than two of every three adults in Missouri are overweight (34.4%) or obese (35.3%). 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 in life. About 90% of Missouri school districts provided data through the DESE/DHSS data system collaborative. Of those students, 7.6% had asthma and received medication at home or school during the 2024-2025 school year, potentially limiting participation in physical activity. Additionally, 0.33% of students reported having diabetes. Obesity and chronic condition prevalence rates were significantly higher among African American and Hispanic communities, further compounding disparities in health and educational attainment for children from these minority groups.

Addressing obesity requires collaboration among multiple organizations. Missouri brings these partners together through the Missouri Council for Activity and Nutrition (MOCAN), the statewide obesity prevention council facilitated by the University of Missouri Extension. MOCAN is a coalition of professionals from various backgrounds (e.g., educators, healthcare providers) who collaborate to improve the health of Missourians through policy, system, and environmental changes related to physical activity and nutrition, and its member organizations are structured into workgroups specific to settings or topics, such as schools and child care, physical activity, worksites, food systems, and healthcare. DHSS and DESE staff supported by Title V funding participated in MOCAN workgroups to support statewide improvements in physical activity, including workgroup input and collaboration for the Missouri MOve Smart Child Care program (physical activity recognition program for Missouri early care and education programs), Go NAPSACC (Nutrition and Physical Activity Self-Assessment for Child Care), and the Nemours PALS (Physical Activity Learning Sessions). PALS recognizes the importance of family and community involvement in promoting physical activity for young children and encourages child care providers to engage families in physical activity initiatives and connect with community resources that support healthy lifestyles.

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 supports opportunities for children, youth, and families to develop healthy physical activity practices. Strategies to promote policy and environmental changes that foster healthier communities include collaboration with internal partners, LPHAs, youth, and statewide and community organizations with similar goals. Program staff in the Bureau of Community Health and Wellness (BCHW) contracted with LPHAs to implement policy and environmental changes that increase opportunities for children to engage in physical activity in early care and education (ECE) settings. In FY 2024, 15 Child Care Health Consultants completed the PALS Train the Trainer (TtT). In follow up to the TtT, graduates had an opportunity to host a PALS Summer Workshop for the ECEs in their respective county/region and receive reimbursement for their efforts in hosting the workshop. Three LPHAs utilized the opportunity to offer the PALS Summer Workshop in their respective county/region.

The LPHAs used the University of North Carolina's Go NAPSACC online system to assist child care providers in improving the health of young children through practices, policies, and environments that instill habits supporting lifelong health and well-being and track child care providers' progress. The Child Care Health Consultation (CCHC) Program Coordinator assisted 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.

DHSS continued supporting ECE providers in implementing policies and practices supporting physical activity. DHSS provided training, resources, and technical assistance related to physical activity policies and practices to ECE providers aiming to become recognized as a Missouri MOve Smart Child Care. In FY 2024, one new ECE program earned MOve Smart recognition at the advanced level, potentially impacting 42 children.

The CCHC Program at DESE provided training and consultation hours for child care providers to support the implementation of policies and procedures supporting physical activity and nutrition. Consultation hours focused on physical activity and nutrition guidelines, policies and procedures to promote indoor and outdoor physical activity, barriers to indoor and outdoor activity, and implementing screen time policies. Child care providers additionally received training on becoming a Missouri MOve Smart Child Care designated facility. CCHC clock hours were also made available to child care providers who completed GoNAPSACC training modules.

Professional Development, Training, and Resources

BCHW continued to support Missouri communities in their obesity prevention efforts by providing professional development and training opportunities on obesity prevention strategies for local communities and key stakeholders. To ensure staff were well informed and could provide quality assistance, they participated in professional development opportunities, such as annual conferences of professional associations and other evidence-based training. Technical assistance and resources were available to assist in increasing regular physical activity and healthful eating and assuring interventions were universally accessible for individuals of all abilities.

The CCHC Program provided consultation and training for child care providers and health promotion presentations for children in child care on the importance of nutrition and physical activity. Specifically, the program provided 175.75 hours of training and consultation for child care providers that focused on physical activity and its positive effects on weight, physical and mental health, and development of motor, social/emotional, and cognitive skills. Trainings also addressed how to incorporate structured active play and free active play into daily routines, addressed AAP guidelines for screen time, and provided examples and materials for age-appropriate activities and games to promote physical activity. In FY 2024, an additional 14 Child Care Health Consultants completed Nemours PALS 'train the trainer' sessions, making a total of 55 Child Care Health Consultants completing the train the trainer sessions since the project began in June 2022. These consultants are equipped to provide physical activity trainings for child care providers based on nationally recognized practices for physical activity.

In FY 2024, an additional 5 Child Care Health Consultants completed the Nemours Nourishing Healthy Eaters (NHE) in ECE settings 'train the trainer' sessions, for a total of 48 Child Care Health Consultants completing the sessions since the project began in January 2023. These consultants are equipped to 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. The 12345 Fit-Tastic! Healthy

Lifestyles Initiative, Kansas City Healthy Lifestyles Collaborative, developed by Children's Mercy Hospital, includes guidelines for children's nutrition and physical activity. These guidelines have been incorporated into training and health promotion materials, making them easily accessible and user-friendly.

The CCHC Program provided 472 hours of health promotions for children in child care, delivered through fun, developmentally appropriate, and engaging presentations, on the topics of physical activity and nutrition. These presentations increased children's knowledge on how physical activity and proper nutrition keep their minds and heart healthy and promoted their involvement through fun activities, songs, books, and play that promoted nutrition and physical activity. CCHC Program services provided evidence-based resources and educational materials for child care providers and parents/guardians of enrolled children and promoted collaboration with community-based organizations that promote physical activity and nutrition for children. CCHC Program services included adults and children of all abilities, and family participation was encouraged in all program services.

Partnerships

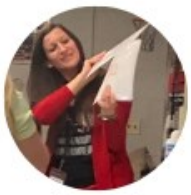
BCHW staff participated in coalitions and partnerships to advance progress towards the state's goals and objectives of improving access to nutritious foods and physical activity. Examples of groups in which staff participated included MOCAN, Missouri Coordinated School Health Coalition, DESE Healthy Schools Project, and Missouri Complete Streets Advisory Council. Staff had 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 promoted the use of and shared resources on the Whole School Whole Community Whole Child framework in Missouri schools. The Workgroup worked to strengthen district wellness policies and practices that promote healthier school environments.

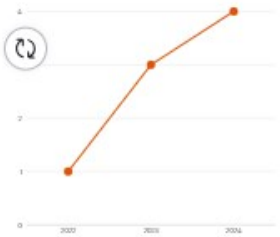
Through the MOCAN Health Care Work Group/Missouri Healthy Weight Advisory Committee, BCHW staff supported work to increase health care workforce capacity to provide evidence-based and family-based treatment programs for children that are overweight and obese. In 2022, the state's Medicaid program made it possible for providers to bill for obesity treatment for pediatric patients. Health care providers (registered dieticians/licensed clinical social workers/etc.) were surveyed to identify existing capacity to provide family-based obesity therapy and additional resources needed to increase health care provider capacity to provide these services. Plans are underway to establish a training and certification program to increase the providers that can provide these services. The University of Missouri Office of Health Outreach, Policy, and Education (HOPE) worked with the Healthy Weight Advisory Committee (HWAC) on webpage development to include a domain name and website outline, including content about obesity training and treatment, a calendar with training events, and links to family-based/intensive behavioral treatment trainings. They began developing two Canvas Courses: Medical Nutrition Therapy and a training for medical providers caring for families with obesity, with the work ongoing.

The CCHC Program Coordinator continued to participate 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 included DHSS, the MOCAN Child Care Work Group, the Kansas City Healthy Lifestyles Collaborative Early Childhood sector, the CDC-funded Missouri Physical Activity and Nutrition (MPAN) Grant, and the Missouri Breastfeeding Coalition.

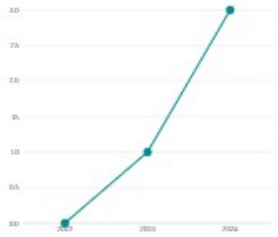
The MCH Services Program continued contracting with the 23 LPHAs that selected promoting physical activity and reducing and preventing obesity as a Priority Health Issue in their FY 2022-2026 MCH Services contract work plan. LPHA efforts to prevent and reduce obesity and increase physical activity among children and adolescents included:

- The Dallas County Health Department increased the number of local organizations implementing Memorandums of Understanding to increase physical activity for children from a baseline of one in FY 2022 to four at the end of FY 2024. The health department partnered with the Dallas County R-I School District and is currently piloting The Walking Classroom with one fourth grade classroom. The pilot classroom is home to 22 students, and the teacher reports the students look forward to using The Walking Classroom. Students share their mood and learning are positively impacted by physical activity. The classroom is currently using social studies, science, and language art educational tracks. The mission of The Walking Classroom is to help strengthen the physical, mental, and academic health of children. The program teaches children to establish and maintain healthy lifestyle habits and builds health literacy and core content knowledge, while students walk, listen, and learn.

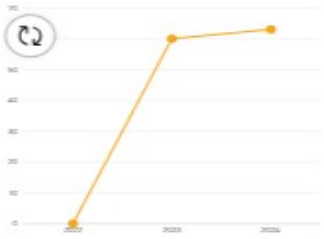




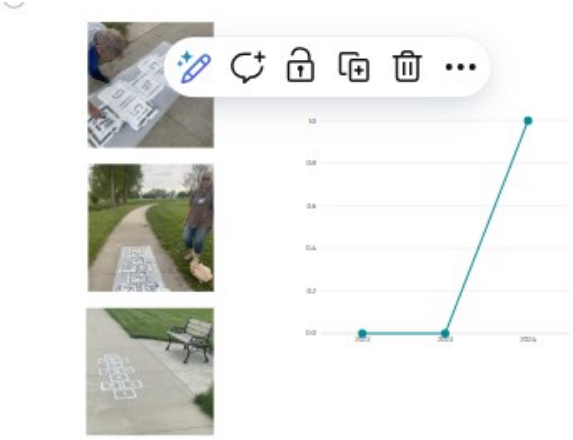
- The Shelby County Health Department increased the number of youth-serving organizations that include healthy lifestyle changes into their programs and activities from a baseline of zero in FY 2022 to a total of three at the end of FY 2024. The health department worked with the North Shelby School District and the local winter and summer youth sports recreational leagues to incorporate healthy food options in their concession stands, including items with reduced sugar, foods with protein, and fruits and vegetables.



- The Shannon County Health Center increased knowledge and skills around nutrition and physical activity and increased the number of children who were physically active at least 60 minutes/day from a baseline of zero in FY 2022 to a total of 150 at the end of FY 2024. The health center developed the Shannon County Health Center Childhood Obesity Prevention Program, partnering with school districts in Shannon County to implement the program with 5th grade classrooms. The health department staff went on-site at the school for one hour once a month, spending 30 minutes on nutrition education using *MyPlate*, followed by 30 minutes of physical activity. Height and weight were obtained with parental consent to measure changes in body mass index (BMI) from the beginning to the end of the program.



- The Carroll County Health Department increased the number of providers within the community that promoted best practices to increase physical activity among children and adolescents from a baseline of zero in FY 2022 to one in FY 2024. Painted playgrounds and walking trails have shown an increase in physical activity in children, and playground stencils are available to borrow from DHSS. The health department worked with the Carrollton Recreation Park Superintendent to add stenciled activities to the walking trails. The walking trail system features 2.1 miles of paved surface with multiple benches.



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 2022-2023 data, 79.2% of children ages 1-17 years had a preventive dental visit in the past year. This percentage was higher than in Missouri (75.0%). A lower percentage of Missouri children ages 1-5 (51.6%) had a preventive dental visit than their national counterparts (60.9%). This age group also had a lower percentage than Missouri children ages 6-11 (82.5%) and 12-17 (85.8%). Children who most frequently had a preventive dental visit in the past year lived in college-educated households (82.0%), followed by high school graduate or GED households (71.6%) and some college or technical school (62.6). Children with private insurance only more frequently had a preventive dental visit (80.2%) than publicly insured only (70.4%) and uninsured (57.6%). Nationally, children in two-parent, married households reported having more frequent preventive dental visits (81.9%) than in Missouri (77.7%). Children in single-parent households nationally also reported more frequent preventive dental visits (75.9%) than in Missouri (73.3%).

Efforts to Enhance Access to Oral Health Services for Children

Information for ordering oral health resources from the Office of Dental Health (ODH) was provided to all MCH-funded home visitors to promote National Children's Dental Health Month, observed annually in February. National Children's Dental Health Month was also 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 highlighting the importance of annual preventive dental care among children. The Missouri WIC Program collaborated with ODH to make infant and toddler toothbrushes available in local WIC clinics. Additionally, literature was available to LPHAs, dental offices, and community outreach events, such as health fairs. The importance of regular dental care is also emphasized within the context of ODH's promotion of dental sealants. The referral and care coordination components of the Preventive Services Program (PSP), an evidence-based fluoride varnish and oral health education program, encouraged regular dental visits for children, particularly those identified as having oral health needs.

PSP served about 90,000 children during the 2023-2024 school year. (See table below.) Each child received an oral health screening by a health care professional, two doses of fluoride varnish, which has been shown to decrease dental decay with two or more annual applications, and oral health education, literature, and supplies. The oral health education was provided either by school staff or dental or medical professionals who volunteered to operate PSP. Educational materials for grades K-12 were provided by ODH, but some schools chose to use their own materials. Restrictions on visitor access to school buildings due to the Coronavirus pandemic have been lifted for most schools, and PSP was able to continue regular operations. The State Dental Hygienist and Chief Dental Consultant advised school nurses on possible dental health needs. School nurses were able to take pictures of a child's teeth if there was a questionable issue, and the State Dental Hygienist or Chief Dental Consultant helped determine the need for further dental care. Narrated educational videos, created by ODH during the Coronavirus pandemic and specific to K-12 grade levels, remain publicly accessible on the DHSS website. ODH started working with an intern in September 2024 to update the videos.

Promoting Healthy Smiles through Education and Prevention

Missouri 2023-2024		
Condition	**Number of Students**	**Percent of Students**
Total Number of Students Screened	71,222	
Oral Hygiene Satisfactory	56,634	79.52%
Oral Hygiene Not Satisfactory	14,433	20.26%
History of Rampant Caries - Yes	8,110	11.39%
History of Rampant Caries - No	62,816	88.20%
Untreated Decay - Yes	16,883	23.70%
Untreated Decay – No	54,287	76.22%
Treated Decay – Yes	22,801	32.01%
Treated Decay – No	48,362	67.90%
Urgent Care Needed	2,836	3.98%
Sealants – Yes*	14,283	27.48%
Sealants – No*	37,533	72.21%

*Age of Students: 0-5 = 6; 6-10 = 113; 11-15 = 170; 16-21 = 134

When PSP was developed almost 20 years ago, only licensed dentists or hygienists could conduct the PSP oral health screening. Due to ongoing workforce shortages and the lasting impacts of the COVID-19 pandemic on providing oral health services, many dental professionals are not able to volunteer for PSP as they once were. Additionally, the dental health workforce has seen a 5-10% decline, with some dentists and hygienists transitioning to other fields. As a result, they may no longer hold active licenses or have other work commitments, further limiting participation in PSP. To address this gap, ODH worked 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. A dentist from KCU and ODH regional hygienists provided the training. LPHA nurses visited local schools to conduct basic oral health screening, offer oral health education, provide oral care supplies, and help with referrals and fluoride varnish applications. The LPHA purchased fluoride varnish, reimbursable through Medicaid, supporting program sustainability. ODH is evaluating project outcomes to determine the feasibility of expanding to LPHAs in other areas suffering from workforce shortages.

To further combat the workforce shortage and grow PSP, ODH worked with the University of Missouri–Kansas City and Score 1 for Health, a preventive health program that provides free, in-school health screenings for elementary-aged children with the greatest need, including families living in the urban core and low-income families from under-resourced neighborhoods, to train medical students to perform PSP screenings. This project addresses the dental workforce shortage and its impact on PSP and provides a learning opportunity for medical students, with the objective of medical students becoming accustomed to performing a quick visual oral health assessment as part of routine medical practice, thereby increasing early identification and treatment of oral health issues.

The Adolescent and School Health Program (ASHP) coordinated with ODH and other programs to provide school nurses with evidence-based information, resources, and professional development opportunities. This support helped school nurses promote best practices for children and parents, emphasizing the importance of regular dental check-ups and preventative measures. During statewide meetings targeting school nurses, ODH recruited additional schools to offer school-based oral health services. ODH continued distribution of Dental First Aid Kits, as funding allowed. The kits included 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. Supported by Title V MCH funding, ODH purchased, assembled and distributed over 3,000 kits to schools throughout Missouri. The ASHP offered a 60-minute orientation on the kits and the PSP to 73 school nurses. 100% of evaluation responses indicated the information was relevant to their practice, participants learned new information, and they would recommend the orientation to others. Additionally, the ASHP helped with direct outreach to targeted school districts to facilitate introduction between ODH staff and school nurses, foster collaborative relationships, and enroll districts in the state-provided PSP.

ODH promoted the use of dental sealants as an effective means of preventing decay on newly erupted molars and actively pursued new

partnerships to provide dental sealants in school-based clinics. ODH leveraged a CDC grant to work with two LPHAs and four dental health clinics to apply sealants in their clinics and at local schools. Leveraging another grant, ODH contracted with two dental clinics and four dental hygiene schools to provide teledentistry services to schools. ODH continued to work with WIC Programs at LPHAs to support fluoride varnish application for high-risk children. These services targeted counties with very few or no dentists and provided dental services to children who may not have otherwise had access.

Through an agreement with DESE, ODH continued to provide free oral health screenings, fluoride varnish, and oral care supplies to children at the Missouri Schools for the Severely Disabled. The State Dental Hygienist provided screenings, alerted the school nurses when the child had an issue needing immediate attention, and provided fluoride varnish. ODH piloted an online screening form to be used to record and gather results of the screenings. (See table below. Note: Noncompliant refers to refusal or failure to comply with oral health screening and/or treatment.)

Promoting Healthy Smiles through Education and Prevention
Missouri State Schools for the Severely Disabled Program

Final Report 2023 - 2024		
Condition	**Number of Students**	**Percent of Students**
Total Number of Students Screened	413	
Oral Hygiene Satisfactory	165	39.95%
Oral Hygiene Not Satisfactory	89	21.55%
Oral Hygiene Noncompliant	140	33.90%
History of Rampant Caries - Yes	13	3.15%
History of Rampant Caries - No	221	53.52%
History of Rampant Caries Noncompliant	161	38.98%
Untreated Decay - Yes	25	6.05%
Untreated Decay - No	195	47.22%
Untreated Decay Noncompliant	179	43.34%
Treated Decay - Yes	67	16.23%
Treated Decay - No	155	37.53%
Treated Decay Noncompliant	175	42.38%
Urgent Care Needed	11	2.66%
Urgent Care Needed Noncompliant	169	40.92%
Sealants - Yes*	10	2.42%
Sealants - No*	167	40.44%
Sealants Noncompliant*	218	52.78%
Varnish Applied	272	65.86%

*Data reported on ages 8 and up

The TEL-LINK Program collaborated with ODH to increase awareness of community resources and provided 102 dental health referrals. TEL-LINK collaborated with partners 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 program promotes this service through effective marketing strategies and search engine campaigns to provide outreach to at-risk, underserved populations. Through this campaign, over 8,000 individuals clicked on the ad to learn more about the services TEL-LINK provides. The search engine strategy utilizes geographic and demographic targeting, which directs individuals to TEL-LINK so operators can provide the most closely located resources. The program collaborated with ParentLink, WIC, and DSS to promote TEL-LINK.

The Child Care Health Consultation (CCHC) Program at DESE provided 41.75 hours of consultation and training for child care providers and 224.25 hours of health promotion for children in child care on the importance of oral health and the impact of oral health on physical health. Consultations increased awareness of evidence-based policies and procedures that promote optimal oral health for children and provided the opportunity for consultants to provide technical assistance to child care providers. Trainings increased the child care provider's knowledge of 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 (cshcn). Health promotions for children in child care provided developmentally appropriate and fun oral health education to help children understand

why it is important to take care of their teeth, identify unhealthy snacks and beverages that could harm their teeth, participate in hands-on demonstrations of proper tooth brushing and flossing techniques, and learn what to expect when they visit the dentist. CCHC Program services continued 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 also increased parent/guardian awareness on the importance and recommended frequency of preventive dental checkups and other ways to promote oral health at home. CCHC services continued to include 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.

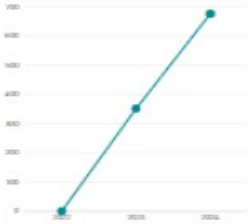
The MCH Services Program supported LPHA efforts to:

- 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, receiving a preventive dental visit in the last year.

The MCH Services Program continued 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.

- The Audrain County Health Department increased the number of children who received an annual oral health screening from a baseline of zero in FY 2022 to a total of 464 at the end of FY 2024 by collaborating with the WIC program. Staff were trained to perform an oral health screening, apply fluoride varnish with consent, and provide oral health education. A health department nurse provided oral health screening and education to 464 children and applied fluoride varnish to 278 of those screened.

- The Wright County Health Department increased the number of children who received an annual oral health screening, oral health education, and a dental hygiene kit from a baseline of zero in FY 2022 to a total of 676 by the end of FY 2024 by collaborating with the WIC program and nursing staff who provide services at both office locations in the county. The health department created oral health kits that included a toothbrush, floss, and toothpaste and gave the kits to all children ages 1-17 who visited the health department. In addition, 279 children received fluoride varnish.



ODH continued to create social media posts for DHSS programs and the LPHAs to use throughout the year. ODH was selected by ASTDD to receive technical assistance to increase social media presence and develop social media postings. ODH also forwarded Missouri Coalition for Oral Health's social media postings for broader sharing.

ODH disseminated and engaged partners in ongoing discussions related to the Five-Year State Oral Health Plan and continued 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 through the DHSS website and partners like the Missouri Coalition for Oral Health and the 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 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 collaboration with the DHSS Office

of Rural Health and Primary Care on incentive programs for dental professionals; and
- Implement PSP referrals, linking children with an identified dental need to local dental providers. This is coordinated through school nurses and other regional champions.

Additional ODH activities included educating 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. ODH continued to improve the Missouri Oral Health Surveillance System, which includes updated fact sheets on topics of interest and regional reports compiling oral health statistics and related information.

The Home Visiting Program's contracted home visitors provided educational materials and support to enrolled primary caregivers about the importance of beginning good oral health care early in life and contacting a local dental health professional or FQHC to plan how and when to introduce a young child to a dental health provider. Performance measure data showed 32.4% (58/79) of children enrolled in home visiting had a regular source of dental care. Challenges with accessing oral health care services were discussed with home visitors during annual professional development events.

Other Title V MCH Activities Related to the Child Health Domain

Developmental Screening
The CCHC Program provided consultations and trainings for child care providers around health and safety topics related to optimal growth and development, including social-emotional learning, language/communication, cognitive development, and movement/physical development. The CCHC Program provided 145 hours of training and consultation for child care providers regarding developmental screenings and child growth and development. Consultations and trainings for child care providers focused on incorporating developmental monitoring tools and checklists, strategies that positively impact child development, and individualized health plans for children with developmental delays and disabilities. Trainings for child care providers included the CDC "Learn the Signs. Act Early." (LTSAE) campaign materials, with the most recent developmental milestones checklists. Trainings stressed the importance of monitoring developmental milestones and provided communication strategies that child care providers can use when communicating with parents/guardians regarding child development concerns. The CCHC Program provided health promotions for children in child care, delivering education related to multiple areas of child development with fun, developmentally appropriate, and engaging presentations. 278.5 hours of health promotion for children in child care focused on growth and development topics. Health promotion lesson plans for children in child care supported all domains of child development. CCHC Program services provided resources about child development and developmental monitoring and screening for child care providers and parents/guardians of children in child care. Parents/guardians were encouraged to participate in all program services provided.

Inclusion Specialists provided parents with a listing of child care providers based on their geographical location, ensuring they could choose child care to meet the needs of their child. This personalized approach increased the likelihood of maintaining placement, thereby supporting the child's educational needs. Inclusion Specialists also offered onsite consultation to assist child care providers in developing strategies and adaptations to include cshcn in classroom activities and set achievable goals for the child's ongoing development. In addition, they delivered group training to increase child care providers' knowledge on how to include cshcn. By adding a social-emotional learning project, specialists delivered evidence-based training to child care professionals, providing practical strategies to foster social-emotional development.

The Home Visiting Program's contracted home visitors used the Ages and Stages Questionnaire® - 3 (ASQ-3) screening tool to identify children's developmental needs. Home visitors provided referrals for children who scored below standardized cut-off points, indicating a need for additional developmental assessment, information, activities, community support, and/or early intervention services through Missouri First Steps or Early Childhood Special Education to contribute to improved school readiness. 80.12% (133/166) of ASQ-3 developmental screenings were conducted at 9, 18, and 30 months of age, as recommended. Additionally, 69.23% (9/13) of children who scored below the cut-off points on the ASQ-3 received a completed referral.

Home visitors continued best practices to screen all children, birth to kindergarten entry, for social-emotional development using the Ages and Stages Questionnaire®: Social Emotional (ASQ:SE-3). Home Visitors provided developmental activities for parents/children who scored in the "monitoring" range and assisted families in accessing services, as indicated and appropriate. The Home Visiting Program provided all contracted home visitors with education on childhood mental health conditions and warning signs

through a variety of communications, including the Office of Childhood Monthly Newsletter and during annual professional development events. TEL-LINK and the University of Missouri's ParentLink Program were promoted as resources for both home visitors and caregivers.

The Newborn Health Program partnered with various community health providers to distribute 23,000 copies of the *Pregnancy and Beyond* booklet, along with other educational materials that provide information on developmental screening. The program tracked the distribution of these materials and obtained feedback from its partners on how the materials were being used and how to improve them. The booklet is undergoing revisions and updates based on the feedback received.

The Missouri WIC Program promoted 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 to WIC agencies, home visitors, Head Start, Parents as Teachers, health care providers, library staff, and other community partners. The WIC Program distributed books developed as part of the LTSAE public health campaign and created and disseminated handouts to provide caregivers with tips on fun and easy ways to improve a child's learning.

The MCH Services Program supported 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 immunizations; and
- Refer infants and children with potential developmental delay or failure to meet expected developmental milestones.

The Childhood Lead Poisoning Prevention Program (CLPPP) provided information about the potentially harmful cognitive and developmental effects that may occur following a child's blood lead level elevation. Information was provided to:

- The public;
- Pediatricians and other health care providers;
- LPHA and health plan lead clinical case managers, including 15 trainings, with156 people trained;
- WIC staff;
- Families enrolled in Newborn Home Visiting Program;
- 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 provided information about the following:

- Substances and environments that are likely to be sources of lead exposure;
- The importance of 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 AAP recommendations;
- Medicaid blood lead level testing requirements;
- The recommended environmental and clinical follow up of children with elevated blood lead levels;
- The recommended tracking of blood lead testing; and
- Extended developmental monitoring of children with elevated blood lead levels.

CLPPP worked to address community factors that influence health outcomes by providing health literate and linguistically appropriate materials. CLPPP translated "What Your Child's Blood Lead Level Means" into 5 languages, African French, Burmese, Pashto, Spanish, and Swahili, and made the publications accessible online. The program created multiple social media video clips and three videos on proper cleaning techniques to minimize the dangers of lead in the home. The "Cleaning Up Lead in Your Home" videos, in English and Spanish, are also accessible on the website. CLPPP referred 100% of children identified with an elevated blood lead level to appropriate services (case management, risk assessment, medical follow up) and continued 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. CLPPP aims to increase compliance with harm reduction activities related to lead poisoning. The strong partnership between MCH Leadership and CLPPP activities enhanced the program's impact.

Additional Performance Analysis

Pre- and post-test data related to obesity training and treatment for MU HOPE and HWAC is collected in Canvas, and data analysis will be done using a combination of the capabilities of the Canvas platform and HOPE expertise.

Over the past 7 years, ODH has seen a 4% decrease in dental decay among PSP participants. In many instances, the oral care supplies given to PSP participants are the only ones they receive. Feedback from school nurses who participate with PSP has been extremely favorable.

Challenges

Limited DHSS, LPHA, and partner workforce capacity, workforce turnover, and financial constraints limit the scope of existing program activities and services and prevent implementation of new program activities and services to increase physical activity among children and adolescents and provide evidence-based and family-based treatment programs for children that are overweight and obese to prevent and reduce obesity.

Follow-up data collection on some CLPPP referrals has historically been a challenge.

Financial constraints and rising costs of oral care supplies and shipping prevent expansion and threaten sustainability of existing program activities and services or implementation of new program activities and services. It will be difficult to continue serving the same number of children through PSP.

Home visitors report that recommendations for the age a child should begin seeing a dentist differ between oral health providers. Some providers recommend an introductory visit as soon as the child will allow, but others recommend the child not be seen until first teeth appear or later. Home visitors occasionally have challenges completing developmental screenings within recommended timeframes, and various home visiting models have different screening timeframes, resulting in difficulty maintaining consistency across all local implementing agencies.

Opportunities

There is an opportunity to expand MU HOPE and HWAC efforts related to obesity training and treatment through the development of continuing education courses.

Efforts to advance access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children and adolescents, including children and youth with special health care needs, will provide the opportunity to promote healthy lifestyles and effectively case manage obesity and other chronic conditions.

ShowMe WorldCare surveillance/case management system allows new opportunities for data collection and dissemination for CLPPP. First Step referrals will now be captured in the system and follow-up information can be added, increasing follow-up data collection and cross collaboration within programs.

When shipping PSP supplies, both applications of fluoride varnish will be shipped together with the other PSP supplies, instead of shipping the second application of varnish separately. To streamline educational literature, ODH is exploring the creation of shorter informational materials for parents. ODH has created an online screening form to supplement the paper screening forms. Some schools do not have reliable internet access and still submit paper forms, but approximately 60% of schools submit the online screening form.

Home Visiting is developing a training for home visitors to complete an annual functional hearing, vision, health and oral health assessment for all enrolled children.

Efforts to advance access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children and adolescents, including children and youth with special health care needs, will provide the opportunity to promote

routine preventive dental care and coordination of service delivery across the care continuum.

Expanded partnership among oral health programs, nutrition services, the CCHC Program, LPHAs, home visitors, etc. is needed to increase awareness and parent/caregiver understanding of oral health risks associated with practices such as poor oral hygiene, frequent consumption of sugary foods and drinks, especially before bed, putting infants and toddlers to bed with a bottle, and infrequent dental visits.

Child Health - Application Year

NPM: Medical Home – Family Centered Care - Access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children without special health care needs.

Please note: Some strategies and activities listed below may be relevant for both the Child Health and Children with Special Health Care Needs (CSHCN) domains.

ODH will work with the Missouri Coalition for Oral Health and the University of Missouri Kansas City Dental School to educate dental professionals on the dental home and increase access to routine and emergency dental care for all children.

BCHW will collaborate with the Missouri Council for Activity and Nutrition (MOCAN) Health Care Work Group, whose members provide expertise and advice to advance and monitor collaborative, sustainable, evidence-based strategies for increasing the number of children at a healthy weight. BCHW supports the Work Group in efforts to address educational gaps and desired learning outcomes of health professionals to increase health care workforce capacity to provide evidence-based, family-centered treatment programs for children that are overweight and obese, delivering weight management treatments aligned with the newly available MO HealthNet benefit for children and adults. In 2022, MO HealthNet made it possible for providers to bill for obesity treatment for pediatric patients. Health care providers (registered dietitians, licensed clinical social workers) were surveyed to identify existing capacity to provide family-based obesity therapy and additional resources needed to increase health care provider capacity to provide these services. BCHW will work with the University of Missouri Office of Health Outreach, Policy and Education (HOPE) to expand efforts to train health care professionals in respectful, person-centered care, disseminate trainings and offer continuing education credits to additional healthcare professionals, evaluate training and outcomes, update trainings as new evidence becomes available, and further populate and maintain the trainings and other resources housed on the webpage for obesity and family-based/intensive behavioral treatment. Continuing education courses being developed include Medical Nutrition Therapy, Medical Assessment and Treatment, Structural Risk Factors and Weight Stigma, MO HealthNet Obesity Treatment Benefit, and Family-Based Behavioral Treatment/Intensive Behavioral Treatment trainings for dietitians, medical providers, and health care professionals interacting with families with obesity.

Newborn Screening
Since 2017, information about the importance of a medical home for children has been included in the Newborn Screening booklet produced by the program and distributed to new and expectant parents. On average, approximately 4,000 Newborn Screening booklets are requested monthly and provided at no cost 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 obstetrics and gynecology clinics. The Newborn Screening Program will distribute an electronic parent survey, including a definition of medical home, to educate parents on the concept and pose questions to help parents assess whether their child has a medical home. In addition, the program gleans parental insight who/where they identify as their child's medical home. The survey is provided to parents whose child was diagnosed with a disorder identified because 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 parent survey also invites families to share their experience with the newborn screening process to help the program identify common concerns. Parents frequently report health care providers do not convey screening results to them. The program can use this feedback to bring the importance of discussing the results with parents to the health care providers. Discussing all screening results, including normal results, with parents helps build trust in the newborn screening process and respects family decision-making, should additional testing or treatment be needed.

Adolescent and School Health
The Adolescent and School Health Program (ASHP) considers school nurses as a component of a medical home, assuring students have insurance coverage and access to whole-person, patient-centered, coordinated, and comprehensive care and services and ensuring children with a potential for a life-threatening event (seizure, asthma exacerbation, anaphylactic episode, abnormal blood sugar level, etc.), or a special health care procedure (tube feeding, urinary catheterization, dressing change, etc.) 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. ASHP will promote the School Nurse Chronic Health Assessment Tool (SN CHAT) to engage school nurses and parents in developing individual health and emergency action plans.

ASHP will support school health staff in public, private, and charter schools across Missouri in providing evidence-based strategies and guidance for implementing vision, hearing, and dental screenings in collaboration with LPHAs, ODH, and other organizations, such as Colgate Bright Smiles and the Bright Futures program, to increase early screening, detection, and referral to appropriate services and resources. ASHP will provide trainings and technical assistance on screening procedures to school health staff and LPHA partners during statewide conferences and meetings, including the Missouri Coordinated School Health Coalition Conference and a pre-conference session at the Missouri Public Health Conference.

ASHP will facilitate N.E.W.S., a weekly one-hour Nurse Education Webinar Series and professional development opportunity for school health staff on a variety of topics related to school health. ASHP disseminates regular weekly communication blasts, called "News You Can Use," to school health staff, sharing pertinent information for the medical care of children, training opportunities, and other pertinent information. ASHP will participate in multiple partnerships and collaborations through committee and board participation, such as the Lead Advisory Committee with DHSS, School Safety Committee with the Missouri School Boards Association, Missouri Association of School Nurses Board, and more, to increase awareness around the need for and promote medical homes for children.

ASHP will partner with LPHAs, school districts, and community partners to provide an evidence-based curriculum for adolescent females ages 14-24 focused on healthy decision-making around relationships, pregnancy, parenting, and more. Each lesson has a supplemental session to facilitate guest presentations on a variety of topics related to pregnant and parenting teen mothers. One of these sessions will cover the importance of comprehensive care and provide information on routine vaccinations, well-child checks, and other clinical supports offered by LPHAs and various community providers.

Local Public Health Efforts

Two LPHAs will complete year five contract work plan activities to ensure coordinated, comprehensive, and ongoing health care services for children with and without special health care needs and achieve targeted system outcomes outlined in FY 2022-2026 contract work plans. A contract outcomes report will be completed, evaluating performance trends and providing conclusions across the five-year contract work plan cycle. Tri-County and Warren County Health Departments will work to ensure coordinated, comprehensive, and ongoing health care services for children with and without special health care needs. Warren County Health Department plans to change internal organizational practices and develop a policy to screen all children 0-17 for a medical home and refer, as indicated.

The MCH Services Program plans to increase both educational and technical assistance opportunities to increase LPHA knowledge and skills to develop FY 2026-2030 contract work plans utilizing the MCH Evidence *What Works Evidence Accelerators*, including the following evidence-based strategies to increase the percent of children with and without special health care needs, ages 0 through 17, who have family-centered care:

- Healthcare provider training and education;
- Trauma-informed health care;
- Communication and information sharing;
- Medical Home models;
- Parent and caregiver partnership;
- FQHCs;
- Patient Navigators; and
- School-Based Health Centers.

State Agencies and Partners

To promote comprehensive access to care, MCH Leadership and programs will collaborate with stakeholders to ensure families are informed about and connected to appropriate insurance coverage, including guidance to help families explore coverage options available through the Affordable Care Act, employer-sponsored plans, and private insurance, with the goal of ensuring all children have access to adequate and continuous health coverage.

MCH Leadership will share resources and implementation tools on the medical home approach and ensure all programs and contracts include activities to promote coordinated, comprehensive, family-centered, and ongoing health care services for all children. Title V funded programs and contractors, including home visitors, will be required to promote the medical home approach, promote

coordinated systems across the child/family care continuum, promote comprehensive access to care, including adequate insurance coverage, for children, and promote shared care planning to operationalize core values of patient/family-centered care and ensure families are full partners in their child's health. Programs and contractors will collaborate with multi-sectored stakeholders to integrate the medical home approach and promote care coordination and community referrals to facilitate the linkage of children and their families with appropriate services and resources. Partners and stakeholders, including providers, will be educated on and encouraged to promote the medical home approach to ensure access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children with and without special health care needs. MCH Leadership will expand partnership with MO HealthNet and the Managed Care health plans to leverage health homes as catalysts to advance the medical home approach by expanding the scope of care coordination to promote whole-person, patient-centered, coordinated, and comprehensive care and services for children and families and improve the health and well-being of all children.

MCH Leadership will collaborate with the Missouri chapter of the AAP and the National Resource Center for Patient/Family-Centered Medical Home to promote implementation of high-quality primary care and integrated behavioral health services for children and youth and partnership with state and local MCH programs and services, pediatric clinicians, families, community members, and policy makers.

MCH Leadership, programs, and partners will promote enrollment in children's health coverage programs, including *Show Me Healthy Kids,* a specialized managed care plan offered through MO HealthNet and administered by Home State Health, which allows the most vulnerable MO HealthNet members to access a care network designed to meet their needs, as appropriate. The plan works with many doctors, clinics, and hospitals to provide regular checkups, exams, primary care, and specialist care when needed. Individuals who qualify for coverage are automatically enrolled in this health plan the day they are approved for MO HealthNet benefits and will continue to receive health care coverage through this plan as long as they are eligible. Eligibility groups for Show Me Healthy Kids include:

- Children in the care and custody of the Department of Social Services.
- Children or youth in alternative care.
- Children receiving adoption or legal guardianship subsidies.
- Former foster care youth under the age of 26 who were in foster care on their 18th birthday and covered by MO HealthNet and who meet other eligibility criteria.
- Former foster care youth under the age of 26 who were in foster care on their 18th birthday and covered by Medicaid from another state, and who are not currently eligible for Medicaid coverage under another program.

In addition to the medical and behavioral benefits included in other plans, *Show Me Healthy Kids* includes:

- Dedicated local teams to assist with health care coordination and support for navigating the health care system.
- Help finding the right health providers.
- Health care coordination for members with multiple or complex health care needs.
- Smooth transition of health care services when members are hospitalized or change placements.
- Education and assistance to members who are transitioning from foster care to independence.
- Assistance with finding community resources through findhelp.org.
- A 24/7 Nurse Advice and Crisis Line. Members and their families can talk to their assigned health care coordinator by phone during business hours and by voicemail at any hour of the day or night.
- 24/7 access to virtual telehealth doctors via Teladoc Health.
- Additional services to support better health outcomes like access to an online health library, wellness programs, maternity program, no-cost cell phone, and more. Some programs are subject to eligibility.
- Assistance with transportation to healthcare appointments.

NOTE: The percent of children with and without special health care needs, ages 0 through 17, who receive family-centered, coordinated, comprehensive, and community-based health care services and supports was selected as the NPM in the CSHCN domain. As required, reporting related to Medical Home is included in both the Child Health and CSHCN domains, but the majority of application narrative content is included in the CSHCN domain.

NPM: Preventative Dental Visit – Child - Access to holistic oral health care services for children.

ODH will provide and expand the Preventive Services Program (PSP) to bring school-based oral health services directly to more children. PSP provides a free oral health review/screening, oral care supplies, oral health education, two applications of fluoride varnish, and a child-friendly "SWAG" item, such as a water bottle sticker, mirror cling, or bookmark, to remind children to brush their teeth. School nurses are notified when a child is found to have an emergent dental health need so the nurse can contact the parent and inform them of the of the situation and need for prompt treatment. Often, the dental health professional performing the oral health screening coordinates with assistants to note who needs follow-up care and when an appointment should be made, and referral information is shared with school nurses to provide to the families of children needing further oral care.

ODH is working to expand PSP into more schools and with FQHCs. For example, Access FQHC's mobile van in the Joplin area has been providing dental services to school children, but Joplin schools do not participate in PSP. ODH's goal in partnering with Access FQHC and the Joplin schools is to bring PSP directly to students, so children receive PSP services and are identified and referred for follow-up care, when needed. This allows the school nurse to know exactly which children need to be seen by Access' mobile van, streamlining the FQHC's work at the schools. ODH is also piloting a partnership with Delta Dental to offer their "Land of Smiles" educational video and in-person training, along with oral care supplies for children in grades K-3, during PSP events. This partnership will help extend ODH's PSP oral care supplies across more events and support expansion of Delta Dental's education program. As funding is available, dental care first aid kits, containing a variety of necessary oral care supplies that can be used in case of a dental emergency, will be distributed to schools.

When shipping PSP supplies, both applications of fluoride varnish will be shipped together with the other PSP supplies, instead of shipping the second application of varnish separately. To streamline educational literature, ODH will explore creation of shorter informational materials for parents and will track utilization of the online screening form by schools without reliable internet access.

The WIC Fluoride Varnish Program was originally funded by another grant that has since ended, however, over 20 LPHAs continue providing the service to children enrolled in WIC. The program allows the LPHAs to purchase fluoride varnish, apply the varnish to Medicaid-eligible children, and bill Medicaid for reimbursement, as long as a nurse or dental health professional applies the varnish. These LPHAs also purchase varnish to provide the PSP oral health screening in schools and bill Medicaid for reimbursement for Medicaid-eligible children. This has extended services to a greater number of children in more communities. ODH will continuing hosting and providing technical assistance through quarterly calls with these LPHAs to support efforts.

ODH will continue educating families, medical and dental providers, and community partners about the importance of dental visits and holistic oral health care services for children, including ongoing collaboration with MO HealthNet. ODH works with MO HealthNet to promote oral health at annual regional meetings with doulas, LPHAs, and other service providers. ODH will work closely with MCOs and other funders to identify joint opportunities for expanding oral health services. In FY 2026, ODH aims to partner with at least two MCOs on different events and programs to promote the importance of dental health. As requested, ODH will speak at school nurse conferences, MO HealthNet workshops, other webinars and conferences, and meetings such as the quarterly update meetings with MPCA and Missouri Coalition for Oral Health Board and Policy meetings.

ODH will provide training for health care, oral care, and public health professionals, including pediatric providers, to strengthen knowledge and support for water fluoridation. This training will build on ongoing efforts to promote the safety, efficacy, and benefits of community water fluoridation, including presentations and exhibits at conferences, meetings, and health events, technical assistance, and web-based evidence-based resources. As ODH becomes aware of a community's intent to discontinue water fluoridation, partners who may be positioned to support efforts to maintain fluoridation will be informed, and ODH will educate city officials, dental and health care professionals, public health authorities, and the community on the protective benefits of water fluoridation.

The Adolescent and School Health Program (ASHP) will collaborate with ODH to encourage school districts to participate in PSP. ASHP shares communications and guidance from ODH with school nurses via News You Can Use email blasts and provides Nurse Education Webinar Series (N.E.W.S.) virtual learning opportunities. ASHP plans to review and evaluate the schools not participating in PSP and identify areas for individual outreach to encourage discussion around participation and support that can be provided. As possible, the ASHP and ODH would like to offer education and training on dental screenings via conference presentations and regional training opportunities, such as the annual Joint Public Health Conference.

The Child Care Health Consultation (CCHC) Program will provide consultation and training for child care providers and health promotion for children in child care on the importance of oral health for overall health. Consultations will increase awareness of evidence-based policies and procedures that promote optimal oral health for children. 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 implications for oral care for children with special health care needs. Health promotions for children in child care will provide developmentally appropriate and fun oral health education and help children understand why caring for their teeth is essential, identify unhealthy snacks and beverages that could harm their teeth, and participate in hands-on demonstrations of proper tooth brushing and flossing techniques. LPHAs will 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 their ability to participate in oral care at home. 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. Family engagement is a required element of Health Promotion services, and trainers are required to provide evidence-based health and safety-related educational resources for children and families. CCHC services will include 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. Future program trajectory, activities, and focus will be steered with input from LPHA Child Care Health Consultants, child care program directors and staff, and identified needs of families and children enrolled in child care programs across the state. The CCHC Program will promote PSP by increasing LPHA, Child Care Health Consultant, and child care programs' awareness of available PSP services.

Seven LPHAs will complete year five contract work plan activities to increase the percentage of children, ages 1 to 17, who had a preventive dental visit in the last year and to achieve desired system outcomes outlined in FY 2022-2026 contract work plans. A contract outcomes report will be completed, evaluating performance trends and providing conclusions across the five-year contract work plan cycle. Wright and Audrain County Health Departments will work to increase the number of children who receive an annual oral health screening and education by collaborating internally with their WIC offices and embedding education and screening into other clinical services for children and families.

In partnership with ODH, the MCH Services Program plans to provide educational and technical assistance opportunities to increase LPHA's knowledge and skills on utilizing the MCH Evidence *What Works Evidence Accelerators* to develop the FY 2026-2030 contract work plans, including the following evidence-based strategies to increase the percentage of children, ages 1 to 17, who had a preventive dental visit in the last year:

- School-based screenings and follow-up;
- Caregiver/patient education and/or counseling;
- Mobile oral health programs;
- Preventive oral care outreach;
- Early Head Start integration;
- School-based dental programs; and
- Information about and implementation of Teledentistry.

Expanded partnership among oral health programs, nutrition services, the CCHC Program, LPHAs, home visitors, etc. will increase awareness and parent/caregiver understanding of oral health risks and the importance of good oral hygiene, routine dental visits, healthy eating, hydration, and protecting the mouth when playing sports or riding a bicycle to prevent orofacial injuries.

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

Other Activities to Promote Child Health

The Newborn Health Program (NHP) will partner with various community health providers to distribute the *Pregnancy and Beyond* booklet and other educational materials related to normal growth and development and developmental screening. NHP will track the distribution of these materials and obtain feedback from partners on how the materials are being used and ways to improve them.

The CCHC Program will provide consultations and training for child care providers around health and safety topics, including social-

emotional learning, language/communication, and cognitive and motor development in children. Consultations and training for child care providers will focus on incorporating developmental monitoring tools and checklists, strategies that positively affect child development, and individualized health plans for children with developmental delays. Training for child care providers will cover the updated developmental milestones checklists included in the CDC "Learn the Signs. Act Early" campaign materials. Training will stress the importance of monitoring developmental milestones and providing communication strategies that child care providers can use when communicating with parents/guardians regarding child development concerns. Health promotion lesson plans for children in child care will support all domains of child development. CCHC services will provide resources on child development and developmental monitoring and screening for child care providers and parents/guardians. Family engagement will be a required element of health promotion services, and parent/guardian participation in all program services will be encouraged. Trainers will be required to provide evidence-based health and safety-related educational resources for children and their families. Future program activities will be determined with input from consultants at LPHAs, child care program directors and staff, and identified needs of families and children enrolled in child care.

A child enrolled in a child care program that supports their educational needs will increase the likelihood of maintaining placement, and parents are encouraged to choose child care that will meet their needs. Inclusion Specialists will provide parents with a list of childcare providers based on parent location preferences and will provide onsite consultation, technical assistance, short-term consultation, and training for the provider caring for the child to ensure the child's needs are met. Specialists will deliver evidence-based training to childcare professionals to help them understand how children develop socially and emotionally, assist in setting achievable goals for the child's ongoing development, and emphasize real and practical strategies to foster social-emotional development.

The MCH Services Program will continue to support LPHA efforts to:

- Utilize the WIC Developmental Milestones Program to provide infant and early childhood developmental and social-emotional screening services during WIC appointments;
- Provide developmental screening for children enrolled in LPHA home visiting programs;
- Participate in preschool and pre-K screening;
- Collaborate with Parents as Teachers, an evidence-based home visiting model, to provide various services to families with children from prenatal through kindergarten;
- 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 strong partnership between MCH Leadership and the Childhood Lead Poisoning Prevention Program (CLPPP) will enhance program activities and impact. CLPPP will support and improve coordinated systems of care to address the needs of maternal, infant and child populations at risk for or experiencing lead exposure. CLPPP will provide information about the potentially harmful cognitive and developmental effects that may occur following a child's blood lead level elevation. Information will be provided to:

- The public;
- Pediatricians and other health care providers;
- The LPHA and health plan lead clinical case managers;
- WIC clinic staff;
- Home visitors and Parents As Teachers (PAT), Head Start, and Early Intervention/First Steps staff;
- School nurses; and
- Parents of children with elevated blood lead levels.

CLPPP will address community and population-level factors that influence child health outcomes by providing health-literate and culturally and linguistically appropriate materials related to lead poisoning prevention. Based on identified population needs, CLPPP will conduct a health literacy review of three publications and translate at least three documents into additional languages. CLPPP will work to increase implementation of harm reduction activities to reduce lead exposure in the environment and prevent its harmful effects. Information provided by the CLPPP will include:

- Substances and environments likely to contribute to lead exposure;
- Strategies to avoid/remove/prevent a child's exposure to environments or substances with lead;
- Blood lead testing guidelines for children under the age of 6 years per the current CDC and AAP

recommendations;
- Medicaid testing requirements;
- The recommended environmental and clinical follow-up of children with elevated blood lead levels;
- The recommended tracking of blood lead testing results; and
- Extended developmental monitoring of children with elevated blood lead levels.

BCHW is the state lead for Missouri Safe Kids and provides support and technical assistance to ten Safe Kids Coalitions covering 53 counties across the state. The coalition's focus is on preventing unintentional injuries in children aged 0-19 years through education, research, advocacy, environmental improvements, and interventions that educate and raise awareness among families and communities. The coalitions will continue to distribute safety devices and provide evidence-based prevention programs and education to expectant parents, new parents/caregivers, and grandparents in at-risk populations.

BCHW coordinates the Missouri Injury and Violence Prevention Advisory Committee (MIVPAC). BCHW will continue collaborating with stakeholders on the MIVPAC to help improve the health of all Missourians by preventing and reducing intentional and unintentional injuries.

Missouri legislation requires every county in the state (including the City of St. Louis), at a minimum, maintain a multidisciplinary panel comprised of a prosecuting attorney, coroner/medical examiner, law enforcement representative, juvenile officer, Children's Division representative, public health representative, and emergency services representative to examine the deaths of all children under the age of 18. The Missouri Child Fatality Review Program (CFRP) is a county-based initiative that encourages an improved community understanding and response to child fatalities from all causes. CFRP's purpose is to enhance the knowledge base of the mandated investigators, evaluate and address the potential need for services, identify and implement prevention interventions for the family and community, and enhance multidisciplinary communications and coordination. The state CFRP panel provides oversight and brings concerns to the attention of the State Technical Assistance Team (STAT), which aids multidisciplinary teams and local law enforcement agencies in investigating and prosecuting child sexual abuse, child exploitation and internet crimes against children. Appointed by DSS, the MCH Director serves on the state CFRP panel and collaborates to leverage state and local expertise, identify systemic needs and problems, and align efforts to reduce and prevent child mortality.

Missouri Children's Cabinet
DHSS, DESE, DMH, and DSS are executing a MOU to establish the Missouri Children's Cabinet as a collective agreement between these agencies to identify and address gaps in services available to the children of Missouri through strategic collaboration of state agencies. These efforts will bring efficiency and effectiveness to state government and improve child and youth outcomes. The Children's Cabinet is working to gain understanding of what programs exist across agencies and the sustainability of these programs. Then the Children's Cabinet will determine next steps and future goals to ensure the Cabinet works to inform government decision-making impacting children and families and makes recommendations for aligning strategies, programs and services and collectively improving systems. The Director, MCH Director, GHC Bureau Chief, SHCN Family Partnership Manager, and Operational Excellence Leader represent DHSS on the Cabinet.

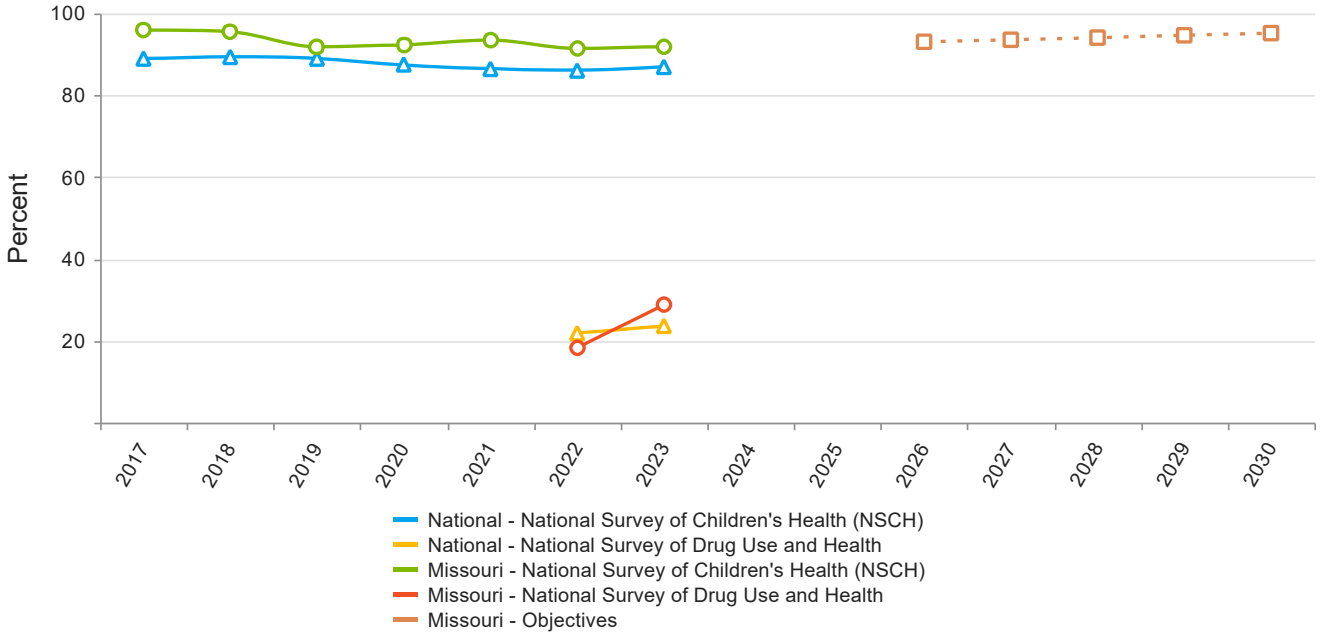
NOTE: The Perinatal and Infant Health and Adolescent Health domains also contain content relevant to child health.

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance - ADM

Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	91.8
Numerator	438,703
Denominator	477,900
Data Source	NSCH
Data Source Year	2022_2023

Federally Available Data	
Data Source: National Survey of Drug Use and Health	
	2024
Annual Objective	
Annual Indicator	28.8
Numerator	136,000
Denominator	470,000
Data Source	NSDUH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	92.9	93.4	93.9	94.5	95.0

Evidence-Based or –Informed Strategy Measures

ESM ADM.1 - Number of LPHAs contracted to develop adolescent youth leadership initiatives to ensure youth engagement in decision-making, program planning, service delivery, and quality improvement activities at local and state levels.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	4.0	4.0	4.0	4.0	4.0

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC
Indicators and Annual Objectives

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Adolescent Health - All Adolescents

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Adolescents	
	2024
Annual Objective	
Annual Indicator	18.3
Numerator	88,936
Denominator	486,513
Data Source	NSCH-All Adolescents
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	19.2	19.7	20.1	20.6	21.0

Evidence-Based or –Informed Strategy Measures

ESM TAHC.1 - Number of school health staff educated on supporting high school students' development of health self-advocacy skills.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	200.0	100.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (Missouri) - Adolescent Health - Entry 1	
Priority Need	
A stable and supportive relationship with a caring non-parental adult to enhance adolescent psychological well-being and empower youth with the tools and training to reach their full potential.	
NPM	
NPM - Adult Mentor	
Five-Year Objectives	
By September 30, 2030, Missouri will increase the percent of children, age 6-17 years, who report having an adult, other than someone in their home, in the child's school, neighborhood, or community who knows them well and who they can rely on for advice or guidance from 91.8% to 95.0% (NSCH 2022-2023).	
Strategies	
Develop mentoring opportunities that are responsive to the unique needs and goals of adolescents and reinforce healthy behaviors, life skills, and positive identity development.	
Implement a foundational training framework to prepare adult mentors to guide adolescents in identifying and accessing relevant programs, care, and resources, including topics such as adolescent health, youth-centered communication, and resource navigation.	
Embed youth-driven goal setting within mentoring relationships to promote self-efficacy and support health-related behaviors.	
Promote cross-sector collaboration to support person-centered, coordinated, and integrated services for adolescents, support adolescent psychological well-being, and empower youth.	
Engage community-based organizations, community partners, and community members in developing, implementing, and maintaining programs and initiatives to promote adolescent psychological well-being and empowerment.	
Support a leadership role for local public health agencies to partner with youth to develop youth leadership skills and amplify youth voice in local and state public health decision-making and initiatives.	
ESMs	**Status**
ESM ADM.1 - Number of LPHAs contracted to develop adolescent youth leadership initiatives to ensure youth engagement in decision-making, program planning, service delivery, and quality improvement activities at local and state levels.	Active

NOMs

Adolescent Depression/Anxiety

Flourishing - Child Adolescent - CSHCN

Flourishing - Child Adolescent - All

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

Priority Need

Smooth and successful transition from child-centered to adult-oriented healthcare, promoting continuity of care, improving health outcomes, and empowering youth to manage their own health.

NPM

NPM - Transition To Adult Health Care

Five-Year Objectives

By September 30, 2030, Missouri will increase the percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to successfully transition to adult health care from 18.3% to 21.0% (NSCH 2022-2023).

Strategies

Promote application of the Six Core Elements of Health Care Transition in a variety of pediatric and adult health care settings and programs.

Promote partnerships with youth and youth-serving organizations to ensure youth engagement in decision-making, program planning, service delivery, and quality improvement activities.

Partner with cross-sector stakeholders to provide training for health care professionals related to transition from child-centered to adult-oriented healthcare and encourage adoption of evidence-driven health care transition (HCT) practices and policies.

Promote planning activities and services, transfer assistance, integration into adult care, and care coordination to support adolescent transition from pediatric to adult health care.

Partner with care coordinators at clinics to help facilitate services, scheduling, education, and other health care transition services.

Incorporate transition strategies into medical home models and systems, integrating existing efforts addressing adolescent health and behavioral health to promote continuity of care.

Partner with local public health agencies and youth-serving organizations to create and implement a peer support and mentorship program for adolescents related to health care transition.

Engage in cross-sector partnerships and collaborations to design, implement, and evaluate QI initiatives to increase adolescent well-visit engagement and promote evidence-based prevention and emergency mental health programs.

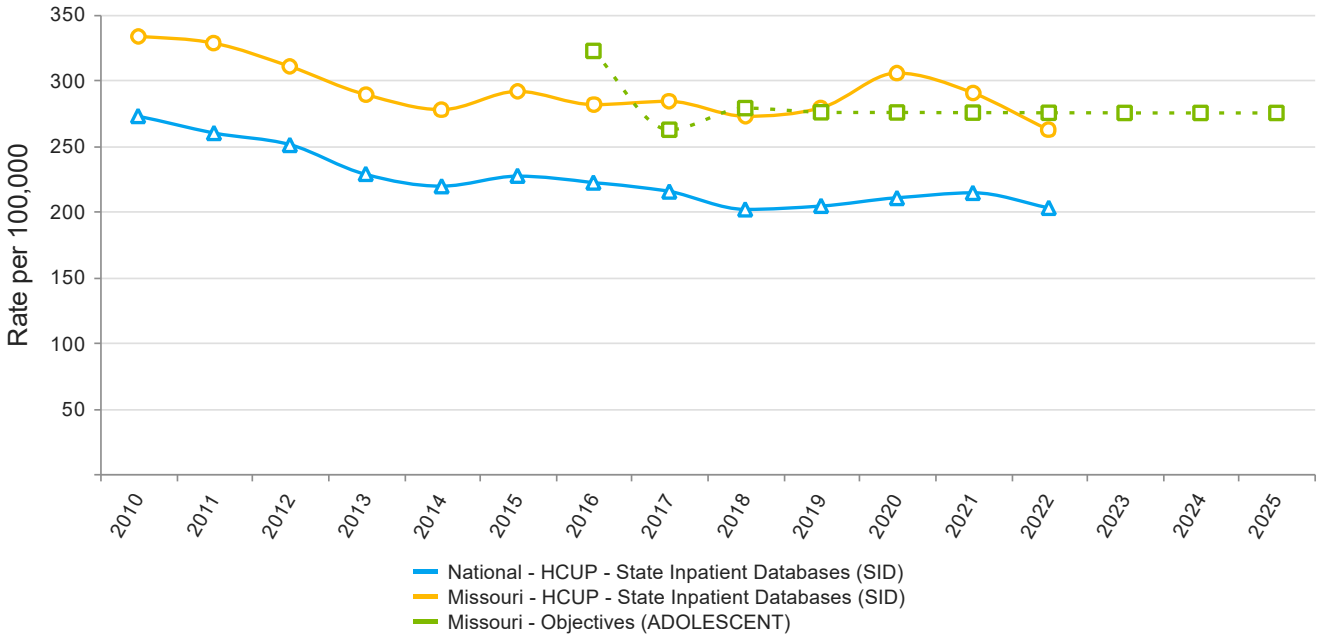
Provide health information that is accessible, clear and actionable to enhance health literacy skills for adolescents and their families.

ESMs	Status
ESM TAHC.1 - Number of school health staff educated on supporting high school students' development of health self-advocacy skills.	Active

NOMs
CSHCN Systems of Care

2021-2025: National Performance Measures

2021-2025: NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent Indicators



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)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	275.1	275	274.9	274.8	274.8
Annual Indicator	271.9	278.6	304.6	290.1	261.7
Numerator	2,130	2,175	2,371	2,322	2,072
Denominator	783,327	780,786	778,428	800,527	791,866
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2018	2019	2020	2021	2022

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM IH-Adolescent.1 - Percentage of high school students who reported distracted driving.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		45	44.2	43.5	42.5
Annual Indicator	45.8	45.8	42.5	49.2	49.2
Numerator	722	722	197	122	122
Denominator	1,576	1,576	464	248	248
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2019	2019	2021	2023	2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: State Performance Measures

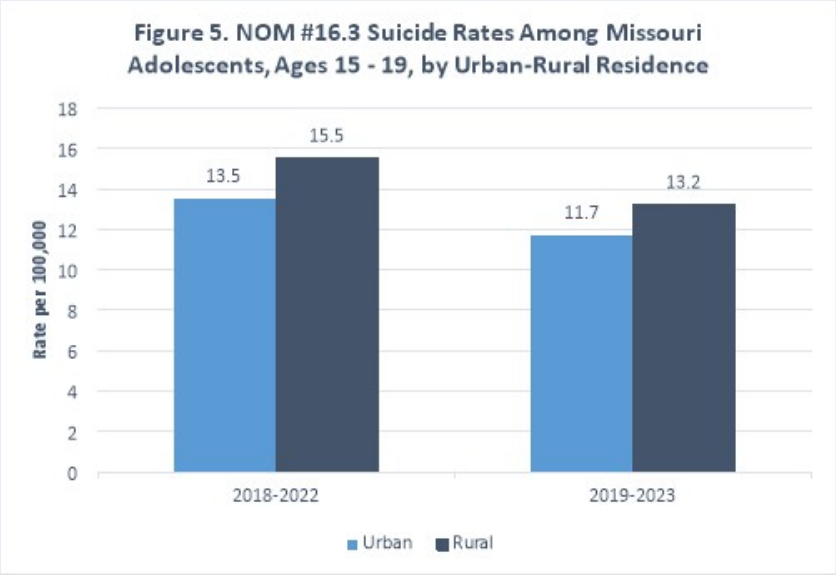
2021-2025: SPM 2 - Suicide and self-harm rate among youth ages 10 through 19

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		17.4	16.8	16.2	15.5
Annual Indicator		17.4	29	25.6	25.6
Numerator		1,200	274	151	151
Denominator		6,897	945	590	590
Data Source		YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year		2019	2021	2023	2023
Provisional or Final ?		Final	Final	Final	Final

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

Please note that some 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 more significant impact, but it should be noted that some strategies and activities may address a wider age range.

Among Missouri adolescents 10 to 19 years, the rate of non-fatal injury hospitalizations was 261.7 per 100,000 in 2022, lower than 290.1 in 2021. The top three causes of injury deaths among Missourians 10 to 19 years in 2022 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. In 2023, the overall suicide rate in Missouri for all ages decreased from 19.7 per 100,000 in 2022 to 18.4 but was still higher than the national rate of 14.7. According to 2023 National Vital Statistics System data, suicide was the 9th leading cause of death for all ages and the 3rd leading cause of death among adolescents 15-19 years. The 2023 suicide rate of 10.5 among Missouri adolescents aged 15-19 was higher than the national rate (9.8) but a decrease from Missouri's 2022 rate of 12.2. Consistent with previous years, suicide rates indicated 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 were implemented to address unintentional and intentional injuries in Missouri.



Injury Prevention

BCHW served as the state lead for Safe Kids Worldwide and provided funding for 10 Safe Kids coalitions in FY 2024. The coalitions, led by LPHAs, non-profit entities, and local hospital systems, reached 53 counties and provided unintentional injury prevention services to children 0-19 years. The coalitions offered various injury prevention and educational activities, such as the National Safety Council's Defensive Driving Course. Teens ages 15 and up with a learner's permit are encouraged to take the course and learn state and local traffic laws, distracted driving prevention, and safe driving practices. A Drivers Education Program was also offered to permit drivers to better prepare youth for driving. The program was taught by certified National Safety Council instructors through interactive behind-the-wheel lessons. The complete program included six modules, with each module increasing in complexity as students master each driving skill. To pass this course and receive a certificate of completion, students must pass all six modules. In addition to and separate from the Drivers Education Program, interactive learning experiences designed for classrooms and community settings were offered to help kids make safe decisions. The learning experiences included a driving simulator, mock impairment activities, including the use of fatal vision goggles, and seatbelt use training. Additional injury prevention activities included participating in health and safety fairs, providing education through school and community events, hosting drug take-back events, conducting media campaigns with prevention messages, and working with policymakers 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, community agencies, public policymakers, and, most importantly, adolescents, to reinforce teen driver safety. The coalitions provided services to over 3,700 children and parents through 36 teen safety educational events. DHSS hosted quarterly conference calls with the Safe Kids Coalition coordinators and hosted a one-day Safe Kids Missouri workshop for Coalition coordinators. The workshop attendees received information about fire safety, consumer product safety, the child fatality review board, Parents as Teachers, and Children's Division (DSS).

The Alliance of Southwest Missouri, the Safe Kids coalition site in Joplin, provided education on fire safety through their Smoke and Fire Trailer. During this presentation, children worked together as part of a team. The trailer was set up with visuals, including a fireplace to teach fire safety, a kitchen to teach cooking safety, heated doors to teach how to check for fire in the adjoining room, functional smoke alarms to stimulate an alarm and learn how to check the smoke alarm battery, fire extinguishers to show the children how to use them, and a bedroom to explain how to escape a real-life setting . The bedroom included a bed, sliding glass door, and operational windows to show children how to open and exit a window in case of an emergency/fire. A fire ladder was located outside the bedroom window to show children how to use it in case of fire and the need to escape. A meeting place in case of an emergency/fire was explained, as a meeting place should be designated in a fire safety plan. A fire education video was also shown before the presentation.

The Injury Prevention Program (IPP) continued to build program capacity and partnered with Safe Kids coalitions to provide evidence-based programs, identify service gaps, and increase the number of partners supporting injury prevention. IPP collaborated with TEL-LINK and Text4baby to provide information and resources about car seats and seat belts. IPP also promoted ThinkFirst Missouri traffic safety programs for students in grades 4 through 8. The ThinkFirst For Youth presentation featured 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. ThinkFirst For Kids is available for grades 1 through 3 and may be adapted to kindergarten and Pre-K students, with the goal to increase and raise awareness on protecting your brain and spinal cord, vehicle and bus safety, bicycle and pedestrian safety, playground safety, water safety, and violence prevention. Presentations for ThinkFirst For Youth and ThinkFirst For Kids are tailored to accommodate the needs and size of the audience and have reached approximately 1,000 children and families. Safe Kids coalitions invited families to participate in safety events and workshops, provided families with educational resources, and hosted an annual Safe Kids Day. Families engaged with Coalitions through schools and local communities.

IPP continued to coordinate the Missouri Injury and Violence Prevention Advisory Committee (MIVPAC). The MIVPAC is comprised of representatives from state, local, and regional government agencies, non-governmental bodies, and community members, and supports injury prevention as a state priority and provides expertise and guidance to the IPP. MIVPAC's mission is to improve the health of all Missourians by preventing and reducing intentional and unintentional injuries and the morbidity and mortality of children 0 -19 years due to injuries and violence through collaboration. MIVPAC meets quarterly, and several Title V MCH-funded programs participate in the committee. MIVPAC collaborated with partners and leveraged resources to continue implementing the three-year strategic plan and shared monthly communication among members, partners, and consumers on the MIVPAC website.

The MCH Services Program contracted with 23 LPHAs that identified reduction of intentional and unintentional injuries among adolescents as the priority health issue to be addressed in their FY 2022-2026 MCH work plans. The program supported LPHA efforts to prevent and reduce injury as follows:

- Lewis County Health Department partnered with local government and community organizations, such as local school districts and pediatrician and family practice clinics, to increase knowledge related to safe driving for the entire family, encouraging utilizing tools such as CDC's Parent/Teen Driving Agreement and promoting events such as B.R.A.K.E.S. safe driving school, which requires a parent or legal guardian to attend the training with the teen and be actively involved in their teen's driver education. The number of safe driving campaigns increased by two by the end of FY 2024. Both school districts in Lewis County participated in placing plastic cups in the fence row to spell "BUPD" (Buckle Up Phone Down) for BUPD day in October. Highland High School used the fence bordering a major highway in Lewis County with approximately 2,227 travelers daily. Metal BUPD signs were obtained free of charge from MoDOT and placed at the entrance and exit gates at the local fairgrounds. The BUPD initiative was created to address two of the most impactful

actions a driver can take to prevent crashes or survive if one occurs: every occupant buckling the seat belt every time and putting the phone down or turning it off while driving. The BUPD initiative encourages drivers to protect themselves, their passengers, and others on the road and to share that commitment with family and friends. Health department staff attended Highland High School's after-prom event and provided BUPD education to approximately 100 students. The health department increased the number of school-based educational opportunities related to safe driving by two by the end of FY 2024.

- Camden County Health Department increased knowledge among adolescents regarding safe driving practices from a baseline of zero in FY 2022 to 49 by the end of FY 2024. The health department developed and adopted an internal policy to provide safe driving education to adolescents and their parent/guardian presenting to the health department to request a birth certificate for the purpose of obtaining a learner's permit and/or driver license. The health department created "swag bags" with literature published by MoDOT, and trained vital records staff provided the education. During August and September, a BUPD starter kit, including handouts, branding, and everything needed to support the BUPD movement, was provided to incoming high school seniors who presented to the health department to obtain the required vaccines to meet Missouri school requirements.

- Cedar County Health Department increased the number of school-based educational opportunities related to safe driving from zero in FY 2022 to two by the end of FY 2024. In partnership with the Stockton R-I School District, the health department hosted an Arrive Alive Tour. The Arrive Alive mission is to educate drivers on the dangers and consequences of impaired and distracted driving and promote lifelong safe driving habits. 149 students participated in the simulation. 80 students completed surveys prior to the simulation, with 18.8% reporting they frequently text while driving. Post-simulation, 93.7% of those same 80 students indicated they will never drive distracted again or will at least think twice before doing so and warn others of the dangers.

- Osage County Health Department increased the number of school-based educational opportunities regarding safe driving from a baseline of zero in FY2022 to five by the end of FY 2024. The health department partnered with Arrive Alive to host the Arrive Alive Tour at three Osage County school districts. 299 students participated in the event, with 242 completing pre- and post-surveys. On the pre-survey, 31.4% reported they sometimes text and drive, and on the post-survey, 96.7% indicated they will never drive distracted again or will at least think twice before doing so and warn others of the danger.

- Clark County Health Department worked to prevent and reduce intentional injury related to child abuse and neglect and adopted a written adult-child contact policy for staff and those they serve. The health department provided the Stewards of Children training and increased the number of providers with knowledge and skills related to child abuse and neglect from a baseline of zero in FY 2022 to 13 providers by the end of FY 2024. Stewards of Children® teaches adults practical actions to reduce instances of child sexual abuse in their organizations, families, and communities. In partnership with a variety of community members and leaders, including Parents as Teachers, the Chamber of Commerce, FSD and CD (DSS) Family Prevention Services, and local food pantries, trainings have been offered/provided to community organizations, churches, and local school districts. Through interviews with experts, treatment providers, and a wide-ranging group of people with experiential insight, Stewards of Children® is one of the only evidence-informed, adult-focused child sexual abuse prevention trainings in the United States proven to increase knowledge and change behavior.

Injury Prevention for Young Children

The Child Care Health Consultation (CCHC) Program provided in-person and/or virtual 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. Consultants assisted child care providers in assessing healthy and safe environments using evidence-based tools, developing and reviewing policies, implementing 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. The CCHC Program collaborated with the Missouri Network Against Child Abuse (MO-NACA), formerly Missouri KidsFirst, to provide in-depth training for consultants focused on child advocacy, mandated reporting, community partners and resources dedicated to the prevention of child abuse and care of abused children, and additional training opportunities for consultants on child abuse and neglect prevention. Training and health promotion topics included abuse and neglect prevention, mandated reporting, shaken baby syndrome, behavioral health, emergency preparedness, CPR/First Aid, active supervision, medication administration, poisoning prevention, lead poisoning prevention, safe sleep, and fire, gun, Halloween, motor vehicle, car seat, stranger, water, winter weather, sun, outdoor, and playground safety. The CCHC Program provided 1,895.5 hours of consultation and training for child care providers and 500 hours of health promotion presentations for children in child care on safety and injury prevention topics. Health promotions provided children in child care with meaningful experiences regarding safety and injury prevention that are applicable to their lives both inside and outside of the child care setting and provided educational materials for parents/guardians. The CCHC Program encouraged family participation in all services and provided consultation and training for child care providers on developing and implementing procedures to promote strong family partnerships for optimal health and safety of children in child care.

Safe Kids coalitions addressed injury prevention priorities including child passenger, bicycle/helmet, crib, TV and furniture tip-over, pedestrian, poisoning, water, and home safety and other topics based on community needs. The coalitions provided cribs and car seats with parental education, conducted car seat checks, helped facilitate training for certification of child passenger safety technicians (CPSTs), provided bicycle helmets and helmet fittings, conducted prevention media campaigns, and worked with policymakers to address gaps in policies. The coalitions provided services to over 121,000 children and parents through over 900 educational events.

Over 3,500 bike helmets were fitted and distributed, over 3,500 car seats were distributed, and over 3,000 car seat checks were conducted.

Title V supported two LPHAs to provide home visiting services, an evidence-based strategy to prevent child abuse and neglect, through the Healthy Families America model and two LPHAs and one hospital to provide home visiting services through the Nurse Family Partnership model. The IPP Manager represented the Central District on the Missouri Child Passenger Safety Advisory Committee, maintained contact with CPSTs/inspection stations in the district to provide support and resources, mentored new CPSTs, ordered car seats for the area inspection stations, recruited new inspection stations, collaborated with other district liaisons on projects, and attended the CPS Advisory Committee meeting. The MCH Director, IPP Manager, MCH Services Program Manager, and MCH District Nurse Consultants partnered with safety advocates to prevent intentional and unintentional injuries by serving on statewide and regional safety coalitions, such as the Missouri Coalition for Roadway Safety state and regional coalitions and the Occupant Safety Subcommittee. The MCH Director participated in the Missouri Brain Injury Advisory Council and MIVPAC and served on the Missouri Child Fatality Review Program (CFRP) State Panel. The CFRP 2022 Annual Report highlighted a concerning increase in child fatalities related to fentanyl, and the Fentanyl Case Review Subcommittee was formed to review investigation protocols, identify areas for improvement, and boost safety measures. The Fentanyl Case Review Subcommittee Report included recommendations to cultivate improved practices and foster safe and nurturing environments for every child in Missouri.

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

Research, such as the CDC Kaiser Permanente Adverse Childhood Experiences (ACEs) study, shows the toxic stress and challenges adolescents face can have a significant impact on their long-term health. According to the 2023 YRBS, 44.3% of high school students in Missouri reported being sad or hopeless almost every day for two or more weeks, causing them to withdraw from activities in the last 12 months. According to the National Survey of Children's Health 2022-2023 data, 88.8% of Missouri children between 12 and 17 years who had a mental/behavioral health condition received treatment or counseling from a mental health professional in the last 12 months, compared to 82.5% nationally. Among children who were publicly insured only, 94.6% received treatment or counseling; this is higher than the national level (81.0%). There were comparable levels among children with private health insurance only, with 85.5% in Missouri and 84.9% nationally. Missouri college graduate households had a comparable percentage of children between 12 and 17 years who received treatment or counseling (85.1%) to that nationally (84.9%). Among non-Hispanic White children with a mental/behavioral health condition, 86.6% of Missouri adolescents received treatment or counseling, which was slightly higher than 84.0% nationally. For adolescents with a mental/behavioral health condition in a household with two currently married parents, more adolescents in Missouri (90.0%) received services than nationwide (84.6%). 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.

Mental Health

The Adolescent School Health Program (ASHP) partnered with DMH, DSS, DESE, and other agencies and organizations to identify training and resources and facilitate connections with school districts across Missouri. To increase adult capacity to understand and support youth and improve outcomes across adolescent health indicators, ASHP supported and provided trainings that were sensitive toward, responsive to, and encompassing of youth and families with varied experiences and needs. ASHP provided Foundations trainings to school personnel across Missouri to help districts evaluate and improve policies and curriculums and create environments and practices that promote access, participation, and support for all individuals, including students with disabilities. ASHP supported professional development for school health staff to implement best practice recommendations for being trauma-informed and creating safe and healthy learning environments for all students, especially those at risk. ASHP is an active participant and trainer in the DESE-led School-Based Mental Health training, which provides an array of supports and services to assist school districts in aligning best practices and streamlining resources. These efforts encourage school professionals to collaborate internally as well as with families and community partners to provide safe and healthy learning environments for students using the School Health Assessment and Performance Evaluation System (SHAPE). This training guides districts through seven quality assessments: Teaming, Needs Assessment/Resource Mapping, Screening, Mental Health Services and Supports, Early Intervention/Treatment and Supports, Funding and Sustainability, and Impact.

In conjunction with the Personal Responsibility and Education Program (PREP) and the Sexual Risk Avoidance Education (SRAE)

grants, ASHP continued to implement evidence-based teen pregnancy prevention (TPP) and positive youth development programs across Missouri's highest need areas. The Teen Outreach Program (TOP), Becoming a Responsible Teen, Making Proud Choices, and Making a Difference, continued to improve the knowledge, self-efficacy, and health and education outcomes of Missouri's youth. In FY 2024, 20 contractors implemented positive youth development programs, with a total of 765 youth completing 75% or more of the curriculum. TOP, the most chosen program in Missouri, focuses on social emotional learning (SEL) and building connectedness with the school and facilitator by providing a safe and welcoming environment for all youth. Based on PREP and SRAE exit survey questions, 63% and 58%, respectively, of respondents were much more likely to care about doing well in school, 67% and 58% of respondents were much more likely to resist or say no to someone if pressured to participate in sexual acts, and 92% and 89% of respondents agreed discussions/activities helped them learn program lessons.

ASHP included adolescent input and perspectives at the state-level and implemented Youth Advisory Councils (YAC) and youth advisors as part of the TPP grant contracts. Each contractor was encouraged to hire youth advisors or create a YAC, and these youth are part of a network to advise DHSS on issues facing youth. ASHP worked with contractors to grow skills related to developing YACs, including sharing web-based learning opportunities offered by national organizations, and collaborated with a committee of other youth-serving state and local agencies to plan and develop a statewide YAC.

Through the Connect with Me campaign, ASHP leveraged adolescent pregnancy prevention funds to strengthen adult-child relationships. This campaign encourages parents/guardians, teachers, coaches, and all adults to have stronger relationships and deeper conversations with the youth they care about. Topics included in the conversation starter cards include trauma, healthy body image, taking action to support health needs, etc. ASHP launched a free Connect with Me phone app in February 2024, enabling the program to increase the topics available and expand outreach capabilities to reach more age groups and individuals with limited English proficiency. The app was downloaded 620 times by the end of FY 2024.

Through the Show Me School Based Health Alliance (The Alliance) partnership, the ASHP supported school-based clinics to provide comprehensive care and services, including mental and behavioral health services, on school campuses or nearby. In January 2024, ASHP collaborated with the Missouri School Boards Association and The Alliance to survey every Missouri public school district and collect data regarding what districts are working with local providers to refer and treat school-age children for mental or physical health needs. The survey was sent to 554 districts, and 207 (37%) responses were received, representing 152 (74%) rural school districts, 38 (18%) suburban school districts, 17 (8%) urban school districts, 73 districts with less than 500 students, 79 districts with 500 to 1,000 students, and 55 districts with more than 1,000 students. 89 (39%) districts reported not having a process for referring students with both general and mental health needs, 37 (18%) districts reported offering some on-site general health and mental health services, and 172 (83%) districts would like to expand on-site services. Survey results demonstrated an obvious need for all districts to establish a system for referring students with general and mental health needs. School districts expressed a desire to have expanded general and mental health services for students on-site, including school-based health clinics, mobile clinics, and telehealth options. These services are effective in providing comprehensive care, especially when established in partnership with a FQHC, and such a system would provide services for students in need and accurate data to determine areas of need.

The Injury Prevention Program (IPP), in partnership with ASHP and other stakeholders, developed the Navigating Your Child's Mental Health Crisis Toolkit. The toolkit provides comprehensive guidance for families with a youth experiencing a mental health crisis. Over 400 toolkits have been distributed to school districts for families with youth experiencing a mental health crisis. The IPP manager also participated in the Missouri Suicide Prevention Network Suicide Prevention in Schools committee.

The MCH Services Program supported LPHA and community partner efforts to provide education, screening, and referral for adolescent mental health needs. The MCH Services Program contracted with 32 LPHAs that prioritized prevention and reduction of adolescent suicide and/or self-harm in their FY 2022-2026 MCH work plans. Goals included preventing substance use, preventing and reducing the impact of toxic stress, and building resiliency.

- Columbia-Boone County Department of Public Health and Human Services increased community education regarding mental health resources by creating a *Mindfulness Walk*, consisting of signs placed along two trails to stimulate each of the five senses and encourage walkers to be in the present moment. Both trails are located on paved loops to allow easy access for everyone. The signs include a QR code that links to a survey asking about the user's experience. 51 walkers responded to the survey, with 98% indicating they will practice mindful walking in the future. Additional comments included:
    - "My experience was pleasant. The signs helped me pause and reflect and be more present."

- “It was a great experience. I took a walk during my lunch break at work, and the mindfulness trail decreased my stress and improved my mood.”
- “Beautiful and fun with my four kids!”
- “Helped me clear my thoughts and focus on today.”
- “It was lovely! I really enjoyed the invitation to pause, slow down, and tune in.”

- Utilizing Handle with Care Missouri, Andrew County Health Department prompted five stakeholders, an increase from zero in FY 2020, to change organizational practices to improve communication and response to traumatic events that involve children, adolescents, and families. Handle with Care Missouri teaches providers how to be trauma sensitive and identify interventions to mitigate the negative effects of trauma on children. Law enforcement officers at the scene of crime, violence, and/or abuse identify children who have been exposed to trauma and send the child’s name, age, school, and the words, “handle with care” in a confidential notice to the child’s school before the child starts school the next day. School staff can observe the child’s behavior and/or learning more closely and are ready to provide trauma sensitive support right away so the child can feel safe and ready to learn. The school counselor or social worker will assess the child’s needs to determine if the child would benefit from additional mental health services and make the referral if needed. While the primary focus is on communication between law enforcement, schools, and mental health professionals, the program also emphasizes connecting with parents and caregivers to ensure a coordinated approach to supporting children who have experienced trauma. When school interventions are not sufficient, therapists can provide services on site at the school, as needed. The health department implemented the program among three school districts, totaling eight buildings, and worked with local police and first responders to provide training, resulting in 16 alerts being made.

- Lincoln County Health Department increased individual knowledge and skills around mental health and wellness among adolescents from a baseline of zero in FY 2022 to a total of 2,420 students by the end of FY 2024. The health department partnered with six schools within the county to implement the Signs of Suicide® (SOS) program, an evidence-based youth suicide prevention program with demonstrated improvement in students’ knowledge and adaptive attitudes about suicide risk and depression. SOS has been shown to reduce suicide attempts by 64%. Designed for grades 6-12, SOS teaches students how to identify signs of depression and suicide in themselves and their peers and provides materials that support school professionals, parents, and communities in recognizing at-risk students and taking appropriate action.

- Utilizing Youth Mental Health First Aid®, City of Independence Health Department increased knowledge and skills of adults around symptoms of a mental health challenge or crisis and resources for care from a baseline of zero at the start of FY2022 to a total of 150 by the end of FY2024. Youth Mental Health First Aid® is designed to teach parents, family members, caregivers, teachers, school staff, neighbors, health and human services workers, and others how to help an adolescent (age 12-18) who is experiencing a mental health or addiction challenge or is in crisis. Youth Mental Health First Aid® is primarily designed for adults who regularly interact with young people. The course, available in both English and Spanish, introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Adults completing the course included school district staff and interns and staff from youth-serving organizations. Approximately 98% of attendees reported an increased awareness of signs and symptoms that a youth may be experiencing a mental health crisis and

resources available to help.

- Christian County Health Department increased knowledge and skills regarding mental wellness and resources for 900 individuals by the end of FY 2024, from a baseline of zero in FY 2022. The health department created and distributed “coping kits” through the health department’s mobile unit, school districts, Prosecuting Attorney’s office, victim’s advocate, local libraries, and local counseling centers. The coping kits included a list of coping skills, guided journal prompts, 988 materials, a resource list for Christian County, and stress-relief products.

The violence prevention team in the OWH leveraged the Rape Prevention and Education (RPE) Grant to promote shared risk and protective factors for violence, suicide, and self-harm prevention. These components were incorporated into the RPE-funded Engage Violence Prevention Strategy implemented in college and university settings. Engage promotes community connectedness through social norms change and bystander intervention. Students participate in facilitated conversations to discuss ways to be more connected to their community. Trained facilitators offer scenarios to guide the conversation. Scenarios include dating and sexual violence, mental health concerns and suicidality, how different identities might influence ability/willingness to show care/intervene, and risky drug and alcohol consumption. 25 college campuses are implementing Engage, with over 300 faculty, staff, and students starting training to become facilitators, and 185 completing training. Early evaluation results showed positive outcomes. The Missouri Assessment of College Health Behaviors surveys 25 different campuses in Missouri, including public and private institutions. Over two-thirds (68%) of Missouri college students agreed they feel a sense of belonging to their campus community, 79% believed they have the responsibility to contribute to the safety and well-being of other students at their school, (63%) agreed involvement in campus/community causes is important to them, and 63% believe they should make a difference on campus/in the community. Around 71% of students reported they are currently involved in campus organizations/activities. 67% of students felt they have the skills to intervene/prevent a potentially harmful situation The percent of students reporting non-consensual sexual contact in the last 12 months decreased from 7% to 5.7% in the last five years.

The Child Care Health Consultation (CCHC) Program provided 195.5 hours of training and consultation to help child care providers support their mental health and the mental health of children in their care, promote evidence-based protective factors for children and families, and provide mental health support for children before reaching adolescence. Topics included trauma-informed care, resilience, depression and anxiety, stress management, divorce, grief, separation anxiety, SEL, positive behavior support, discipline, healthy relationships in child care, and substance use awareness and prevention. Staff mental health and wellness training topics for child care providers included suicide prevention and awareness, trauma-informed care, resilience, self-care, stress management, the relationship between physical 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 to optimize the mental health of staff

and children and provide referrals to outside resources, as indicated.

Consultants provided 278.5 hours of health promotion for children in child care to promote mental health in young children. Topics included bullying, emotional expression, positive behavior support, inclusion, anger management, regulation of emotions, sleep, screen time, empathy, self-esteem, social and communication skills, celebrating differences, and living tobacco and drug-free. 40 consultants and two CCHC Program team members also participated in an in-person training on SEL with a Conscious Approach to Discipline provided by the Center for Child Well-Being at the University of Missouri. The training helped consultants understand the relationship between the brain and misbehavior, identify effective practices to support social-emotional development, identify strategies to incorporate a conscious approach to discipline practices, and provided the opportunity to examine attitudes and practices about behavior and discipline. Consultants attending the training received handouts and materials that supported the training concepts, a series of children's books that provide examples of a conscious approach to discipline and social-emotional learning for children, and the *Conscious Discipline: Parent Education Curriculum* book, written by Dr. Becky Bailey, the creator of Conscious Discipline. Consultants not able to attend the training received information on how to attend future trainings on this topic and links to resources that could be used in providing CCHC services. As a result of the trainings and consultations, child care providers had increased access to information and resources to promote early identification of mental health needs and protective factors that can be implemented for children, child care providers, and families. CCHC services provided evidence-based resources to promote mental health and provided children in child care with meaningful experiences, coping strategies, and mental health support to benefit their lives inside and outside of the child care setting. Parents/guardians were encouraged to participate in all CCHC services provided.

Originating in July 2022, the DSS *Show Me Healthy Kids* Specialty Health Plan provides unified healthcare coverage to children and youth in DSS custody, former foster children, and individuals receiving adoption assistance payments. This specialized managed care plan, administered by Home State Health, allows these vulnerable children to access a care network specifically designed to meet their needs. Qualifying children are automatically moved to this plan from their existing health plan or are enrolled in this health plan the day they are approved for MO HealthNet benefits and continue to receive their healthcare coverage through this plan as long as they are eligible. Eligibility groups for Show Me Healthy Kids include:

- Children in the care and custody of DSS;
- Children or youth in alternative care;
- Children receiving adoption or legal guardianship subsidy;
- Former foster care youth under the age of 26, who were in foster care on their 18th birthday and covered by MO HealthNet, and who meet other eligibility criteria; and
- Former foster care youth under the age of 26 who were in foster care on their 18th birthday and covered by Medicaid from another state and who are not currently eligible for Medicaid coverage under another program.

Additional Performance Analysis

The Safe Kids coalitions provide a quarterly summary of their injury prevention activities, including the number of safety devices distributed, specific events held, and the number of event attendees. The summary offers an overview of coalition priorities and activities to help understand local needs.

A QR code on the back of the Navigating Your Child's Mental Health Crisis Toolkit allows users to share their experience with the toolkit. 11 school personnel and one parent/guardian completed the survey. The toolkit was referred by the school nurse and/or school counselor to the parent/guardian of a student 10-14 years of age for concerns of behavior issues and the student threatening to harm themselves or others.

Challenges

Workforce capacity, workforce turnover, difficulty recruiting and retaining qualified workforce members, and financial constraints limit the scope of existing IPP and Safe Kids coalition activities and services and prevent implementation of new program activities and services. Safe Kids coalitions have also experienced a reduction in the number of counties participating.

Due to funding constraints and the cost to make the Navigating Your Child's Mental Health Crisis Toolkit digital, the toolkit is only available in hard copy.

The Missouri Professional Development System does not currently gather specific data related to CCHC services to support evaluation of program impact.

Opportunities

Partnership related to injury prevention is expanding, and IPP continues to create new connections and build support to expand MIVPAC efforts. IPP continues to partner with the Missouri Suicide Prevention Network to connect with others, share resources, and help raise awareness about suicide across the state.

The conditions in which people live, work, and age significantly influence an individual's risk of injury and the effectiveness of prevention strategies, as well as families' capacity to adapt and thrive despite adversity, and addressing these factors is crucial for effective violence and injury prevention and promoting family resilience. Injury prevention, behavioral health, and trauma responsiveness are also intertwined, and simultaneously prioritizing injury prevention, mental health support, substance use prevention, and trauma responsiveness can create a comprehensive framework to not only minimize the occurrence of injuries and trauma but also foster healing and resilience for individuals, families, and communities. There is opportunity to leverage internal and external programs and partners to more systemically and synergistically address whole-person health and safety.

Adolescent Health - Application Year

NPM: Adult Mentor - A stable and supportive relationship with a caring non-parental adult to enhance adolescent psychological well-being and empower youth with the tools and training to reach their full potential.

A trusted adult outside of the family can offer stability, perspective, and guidance and is especially significant in the life of an adolescent. Adult mentors can provide a safe, non-judgmental space for open self-expression and feeling heard; role model healthy, responsible adult behavior; help build self-worth and foster confidence to try new things and face challenges; provide guidance and a sense of accountability; and help adolescents understand who they are, what they value, and where they want to go in life and set and pursue personal, educational, or career goals. Adolescents with mentors are less likely to engage in substance use, delinquency, or early sexual activity and are more likely to stay in school, perform better academically, and plan for higher education or careers.

The State Adolescent Health Leader (SAHL) will lead partnerships to promote connections between youth and caring, consistent adults in their lives to enhance adolescent psychological well-being and empower youth with the tools and training to reach their full potential. MCH Leadership, including the SAHL, will partner with the Adolescent and School Health Program (ASHP), other internal programs, other state agencies, LPHAs, schools, youth-serving organizations, community-based organizations, and more to promote mentoring opportunities, provide training and resources for adults who interact with youth, and elevate the importance of sustained, supportive relationships. The SAHL will explore ways to embed mentoring into broader adolescent health initiatives and ensure youth voice is reflected. The SAHL will leverage platforms, such as the MCH Learning Community, to share best practices, highlight local, state, and national examples, and facilitate shared learning and collaboration.

MCH Leadership will convene a group of relevant subject matter experts to research foundational training frameworks for adult mentors that include core topics such as adolescent health, youth-centered communication, youth-driven goal setting, resource awareness, identifying and accessing relevant programs, care, and resources, and service navigation.

MCH Leadership will partner with a known professional athlete and motivational speaker to plan a messaging campaign and possible training materials based on the athlete's personal story of the power of a stable and supportive relationship with a caring non-parental adult to empower a youth to reach their full short- and long-term potential.

MCH Leadership will collaborate with programs and partners, including LPHAs, schools, youth/community centers, faith-based organizations, and other organizations and groups to raise awareness about the benefits of mentoring, encourage adults to get involved, and develop a framework to support mentors through regular check-ins, supervision, and opportunities for mentors to connect and share experiences.

ASHP plans to partner with school districts, LPHAs, and community organizations to provide evidence-based healthy youth development programs, professional development and technical assistance for individuals working with youth, and resources to facilitate and strengthen connections and meaningful conversations between youth and adults. ASHP will work to increase education related to mandated reporting and youth mental health first aid. ASHP program coordinators and facilitators will be required to participate in trainings.

ASHP works with partners to help DHSS and other state agencies identify health priorities for adolescents, educate against harmful and life-altering decisions, advance strategies to reduce health risks, and promote healthy youth development. ASHP will provide funding to implement the Teen Connection Program, the Teen Outreach Program, and Making Proud Choices. These programs cover social-emotional learning and life skills and build healthy connections with peers, adults, and their community. Participants in these programs receive a voluntary evaluation questionnaire to assess curriculum effectiveness and responsiveness of the youth participating. ASHP is conducting a curriculum review to evaluate current offerings, ensure curricula best meet the needs of contractors and identify other possible curricula for future use and support. The review also includes a curriculum designed specifically for youth with developmental and intellectual disabilities. ASHP will provide technical assistance and training on the curriculums currently being utilized and provide ongoing support for contractors who choose to continue with the curriculum they are currently implementing. The curriculum review will provide the opportunity to consider more current and relevant curricula that more closely align with current efforts and local priorities and allow enhanced flexibility in implementation timelines. Youth recruitment and regular attendance at program activities are common challenges in implementing programs for youth, but youth participating in programs have reported they are more likely not to use drugs and alcohol and to think about consequences prior to making a

decision, manage emotions, resist peer pressure, care about doing well in school, set plans and goals, talk to trusted adults, understand what makes a relationship healthy, and talk with an adult about things going on in their life, including sex.

ASHP is responsible for the Connect With Me campaign, which focuses on encouragement and skill-building tools to aid and encourage meaningful conversations between youth and trusted adults. Connect With Me is also available as a free, downloadable mobile app for Android and iPhone to allow for easier access. The program plans to create updated materials to enhance awareness of this resource and launch advertising campaigns during back-to-school season, the holiday season, spring break, and the end of the school year/summer. Download and usage data, as well as data from previous campaigns, will be collected and reviewed quarterly to evaluate the effectiveness of campaigns and determine any needed alterations to the campaign or target audience. Connect With Me will be shared with adult mentors and embedded in mentor training and support frameworks.

The MCH Services Program plans to increase both educational and technical assistance opportunities to increase LPHA knowledge and skills to develop FY 2026-2030 contract work plans utilizing the MCH Evidence *What Works Evidence Accelerators*, including the following evidence-based strategies to increase the percentage of adolescents ages 12 through 17 who have a trusted adult outside the home who knows them well and on whom they can rely for advice or guidance:

- In-person, online, and hybrid mentoring programs;
- Community centers;
- Youth leadership and apprenticeship initiatives;
- Parent involvement;
- Mentoring programs to prevent youth delinquency;
- Mentoring programs to prevent high dropout and promote high school graduation; and
- Strengths-based approaches.

BCHW aims to prevent Adverse Childhood Experiences (ACEs) for families affected by Substance Use Disorder (SUD) by providing children impacted by substance use with access to supportive environments and relationships through the SUD Grant Program. Grantees can be established businesses or organizations, non-profit organizations, including local or state governments, and community-based organizations that have a minimum of three years of experience working with individuals with SUD and/or who have experienced ACEs and/or individuals and families disproportionately impacted by SUD and/or ACEs. Grantees must also have three years of experience collaborating with partners on strategies to prevent and reduce SUD and/or ACEs. Grantees can select from the strategies below to help increase youth access to safe and supportive relationships and promote a sense of belonging by offering pro-social activities:

- Increasing youth access to safe and supportive relationships, such as through mentoring and peer support programming.
- Increasing youth belonging by providing access to safe and supportive pro-social activities, such as after-school programs, positive community activities, and neighborhood improvement projects.
- Enhancing youth cognitive and social-emotional development through skill-building programs, such as healthy relationships, emotional regulation, problem-solving, and communication skills.
- Reducing the impact of ACEs by providing youth who have been impacted by substance use with services, such as victim-centered services, support groups, and classes.
- Creating a supportive and safe family environment through family skills-building activities, such as family engagement in school settings, parent skill-building and education, and family support activities in SUD recovery and/or treatment programs.
- Improving ACE screening in families impacted by SUD through using standardized screening tools across educational and health care settings, early intervention programming, and monitoring and surveillance.

Grantees may also work on enhancing youth cognitive and social-emotional development through skill-building programs, reducing the impact of ACEs by offering services to youth harmed by substance use, and creating a supportive family environment by working on family skills-building activities and improving ACE screening for families affected by SUD. Grantees will be required to engage key stakeholders to increase support for their proposed project, conduct community outreach activities to enhance project awareness, reach, and engagement, and engage families and people with lived experience related to SUD and/or ACEs in project planning and implementation. Grantees will receive support and technical assistance from the SUD Grant Program and be connected to the Maternal Peer-Based Recovery Support Technical Assistance Center and other available training and resources. The CDC ACEs Prevention Resource for Action was provided to guide project proposals, and grantees must use a data-driven, evidence-based

approach to identify strategies and activities.

Strategic planning and stakeholder engagement to promote a stable and supportive relationship with a caring non-parental adult that will enhance adolescent psychological well-being and empower youth with the tools and training to reach their full potential will be ongoing, with FY 2026 serving as a planning and development period.

NPM: Transition to Adult Health Care - Smooth and successful transition from child-centered to adult-oriented healthcare, promoting continuity of care, improving health outcomes, and empowering youth to manage their own health.

The transition from adolescence to adulthood is a critical time in an adolescent's life and developmental process, and transition from parent-supervised pediatric health care to more independent, patient-centered adult health care is a responsibility shared across professions and specialties serving adolescents. Youth empowerment to manage their own health and improve health outcomes requires a whole person approach; understanding their own bodies; health literacy; the knowledge, skills, and confidence to navigate the healthcare system; access to needed health systems and services; open communication; and encouragement to be active participants in their healthcare decisions and make informed choices about their well-being.

Adolescent and School Health
The Adolescent and School Health Program (ASHP) will partner with LPHAs, school districts, and community partners to provide an evidence-based curriculum, focused on healthy decision-making about relationships, pregnancy, partnering, and more, for adolescent females ages 14-24 years. Supplemental sessions will facilitate guest presentations on a variety of topics related to pregnant and parenting teen mothers, including enrolling in MO HealthNet and WIC, navigating community resources, and exploring services and supports at their local LPHA.

ASHP will implement evidence-based teen pregnancy prevention and positive youth development programs across Missouri's highest need areas to support youth transition to adulthood. The Teen Outreach Program (TOP), Teen Connection Project, and Making Proud Choices (MPC) programs are designed to enhance the knowledge, self-efficacy, health, and school outcomes of Missouri's youth. TOP, the most popular program in Missouri, focuses on social-emotional learning and builds connectedness to the school and facilitator by creating a safe and welcoming environment for all youth. Through training with *Love Notes*, participants discover how to make wise choices about partners, sex, relationships, pregnancy, and more (enrolling in Medicaid, WIC, navigating community resources, services available at LPHAs, etc.). All program curriculums support successful transition into adulthood and include general topics such as, nutrition, housing, transportation, insurance, system navigation, mental health, chronic disease management, making informed choices, etc. The MPC curriculum is focused on promoting healthy life skills, including financial literacy, and emphasizes practical skills like budgeting, saving, understanding credit and debt, making informed financial decisions, consumer financial protection, and the importance of discussing finances with family.

Oral Health
ODH will continue to provide and expand the Preventive Services Program (PSP), with the goals of promoting lifelong oral health and supporting continuity of care into adulthood. PSP provides free oral health screening, supplies, education, and preventive treatment in the school setting. Students and families are engaged through printed educational materials and access to online educational videos. A referral list is shared with school nurses to help connect youth and their families with dental services, helping to establish early dental homes and routine care. Participation in PSP events strengthens adolescents' understanding of the importance of regular dental visits and fosters relationships with PSP volunteers, who are often local dental providers, promoting continuation of regular dental care as they transition into adulthood. ODH is working to expand PSP into more schools, such as St. Louis area schools, and with FQHCs. These efforts are essential for older youth, who may be nearing the transition from pediatric to adult health systems. By establishing strong care pathways and making services available in school settings, adolescents build the skills, habits, and systems of support they'll need to continue managing their oral health as they move into adulthood.

ODH offers age-appropriate educational videos for youth, starting in Pre-K and continuing through high school, providing foundational information on oral health and hygiene. Content progressively builds on previous years, allowing youth to develop a deeper understanding of oral care and supporting a smooth transition from early childhood to adolescence and on into adulthood. The videos cover topics such as the importance of oral health, proper oral care, fluoridated water, mouth safety, tobacco

cessation, and more. By engaging with these videos, adolescents gain the knowledge and confidence to make informed decisions and maintain their health into adulthood.

ODH plans to participate in the 2026 HOSA-Future Health Professionals conference in Missouri. HOSA provides a unique program of leadership development, motivation, and recognition exclusively for secondary, postsecondary, adult, and collegiate students enrolled in health science education and biomedical science programs or have interests in pursuing careers in health professions. Through participating in the conference, ODH will share information regarding the importance of oral health and oral health care professions with high school students.

Myths and misconceptions regarding oral health care being passed from one generation to the next may create potential barriers to successful transition to adult care. If a grandparent, parent, or trusted adult does not understand the need for and prioritize proper oral hygiene and regular dental checkups, the adolescent is less likely to understand the need for and prioritize proper oral hygiene and regular dental checkups. ODH aims to educate all generations and demographics on the understand the need for proper oral hygiene and regular dental checkups.

Service Coordination
Service coordination is essential for people with complex conditions and needs, providing planning activities and services, transfer assistance, integration into adult care, and care coordination to increase the percent of adolescents who receive services to prepare for the transition from pediatric to adult health care. Service Coordinators (SCs) for the Children and Youth with Special Health Care Needs (CYSHCN) and Health Children and Youth (HCY) programs will continue completing annual Service Coordination Assessments (SCA) in collaboration with participants/families to address strengths and needs, to drive service plan development and implementation. The SCA is completed by Service Coordinators (SCs) in collaboration with participants and family members. During home visits, both at initial enrollment and annually thereafter, SCs use the SCA to gather and document participant/family input on each assessment topic, including transition planning. For participants ages 13 through 21 years, CYSHCN and HCY SCs will assess and evaluate the participant's status of planning and preparing to transition from pediatric to adult health care and encourage families to initiate these conversations with their health care team. The SCA contains the following components to assess preparation for transition to adult health care:

1. Have doctors or other health care providers talked to the family/participant about how the participant's health care needs might change when the participant becomes an adult?
2. Has a plan for addressing these changing needs been developed with the doctor or other health care providers?
3. Have doctors or other health care providers discussed having the participant eventually see a doctor who treats adults?
4. Has the participant received any vocational or career training to help him/her prepare for a job when he/she becomes an adult?

If the participant/family reports 'no' to any of the four transition related questions within the SCA, the SC will encourage the participant/family to take steps to facilitate and advocate for a successful transition from pediatric to adult health care. SCs do not have specific resources for these situations; as the assistance, encouragement, coaching, and resources provided would be unique to the participant/family. For questions 1 -3, the SC would most likely encourage the participant/family to bring these topics up at their next medical appointment with their primary care provider and/or other health care providers. For question 4, the SC would most likely refer the participant/family to DMH, DESE/Vocational Rehabilitation, or their school, if appropriate. Other relevant resources include LifeCourse Nexus tools and/or a referral to the SHCN Family Partnership.

Local Public Health Efforts
The MCH Services Program plans to increase both educational and technical assistance opportunities to increase LPHA knowledge and skills to develop FY 2026-2030 contract work plans utilizing the MCH Evidence *What Works Evidence Accelerators*, including the following evidence-based strategies to increase the percentage of adolescents with and without special health care needs, ages 12 through 17, who receive services to prepare for the transition to adult health care:

- Planning and training/educating youth;
- Medical home integration;
- Peer support and mentorship;
- Provider training;
- Adaptation of Got Transition's Six Core Elements of Healthcare Transition 3.0, with quality improvement monitoring; and

- State policy/system development.

Strategic planning and stakeholder engagement to promote a smooth and successful transition from child-centered to adult-oriented healthcare, promoting continuity of care, improving health outcomes, and empowering youth to manage their own health, will be ongoing, with FY 2026 serving as a planning and development period. Planning and development will be informed by:

- The Charting the LifeCourse (CtLC) framework;
- The 2018 update of the clinical report on health care transition, "Supporting the Healthcare Transition from Adolescent to Adulthood in the Medical Home," originally published by the AAP in 2011, with the endorsement of the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP), that included a process for transition preparation, planning, tracking, and follow-through for all youth and young adults; and
- Got Transition's Six Core Elements of Healthcare Transition 3.0 (Transition and Care Policy/Guide, Tracking and Monitoring, Transition Readiness, Transition Planning, Transfer of Care, and Transfer Completion).

Other Activities to Promote Adolescent Health

MCH Leadership will contractually partner with select LPHAs to provide stipends to youth representatives to advise on projects targeting youth in their communities and bring youth voice to local and state activities and initiatives. LPHAs focused on adolescent domain performance measures will be prioritized for the Youth Voice Project.

The Tobacco Prevention and Control Program (TPCP) will offer and promote statewide technical assistance, support, and free resources for schools and youth-serving organizations throughout Missouri, with a goal to increase the number of schools and youth-serving organizations that provide a comprehensive tobacco-free environment, evidence-based prevention, and cessation services for youth and staff. Beginning in FY 2026, TPCP will provide a grant-funded School Vaping TEAMS program for schools and community partners to gather a multi-sector team and increase the number of schools and communities that have comprehensive tobacco-free policies with supportive discipline and cessation.

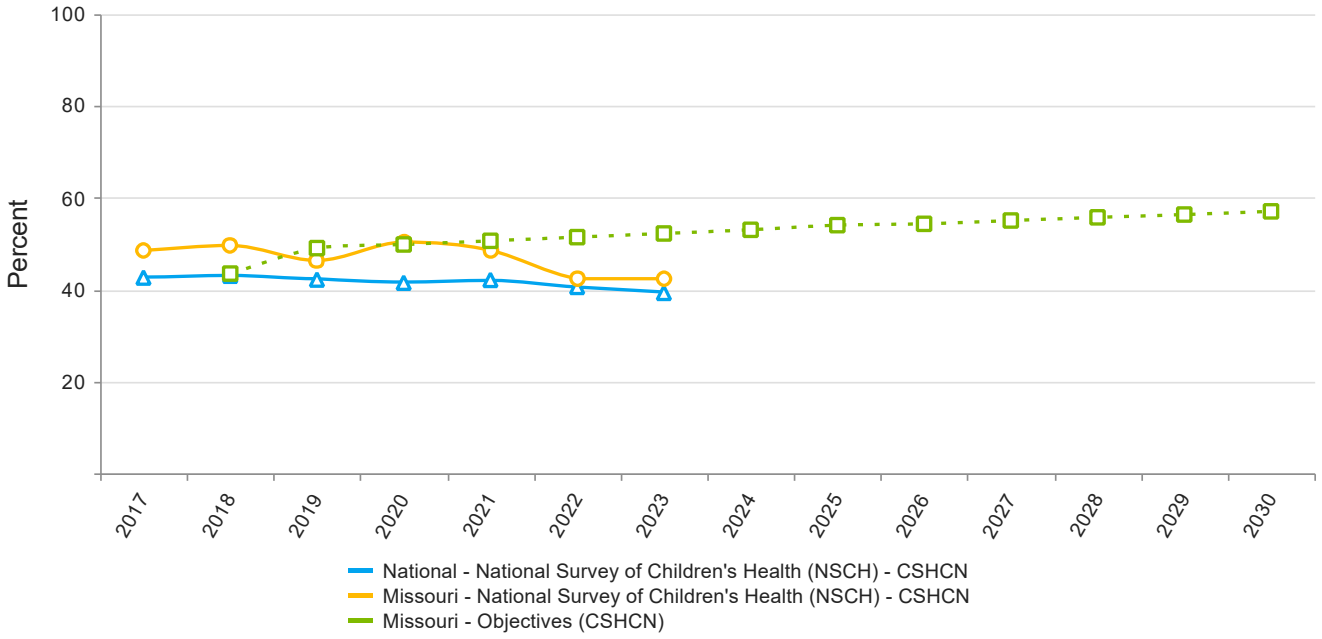
The violence prevention team in OWH will leverage the Rape Prevention and Education (RPE) Grant to promote shared risk and protective factors for violence, suicide, and self-harm prevention. These components were incorporated into the new Engage Violence Prevention Strategy, funded by RPE, to be implemented in college and university settings. Engage is a strategy that works to promote community connectedness through social norms change and bystander intervention. Students participate in facilitated conversations to discuss ways they can be more connected to their community. Trained facilitators offer scenarios to guide the conversation. Scenarios include dating and sexual violence, mental health concerns and suicidality, preconceived opinions and intolerance of difference, and risky drug and alcohol consumption. OWH will measure how many college campuses are implementing Engage, the number of faculty, staff, and students who have started training to become facilitators, and the number that have completed the training. OWH will also utilize results from the Missouri Assessment of College Health Behaviors (MACHB). The MACHB surveys 25 different campuses in Missouri, including public and private institutions. Measures from the MACHB that are a part of the evaluation plan include:

- The percentage of students who agree they feel a sense of belonging to their campus community;
- The percentage of students who believe they have the responsibility to contribute to the safety and well-being of other students at their school;
- The percentage of students who believe involvement in campus/community causes is important to them;
- The percentage of students who believe they should make a difference on campus/in the community;
- The percentage of students who are currently involved in campus organizations/activities;
- The percentage of students who feel they have the skills to intervene/prevent a potentially harmful situation; and
- The percentage of students reporting non-consensual sexual contact in the last 12 months.

Children with Special Health Care Needs

National Performance Measures

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



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	49.8	50.6	51.4	52.2	53
Annual Indicator	46.9	51.9	48.5	44.0	42.4
Numerator	141,727	149,881	135,203	126,340	179,643
Denominator	301,956	288,780	278,712	287,294	423,301
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	54.3	55.0	55.7	56.3	57.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of school health staff educated on the importance and benefits of a medical home for children with and without special health care needs.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		1,800	2,000		
Annual Indicator	1,822	1,057	637	193	193
Numerator					
Denominator					
Data Source	MO DHSS Programs	MO DHSS Programs	MO DSS Programs	MO SHCN Family Partnership	MO SHCN Family Partnership
Data Source Year	2020	2021	2022	2023	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	125.0	125.0	75.0	75.0	75.0

State Action Plan Table

State Action Plan Table (Missouri) - Children with Special Health Care Needs - Entry 1

Priority Need

Access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children with and without special health care needs.

NPM

NPM - Medical Home

Five-Year Objectives

By September 30, 2030, Missouri will increase the percent of children with special health care needs, ages 0 through 17, who have a medical home from 42.4% to 46.0% (NSCH 2022-2023).

By September 30, 2030, Missouri will increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home from 49.6% to 52.0% (NSCH 2022-2023).

By September 30, 2030, Missouri will increase the percent of children with special health care needs, ages 0 to 17, who have family centered care from 82.1% to 85.0% (NSCH 2022-2023).

By September 30, 2030, Missouri will increase the percent of children without special health care needs, ages 0 to 17, who have family centered care from 86.5% to 90.0% (NSCH 2022-2023).

Strategies
Promote coordinated systems across the child/family care continuum to assure evidence-based management of acute, chronic, and/or complex child and adolescent medical conditions by promoting the medical home approach to care for children with special health care needs.
Partner and collaborate with cross-sector stakeholders to integrate the medical home approach and promote care coordination and community referrals to facilitate the linkage of children with special health care needs and their families with appropriate services and resources.
Provide education and outreach on the importance of medical home for children with special health care needs to cross-sector stakeholders serving and engaging with children and their families.
Promote effective partnerships between families and integrated clinical-community health care teams to enhance access to a medical home for children with special health care needs and their families and coordination of service delivery across the care continuum.
Engage in cross-sector partnerships and collaborations to design, implement, and evaluate QI initiatives to increase access to whole person, person/family-centered, coordinated, comprehensive, and community-based health care services and supports for children with special health care needs and their families
Provide training for all types of providers on whole person, person/family-centered, coordinated, comprehensive, and community-based health care services and supports for children with special health care needs and their families.
Promote person/family-centered shared care planning to operationalize core values of person/family-centered care and ensure families are full partners in their child's health.
Promote comprehensive access to care, including adequate insurance coverage, and support community-based support for children with special health care needs and their families.
Establish data sharing agreements and leverage interagency agreements to identify needs and strengthen the medical home model of care for children with special health care needs.
Participate on interagency advisory committees or councils to advance person/family-centered, coordinated, comprehensive, and community-based health care services and supports for children with special health care needs.

ESMs	Status
ESM MH.1 - Number of school health staff educated on the importance and benefits of a medical home for children with and without special health care needs.	Active

NOMs

Children's Health Status

CSHCN Systems of Care

Flourishing - Young Child

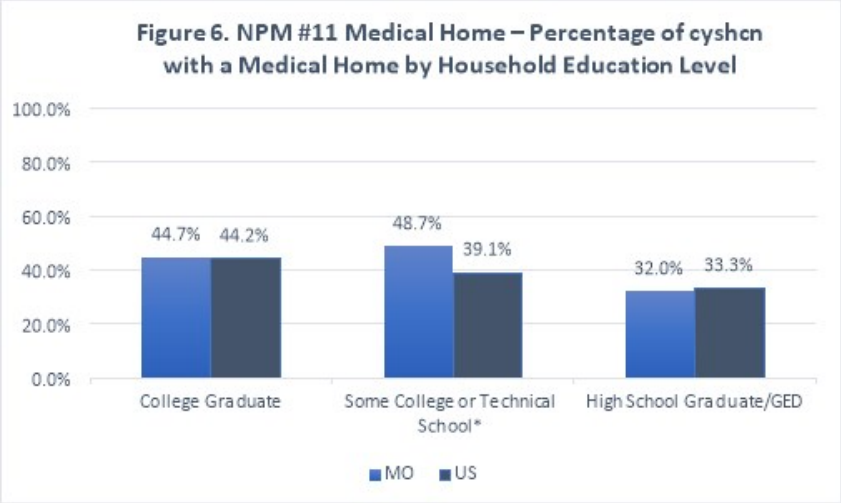
Flourishing - Child Adolescent - CSHCN

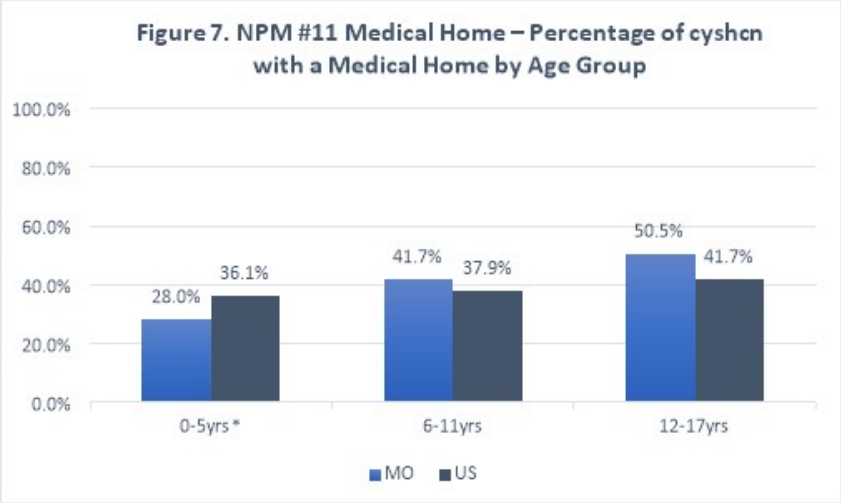
Flourishing - Child Adolescent - All

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 2022-2023 National Survey of Children's Health (NSCH), an estimated 42.4% of Missouri cyshcn had a medical home compared to 39.3% nationwide, and the percentage of cyshcn with a medical home varied by socio-demographic characteristics. Non-Hispanic White cyshcn in Missouri (49.5%) had a medical home more frequently than their national counterparts (45.5%). Additionally, college-graduate households in Missouri had a notably higher proportion than high school graduate or GED households (Figure 6, *interpret MO data with caution, may not be reliable). Nationally, children 0-5 years old were less likely (28.0%*) to have a medical home than 12-17-year-olds (50.5%). In Missouri, younger children had a medical home less commonly (Figure 7, *interpret MO data with caution, may not be reliable). Nationally, cyshcn with only public insurance were less likely to have a medical home (33.0%) than their privately insured counterparts (46.2%). However, the percentage of Missouri cyshcn who had a medical home was higher than their national counterparts for privately insured (47.0%) and publicly insured (37.4%*) youth. In Missouri, single-parent households (30.9%*) had a lower proportion of cyshcn with a medical home than their two-parent, married household counterparts (47.9%).





Nationally, among all children with and without special health care needs, 45.3% received care through a medical home, compared to 49.6% in Missouri. Both percentages are below the HP2030 target of 53.6%. Like cyshcn, the proportions of all Missouri children receiving care through a medical home varied by socio-demographic characteristics. Non-Hispanic Whites (56.3%) had the highest proportion receiving care within a medical home compared to Hispanic (30.1%*) and non-Hispanic Blacks (30.0%*). Missouri children from single-parent households (32.2%) less frequently had a medical home than their counterparts from two-parent, married households (56.0%). Furthermore, children with private insurance only (60.3%) were more likely to receive care in a medical home than uninsured children (32.6%*) and children with public insurance only (36.5%). College graduate households in Missouri (57.3%) had a higher proportion of children with a medical home than some college or technical school households (48.7%) and high school graduates or GED households (35.4%). Missouri children more frequently had a medical home than nationally among college graduate (54.1%), some college or technical school (42.9%) and high school graduate or GED households (33.3%).

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 essential for people with complex health conditions and needs. Service coordination provided through SHCN is comprehensive, person-centered, collaborative, and proactive. It includes 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 FY 2024, 98% of SHCN participants enrolled in the CYSHCN, Healthy Children and Youth (HCY), and Medically Fragile Adult Waiver (MFAW) programs reported having a medical home. For participants/families without a medical home, Service Coordinators provided educational materials to help participants obtain coordinated, ongoing, and 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 and 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, providing 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 DHSS DSDS and 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, and adult services are fragmented across three state departments with separate service structures and eligibility processes. For participants eligible for the MFAW Program after their 21st birthday, SHCN Service Coordinators worked with them to schedule transition meetings with staff from DHSS DSDS and DMH. The transition meetings were coordinated to accommodate the participants'/family's needs. 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, Managed Care Companies, provider agencies, and SHCN is required to ensure effective service provision. Because individuals may switch between Managed Care Companies and/or fee-for-service Medicaid, this may inadvertently impact their services. Not all fee-for-service Medicaid provider agencies are contracted with all Managed Care Companies, so families must prioritize and choose the option that enables them to utilize the most important providers. For participants enrolled in the HCY Program, SHCN assisted with the authorization of in-home services to avoid gaps in services when changes in coverage occurred. In addition, for participants who did not receive in-home services through the HCY Program, SHCN provided MO HealthNet enrollment information weekly to ensure CYSHCN Program participants were provided the opportunity to choose between Managed Care Medicaid and fee-for-service Medicaid. Care coordination for these individuals is extensive, but necessary to access essential services.

In state FY 2024, 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 federal data regarding participants and families reporting partnering in decision-making. Over 93% of SHCN participants and families enrolled in the Adult Brain Injury, 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 assessed insurance availability for medical, vision, and dental services. The SHCN information system is 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 called Missouri Community Options and Resources for cyshcn. Service totals for SHCN in state FY 2024 were:

- CYSHCN Program served 658 individuals.
- HCY Program served 1,032 individuals.
- Family Partnership Program served 16,134 individuals.

The CYSHCN Program demonstrated that Title V funding ensures cyshcn have coordinated, comprehensive, and ongoing health services provided through a medical home. Through contracts with LPHAs, whose funding had remained unchanged since 2016, the Program leveraged a recent funding increase to expand outreach efforts and increase program visibility and engagement with target populations through dissemination of materials at community events. This additional support enabled CYSHCN Service Coordinators to strengthen engagement with both participants and providers, ensuring every child in Missouri with special health care needs had access to all essential resources needed to achieve optimal health and independence.
SHCN administered the MO Kids Assistive Technology (KAT) contract to improve access and independence among cyshcn. In FY 2024, KAT services and devices were coordinated with 77 entities (families, medical professionals, service coordinators, and schools) and reached over 30 children across Missouri. Projects included communication, daily living, mobility, hearing devices, seating and mobility enhancements, and home and vehicle modifications. KAT leveraged funds from five different sources, totaling $57,321.73, to supplement Title V funding. Communication with families, contractors, and service coordinators ensured the projects were completed satisfactorily to meet needs and align with the Americans with Disabilities Act.

SHCN Family Partnership
SHCN Family Partners made a meaningful impact on cyshcn and their families by planning, organizing, and hosting in-person regional and statewide events. These events provided an opportunity for parents and caregivers to share their experiences, identify areas of need, and exchange available resources to better support their families. Through these connections, families gained insights, strengthened their networks, and accessed tools to navigate the challenges of caring for children with special health care needs.

The annual statewide Parent and Caregiver Retreat, titled "It's A Jungle Out There," was held in Osage Beach on September 13-14, 2024. 112 parents/caregivers connected, listened to five speakers, and visited 16 resource booths. Topics, selected by the Family Partners based on pertinent needs of families supporting cyshcn, included Self Care for the Caregiver: Taking Care of Me so I Can Take Care of My Family, Navigating the Early Years (Birth to 12), Navigating Teens and Transitions (13 – 21), Person-Centered Thinking, Don't Overthink It, and Medical Home: A Whole Home Approach.

Through Title V support, attendees also received emergency preparedness items, such as a backup battery, portable phone charger, portable electric cooler and warmer, emergency radio, and emergency go-bag. To assess the impact of the retreat, Family Partners

gathered feedback from attendees to evaluate their satisfaction with the information and resources provided. The infographics and quotes below highlight the retreat's significance in supporting and empowering families of cyshcn.

What will be different for you because of this experience?

- "Will have more resources - gained new relationships with families"
- "New friends and education"
- "Feeling not alone and being able to find better/more resources for my children"
- "Know there's a whole community out there with knowledge and support"
- "Know to better advocate for my child as he grows up at school"

Family Partners collaborated with key stakeholders to increase access to care for cyshcn by educating families on the importance of medical home and distributing resources to support coordinated care. As part of this effort, Family Partnership worked with the MCH Leadership Team to provide ongoing education for professionals by promoting the concepts of medical home and family engagement during a MCH Learning Community with 68 attendees. Additionally, Family Partners collaborated with the Tri-County Health Department to finalize "Your Child's Care Notebook" and offer an electronic version statewide. Hard copies were provided to each family attending the retreat, encouraging them to create a centralized location for storing critical medical information. This resource equips families with essential tools to ensure anyone providing care to cyshcn can respond effectively.

The Tri-County Health Department and Family Partnership were invited to present "Your Child's Care Notebook" and the concept of a medical home to families at the annual Disability Awareness Convention. Through outreach efforts, Family Partners also disseminated the "Missouri Medical Home" brochure to further educate families and strengthen their access to essential care and support services. This brochure was created for families by families to promote the family-centered approach to comprehensive care for cyshcn.

Family Partners played a vital role in assisting families in overcoming barriers to caring for their cyshcn. They provided valuable resources on topics such as family leadership and advocacy, financial planning, guardianship, medical home, respite care, caregiver support, and vehicle and home modifications. Each Family Partner actively responded to families' needs by sharing requested information through various outreach efforts, including email, phone calls, newsletters, and events, to provide families with access to services and resources. (See list below.) Family Partnership publications, including monthly mentions, E-news, and newsletters, can be accessed on the Family Partnership webpage.

Northeast Family Partner:

- Partnered with Washington University Hospital Specialty Clinic to serve children with complex medical needs;
- Collaborated with the Emergency Operations Center of St. Louis County to provide resources for those with disabilities in the event of a disaster; and
- Represented Family Partnership on the Council for Adolescent and School Health (CASH), Kirksville/Northeast Interagency Network, St. Louis Resource and Respite Coalition, and the Gateway Coalition Network.

Northwest Family Partner:

- Joined Family Partnership in December 2023;
- Expanded listserv from 35 to 170 families through enhanced outreach and networking efforts;
- Partnered with Children's Mercy patient and advisory team to advocate for the unique needs of families of children with complex medical needs; and
- Created professional relationships with state schools for children with complex needs, the regional therapeutic preschool for children ages infant to kindergarten, First Steps, Parents as Teachers, social workers, and therapists.

Southeast Family Partner:

- Served as the AMCHP Family Delegate for Missouri;
- Attended the 2024 AMCHP conference;
- Participated in the annual FY 2024 Title V MCH Block Grant Review; and
- Participated on the AMCHP Workforce and Leadership Development Committee.

Southwest Family Partner:

- Expanded listserv from 50 to 108 families through networking and increased outreach;
- Established relationship with area medical supply donation facility offering free pediatric supplies and equipment to families in need; and
- Created a professional relationship with the Director of Outreach and Family Support for Special Learning Center.

Two Family Partners for Deaf and Hard of Hearing (funded by the HRSA Universal Newborn Hearing Screening and Intervention Program Grant):

- Collaborated with Title V funded SHCN Family Partners, who shared additional resources and provided parent support when a complex medical need was identified;
- Networked to develop connections with professionals across the country by participating in Hands & Voices Family Leadership in Language and Learning Center (FL3);
- Participated in the AG Bell Global Listening and Spoken Language Symposium, offered by the Alexander Graham Bell Association for Deaf and Hard of Hearing; and
- Facilitated monthly virtual parent chats to provide parents/caregivers an opportunity to connect and support each other.

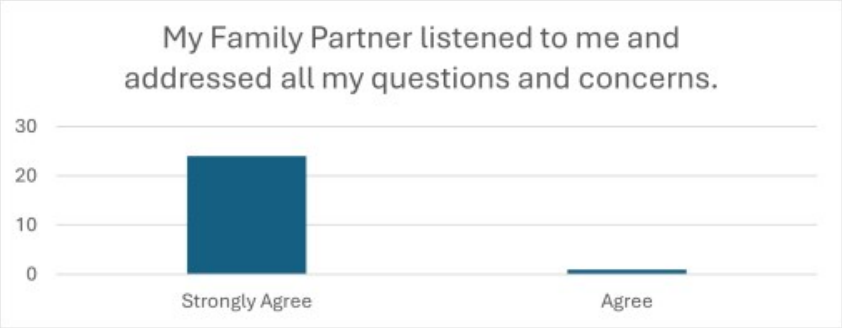
SHCN Family Partnership, along with other SHCN programs, collaborated with LifeCourse Nexus at the University of Missouri Kansas City – Institute for Human Development (UMKC-IHD) to create the "Resource Guide for Missouri Families of Children from Birth to Age 12". This comprehensive guide was designed to strengthen support networks by providing families with detailed descriptions, links, and phone numbers of various statewide resources. Family Partnership also collaborated with LifeCourse Nexus at the UMKC-IHD to create a series of training opportunities for families and professionals. The trainings included "Introduction to Charting the Life Course" (CtLC), "CtLC Workshop: Alternatives to Guardianship", the CtLC Skills Building Series, the CtLC Ambassador Series, and SHCN Good Life Groups. (See table below.) These sessions provided valuable insights and tools to help families and professionals create a vision for a "good life" in the future. The training aimed to empower professionals in transforming their agencies by coordinating and integrating services to help meet the needs of cyshcn and their families. The Introduction to CtLC training was added to the MCH Core Training Plan. SHCN has stored the Charting the LifeCourse Introductions and CtLC Workshop: Alternatives to Guardianship on the SHCN webpage, to provide continuous access for families and professionals. "CtLC Workshop: Alternatives to Guardianship" is available in Spanish and closed captioning on the webpage.

Session	Number of Cohorts	Number of Sessions	Number of Attendees
Intro to CtLC	N/A	3	48
CtLC Workshop: Alternatives to Guardianship	N/A	1	218 Registrants/ 109 Attendees
CtLC Skill Building Series	3	12	29
CtLC Ambassador Series	1	7	15
SHCN Good Life Groups	N/A	6	108 Duplicated/ 57 Unduplicated

47/109 attendees, representing professionals and families, of the "Alternatives to Guardianship" webinar responded to a post-session survey. 96% strongly agreed or agreed they were satisfied with the session, and 91% reported they would recommend the session to others. Additionally, 91% reported their knowledge increased because of the session. One attendee responded, "This was an excellent presentation. Very thorough and should help any family that is curious about options and alternatives to guardianship."

SHCN Family Partnership solicited feedback from families to evaluate the quality of the support and resources provided by the Family Partners. To accomplish this, families of cyshcn referred between July 1, 2024 to September 20, 2024 were given the opportunity to complete an incentivized satisfaction survey following contact with a Family Partner. 25 respondents shared feedback on their level of satisfaction with the interactions, supports received to meet their specific needs, and preferred methods for receiving future communications and resources. The survey results showed:

- Families know how to contact a Family Partner;
- The information provided was helpful to their personal situation;
- Resources were received to support cyshcn and the family;
- In-person (15) and virtual (10) were the preferred methods for networking;
- Preferred methods of communication were email (9), text (9), and phone (6); and
- Preferred modes for delivery of resources were electronic (12), printed (2), both (11).



Family Partnership utilized radio, television, and social media platforms to target parents/caregivers and professionals supporting cyshcn. These outreach efforts aimed to raise awareness of how the Program can enhance the lives of children and youth with complex medical needs by connecting them with a Family Partner. Television reached 164,860 unique households, while Facebook and Instagram linked with 70,861 unique users. By leveraging multiple media platforms, families were informed about the valuable support available by connecting with a Family Partner to ensure they have access to the resources and assistance needed to navigate

their child's care and well-being.

In August 2021, the DESE Office of Childhood (OOC) was awarded the "Early Childhood Comprehensive Systems (ECCS) Health Integration: Prenatal to 3" grant, in the amount of $255,600 annually for 5 years. This funding supports an integrated, sustainable, and comprehensive maternal and early childhood system of care that promotes early developmental health and family well-being and increases family-centered access to care and engagement of the prenatal-to-3 population. Efforts supported by the grant include the ECCS Advisory Council and Parent Advisory Council. In FY 2024, the ECCS Advisory Council prioritized including health integration strategies in the strategic plan for Missouri's childhood system. Family advocacy is critical in building coordinated and comprehensive systems. Over the life of the grant, seven regional PACs will feed into a larger statewide PAC to inform early childhood policy and procedure at local, regional, and state levels. The ECCS Program partners with MCH Leadership to maintain and support the PAC, which historically developed opportunities for parent and family involvement in local communities and across the state. The expanded PAC regional model assures the PAC is representative of all Missouri families.

Dental Home

The Office of Dental Health (ODH) continued implementing the Preventive Services Program (PSP) in Schools for the Severely Disabled (SSDs) under its ongoing agreement with DESE. Through PSP, children received an oral health screening by the State Dental Hygienist, two applications of fluoride varnish for protection against tooth decay, and a referral to a local dental provider. Referrals addressed identified needs and linked children to a dental home. Dental visits, crucial for cyshcn who may have behavioral, dietary, or physical complications that affect their dental health, were recommended at least once or twice yearly for all children.

For SSDs, PSP oral health education is directed toward caregivers and parents. Part of the education emphasizes connecting children to a dental home, regardless of whether a dental issue is identified during the screening. Children also receive toothbrushes and toothpaste, which may be left at school or taken home. The State Dental Hygienist travels to SSDs to screen and apply varnish as allowed. In FY 2024, all schools were reached, and 413 children were seen by the State Dental Hygienist. The State Dental Hygienist was also available to advise on any dental issues students had. Oral health supplies, education, literature, and fluoride varnish were available to any child who did not receive a dental screening. ODH created an online screening survey form for the hygienist to complete, and ODH uses the information to determine which school had a higher participation rate. ODH can then contact 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 to be shared with DESE.

ODH partnered with the Missouri Coalition for Oral Health to educate dental professionals on how to better serve cyshcn. This collaborative effort involved working with the Missouri's Developmental Disabilities Council, DMH, and the University of Missouri Kansas City (UMKC) Dental School. The goal was to improve access to dental care for cyshcn by enhancing dental professionals' knowledge and confidence in working with cyshcn and their families.

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 compliance with regular and urgent dental treatment. The mobile unit is wheelchair accessible and sets up in a central location to facilitate transporting individuals with I/DD. Historically, state general revenue has supported the EMDP and paid for about 950 patient visits and 9,000 procedures. The FY 2024 state budget included increased funding for the EMPD. In addition to state general revenue, the Elk's Benevolent Trust, a non-profit organization, provides supplemental funding so adults and children with disabilities can receive dental care. The EMDP also accepts Medicaid, providing additional funding support. EMDP is the dental home for some individuals due to the shortage of dental professionals willing to accept Medicaid and/or the reluctance of many dental teams to treat individuals with I/DDs.

Newborn Screening

The Newborn Screening Booklet includes information about the importance of a medical home for children with and without special health care needs. The booklet, distributed to new and expecting parents, is provided 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 providers, prenatal classes, and obstetric and gynecological clinics. On average, these entities request approximately 4,000 booklets per month. In addition, the Newborn Screening Program distributed 2,573 electronic parent surveys, including questions

about the medical home to provide insight into parents' definitions of their child's medical home. The survey was 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 collaborated 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, contacted parents of newborns who failed the newborn hearing screening to provide peer support, review resources, and encourage appropriate follow-up with the medical home. Family Partners emphasized the medical home's role in managing the unique needs of an infant with hearing loss through the distribution of the "*EHDI Parent Resource Toolkit for Western Missouri*." Additionally, through a continued contract with the Missouri State University MOHears Program, trained professionals assisted families with newborns diagnosed with permanent hearing loss to access early intervention and make informed choices regarding language opportunities and to contact audiology centers for missing diagnostic results. MOHears helped educate families on the benefits of a patient/family-centered medical home and family engagement in the care of a child who is deaf or hard of hearing.

Early Childhood Professionals

The OOC Quality Initiatives Section at DESE provided inclusion referral services, technical assistance, and training throughout the state to help cyshcn families and caregivers.

Inclusion Specialists provided a variety of services for cyshcn. The Specialists:

- Assisted families with locating appropriate child care to support their child's needs successfully. This included providing the families with a list of licensed or regulated child care facilities that can work with their child. Inclusion Specialists want parents to make the choice that best suits their needs and wishes, and by narrowing down who can accommodate a specific need, the Specialists can save the families a lot of time and frustration. When the list does not produce a facility that can accommodate a specific need, the Specialists contact a program to discuss the requirements of the child in need of care. Inclusion Specialists visit the program to strategize how the facility can make minor adaptations to successfully include the child and offer technical assistance until the facility is fully equipped to meet the child's needs.
- Provided caregivers with training to develop the necessary knowledge and skills to appropriately meet the child's needs while in their care. In FY 2024, 1,810 participants attended the trainings. Each participant filled out an evaluation form to assess participant knowledge of the training topic before and after the training session and calculate participate knowledge gained. There was an average knowledge increase of 95%.
- Connected families with other community resources, as appropriate, based on the specific needs of the child, such as providing information on First Steps, connecting them to the local school district for speech services, and more.
- Provided general classroom and child-specific observations. After the observations, the Specialists helped develop strategies and offer training to further the caregivers' knowledge and skills and provided technical assistance to child care providers regarding the needs of the child or group. 810 on-site visit hours were provided.

The OOC Quality Initiatives Section contractually provided inclusion services to support children with special needs, including children with a perceived developmental disability and/or delay, health/mental health needs, or behavioral issues. They offered technical assistance to child care programs so children with special needs could maintain placement as they grow and develop, thereby reducing preschool expulsion. Inclusion Specialists trained child care providers as new providers entered the workforce and program needs evolved based on children's needs.

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. Preparing the child care workforce to recognize the signs of trauma helps providers meet the needs of the children in their care. Inclusion Specialists delivered evidence-based training to child care providers and families 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 State's Inclusion Services (IS) project was expanded to include 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 knowledge teachers gain from on-site consultation can be carried over to future challenges. However, the primary focus of the IS Project is intervention. Inclusion Specialists help families or providers respond appropriately to a challenge occurring at a specific time. The intervention focuses on helping the teacher work with a particular child or situation. A more comprehensive and proactive program was needed to more effectively prevent preschool expulsions and the short and long-term dangers they present. The SEL Project provides this support. In FY 2024, a total of seven programs with 13 classrooms enrolled and completed the project. (See table below.)

	Title	Clock Hours	Number of Participants
1/20/2024	Building Nurturing and Responsive Relationships	4	14
2/17/2024	An Introduction to the ASQ-SE Questionnaire	2.5	12
2/17/2024	What's DAP	2.5	12
3/16/2024	Social Emotional Responsive Environment	4	8
4/20/2024	Social Emotional Teaching Strategies	4	10
5/18/2024	SEL Cohort Intensive Individual Intervention	4	11
6/15/2024	Calming Corner: Self-Regulation in Action	2	12
6/15/2024	Early Childhood Trauma	2	12
7/20/2024	Social Stories: Teaching Behavioral Norms Through Stories	2	7
7/20/2024	Visual Supports in the Early Childhood Classroom	2	7
8/17/2024	Cultivating Resilient Teachers	2	8
8/17/2024	Mindfulness and Yoga in the ECE	2	8
Total		33 hours	121 participants

A few of the main components of the program are:

- Four-day initial training sessions (once a week for four weeks) for teachers focusing on understanding how children develop socially and emotionally and how teachers can facilitate this development practically. 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 project discussed in the Child Health domain. A total of 13 ASQ:SE were administered.
- Individualized classroom action plans completed by Inclusion Specialists to address environment, relationships, and social-emotional teaching strategies. Three specific pro-social skills were identified and taught to children by the Inclusion Specialists.
- Individualized plans for children identified as being at-risk.
- A minimum of four on-site observation/consultation visits from a Project Specialist over nine months to facilitate the implementation of plans and support teachers through challenges that arise. Progress towards goals was made between visits, with sessions focusing on coaching specific strategies and observing specific children. 50 on-site observations were completed.
- Two Saturday half-day follow-up meetings 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.

- After completing all training/meeting components, participants receive 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 to support teachers' learning.

The Child Care Health Consultation (CCHC) Program provided consultation and training for child care providers at licensed and license-exempt child care programs on topics around health and safety, including issues 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 all-encompassing engagement. The CCHC Program provided 154.5 hours of training and consultation for child care providers on SHCN, child care inclusion, health care access, health policies and regulations, developmental screenings, and referrals to outside resources, such as WIC, developmental screening, immunizations, MO HealthNet, and health care provider access. Consultants assisted child care providers in the development of individualized health care plans (IHPs) with input from other health specialists and parents/guardians. Consultants received in-depth orientation and training on using Missouri Family Resources, a free statewide resource website and mobile app that can be used by families and early childhood professionals to connect children and families to resources in their communities. Consultants also received information about the Childhood Community Leaders, which develop and implement plans to ensure young children and their families can access high-quality programs, services, and resources in their respective communities.

CCHC provided 94.5 hours of health promotions for children in child care. The health and safety lessons on SHCN topics were delivered with fun, developmentally appropriate, and engaging presentations. Health promotion presentation topics included safe interactions with children with food allergies, engaging with peers with autism spectrum disorder, bullying, positive behavior support, self-esteem, celebrating differences, and empathy. CCHC services provided evidence-based and educational materials regarding the physical and emotional care of children with special health care needs (cshcn), optimizing the physical, social, and emotional health of cshcn in the child care setting, and promoting utilization of community-based resources. Child care providers gained knowledgeable about developmental screenings, identifying cshcn in their care, and referring children and families to services available in their communities. CCHC services are necessary to comprehensively address and support the needs of children of all abilities, and family participation and engagement are encouraged.

Child Lead Poisoning Prevention

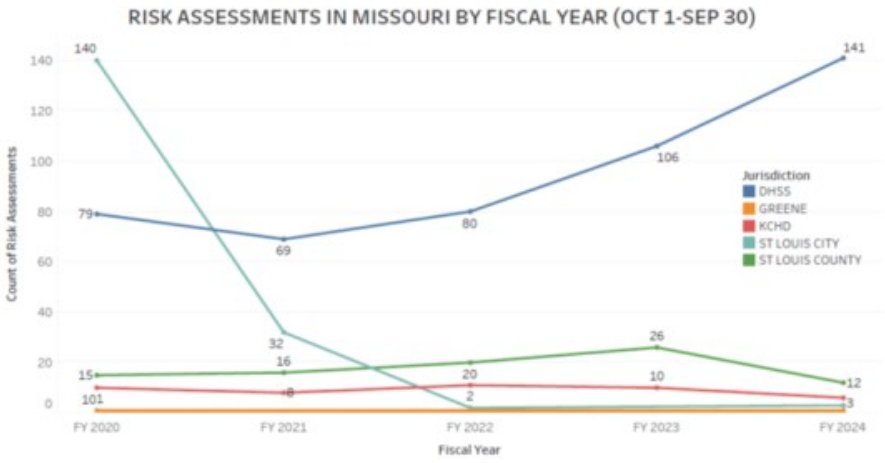
The Childhood Lead Poisoning Prevention Program **(**CLPPP) worked with LPHAs and MO HealthNet lead case managers to coordinate clinical and environmental services for families of children with elevated blood lead (EBL) levels and strengthen the role of primary care providers within the public health domain. Supporting public health relationships involving professionals with various clinical and environmental expertise results in a rapid decline in EBL and prevents further undesirable health effects. These supportive activities included:

- Providing 15 lead education trainings to health care providers, LPHAs, and WIC programs, with 156 people trained;
- Coordinating 10 community activities with over 500 attendees;
- Documenting case managers, physicians, and other clinicians' contact information in the records of children with EBL;
- Including Family Partners and representatives of various clinical and environmental disciplines when designing and implementing strategies. The Lead Advisory Committee met quarterly and developed 2 annual goals;
- Developing strategies to share and document pertinent case management information and actions across multiple disciplines and with family/caregiver input to improve coordination of care in the new data surveillance system, Show Me World Care. This system allows for greater data query capabilities and allows the program to look for trends in case management;
- Working with Family Partners to review program materials and planned activities; and
- Completing over 140 in-home risk assessments by Licensed Lead Risk Assessors across the rural regions of Missouri and providing cleaning kits, funded through Title V, to families.

The CLPPP partnered with other MCH programs, health care providers, and DESE to establish well-coordinated efforts for providing early evaluation and referrals for ongoing monitoring and services for children with lead poisoning. Schools can request, collect, and record EBL information for all children in their district and should have an early and ongoing role in the appropriate and

timely follow-up of children with a history of EBL. Increasing timely referrals allows children with an EBL history to access a variety of expanded and ongoing evaluation, monitoring, and intervention services through school nurses, Parents as Teachers, First Steps Early Intervention Programs, Head Start Programs, and other special services. DESE provides lead awareness education for families/children from birth through high school 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 work with a child's medical providers to ensure that initial and ongoing health, developmental, behavioral, and cognitive assessments/evaluations are performed.

Early identification of blood lead levels is critical to ensuring children are accessing services. CLPPP partnered with LPHAs and Head Start programs to ensure blood lead testing is offered to at-risk populations. CLPPP partnered with 13 LPHAs and FQHCs to provide point of care testing devices in high-risk counties to increase identification of children at risk for lead poisoning and reduce the risks of special health care needs. (See trends graph below.)



The trend of risk assessments for each federal fiscal year (October 1st through September 30th). Color shows details about each Jurisdiction.

RISK ASSESSMENTS IN MISSOURI BY JURISDICTION

Jurisdict..	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
DHSS	79	69	80	106	141
GREENE	1				1
KCHD	10	8	11	10	6
ST LOUIS..	140	32	2		3
ST LOUIS..	15	16	20	26	12
Grand To..	245	125	113	142	163

School Health

School nurses are 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-up, 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 (EAPs) in place. These plans are developed in collaboration with the parent/guardian and approved by a medical provider. The Adolescent and School Health Program (ASHP) promoted the School Nurse Chronic Health Assessment Tool (SN-CHAT) to engage school nurses and parents in developing EAPs and IHPs.

The state school nurse consultant served on the faculty for the Autism ECHO (Extension for Community Healthcare Outcomes). This learning opportunity shares autism specialist knowledge in a virtual learning network. Participants learn about best practices and evidence-based care for children with autism and developmental and/or behavioral concerns, including detecting mental health concerns, making appropriate referrals, and supporting children in their treatment for mental health conditions. The ECHO meets bi-monthly during the school year and targets school nurses and support staff.

The ASHP provided consultation, training, resources, and support to school nurses on health-related topics. The ASHP prepares an annual summary report from data collected by school nurses in public, charter, private, and parochial schools, including 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 received print materials, video presentations, and virtual conferences about MO HealthNet, FQHCs, and other community health resources to facilitate their role in supporting access to health care and other health care services for families and to strengthen their role in the medical home model. The ASHP conducted an annual in-person workshop where new health office staff received training on hearing and vision screening, managing children with chronic health conditions in the school setting, immunization requirements and schedules, skills labs for diabetes and asthma care, making student referrals, and connections to necessary follow up care for students. The ASHP provided 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 ASHP continued efforts to ensure 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, support nursing best practice, and actively promote the school nurse role in care coordination.

A new online program, *Show Me School Health*, was launched in July 2024, and provides school nurses with up to 32.25 continuing education credits through online asynchronous courses: New School Nurse Orientation, Puberty Education for School Nurses, and Comprehensive School Nursing. The website houses information about specialized health care procedures in the school setting that a school nurse will need to be familiar with (ambulation, transfer, diapering, tracheostomy suctioning, tube feeding, stoma care, catheter care, diabetes management, nebulizer treatments, oxygen, etc.) and be able to write an IHP for, as well as a training and delegation plan. Future trainings will include developing 504 plans for students needing an accommodation in the school setting and the role of the school nurse on an IEP team.

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 EAPs. The ASHP engaged and partnered with MSBA on the emergency planning process for students with special needs. The ASHP encouraged 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.

The ASHP partnered with school boards' and principals' associations as well as the Missouri's Family and Community Trust and the MO HealthNet Division to promote access to care through Medicaid enrollment and awareness of FQHCs. The ASHP supported professional development opportunities for school health services staff through trainings, workshops, webinars, and regional conferences to address Medicaid enrollment, Medicaid managed care, and management of cyshcn and chronic conditions. The weekly Nurse Education Webinar series included presentations on FQHCs, Primary Care Health Homes, Home State Health, and developing IHPs. ASHP hosted a session at the Health Office Orientation on "making student referrals" and supported the Missouri Coordinated School Health Coalition's annual conference, at which all three managed care organizations exhibited. The Show Me School Health website, which includes trainings regarding management of chronic conditions, was shared with the listserve of school health staff and LPHAs and included in presentations.

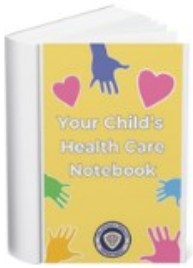
ASHP collaborated with SHCN and the Tri-County Health Department to share and encourage use of the Care Notebook in the school setting and with families of cyshcn. ASHP facilitated sharing the Care Notebook at the 2025 Missouri Coordinated School Health Coalitions annual conference. Participants were able to take a care notebook back to their district, and connections with school nurses were made to assist with enhancements and future development of the Care Notebook.

Local Public Health Agencies

The MCH Services Program contracted 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 access to health services) have 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 children's health by providing preventive and primary care services for low-income children.

LPHA efforts to fulfill the purpose of the MCH Services contract included activities and services that address the needs of cyshcn. Tri-County Health Department increased the number of children and families that know what coordinated, comprehensive health services look like and engaged individuals, families, and providers in utilizing a Care Notebook to ensure children receive the right care, at the right time, and in the right place by. Using feedback from a pilot implementation of the Care Notebook, the health department collaborated with the DHSS SHCN Family Partners to revise the Notebook to better meet the needs of those it is intended to serve. The health department and SHCN Family Partners presented "Medical Home: A Whole Home Approach" at the annual Family Partnership Parent and Caregiver Retreat and provided Care Notebooks to 150 parents and families of cyshcn. A pre-survey conducted at the retreat gathered responses from 71 caregivers and families, with 21 stating it was extremely difficult and 60 stating it was somewhat difficult to keep health information organized and the health team "on the same" page. A post-survey will be conducted in FY 2025 to collect feedback on their experience using the Care Notebook. The Care Notebook is available in printable and fillable formats.



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 received. SHCN programs serving cyshcn include CYSHCN, HCY, and Family Partnership; additional SHCN programs include Adult Brain Injury (ABI) and Medically Fragile Adult Waiver (MFAW). In addition to these programs, SHCN provides funding to Missouri Assistive Technology for the Kids Assistive Technology (KAT) project to improve access and reduce 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 years, have an eligible special health care need (conditions 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 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 Title V funding.

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 including 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, and authorized registered nurse visits). 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 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 SHCN 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 Title V funding 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.

State Agencies and Partners

The overall goal of the Missouri Disability and Health Collaborative is to support individuals with intellectual disabilities in being included in and having access to the full range of evidence-based physical activity and nutrition programs provided through public

health programs. Missouri has developed several strategies to increase access to healthy foods and safe places to be physically active. However, few of these strategies were designed to be accessible to people with intellectual disabilities or with the specific health needs of people with intellectual disabilities in mind. Through the Missouri Disability and Health Collaborative, the DHSS Bureau of Community Health and Wellness continued to contract with UMKC Institute for Human Development to review and adapt existing nutrition and physical activity strategies to ensure engagement of people of all abilities.

In addition to the programs at DHSS, several other initiatives contributed to Missourians receiving coordinated, comprehensive, and ongoing health care services throughout the state. In October 2011, CMS approved Missouri's State Plan Amendment (SPA) to establish Medicaid reimbursement for health homes, making Missouri the first state in the nation with an approved SPA for health home services. This SPA established Community Mental Health Center (CMHC) Healthcare Homes to serve individuals with serious mental illness. A companion SPA, approved in December 2011, established Primary Care Health Homes (PCHH). 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 and addresses community health factors for medically complex individuals. PCHH includes the implementation and evaluation of the Patient Centered Medical Home (PCMH) model. PCHH emphasizes integration of primary and behavioral health care to improve health outcomes. MO HealthNet employs Registered Nurse Case Managers in the Evidence-Based Decision Support Unit, which established a pilot case management project with a multidisciplinary team, including clinicians, to build infrastructure to support participants. Participants are selected for the pilot by utilizing an algorithm to identify participants with needs associated with high costs. The initiative creates a collaborative resource network to identify available resources, and care plans are developed for each participant 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. Family -centered care coordination is also provided through the Beacon Program and Clinic at Children's Mercy Hospital in Kansas City and the Pediatric Advanced Care Team at St. Louis Children's Hospital.

Additional Performance Analysis

The Newborn Screening Program received 117 responses to the parent survey question:

> *The Missouri Department of Health and Senior Services supports and encourages access to a medical home for all children, with and without special health care needs. A medical home is not a building, house, office, or hospital, but rather an approach to providing health care services in a high-quality, cost-effective manner. Individuals with a medical home receive the care they need from a healthcare provider whom they know and trust. The medical home is a partnership between the patient, family, and primary provider in cooperation with specialists and support from the community.*
>
> *Based on the above definition, do you feel your child has a medical home?*

Survey responses were:

- Yes = 68.38%
- No = 10.26%
- Not Sure = 21.37%

The survey sought additional information with the follow-up question, "Which of the following do you consider your child's medical home?" The responses were:

- Primary care = 81.08%
- Local urgent care or emergency department = 1.18%
- Specialist for a diagnosed disorder = 15.29%
- Other = 2.35% (these answers included: "myself," "my husband," "my child's pediatrician and other trusted health professionals," and "it has nothing to do with the newborn blood screen.")

The Newborn Hearing Screening reported the following for 2023, the most recent calendar year of complete data:

- 97.86% of newborns were screened (most recent/final screen) before one month of age (of those screened).
- 69.78% of newborns evaluated were evaluated and diagnosed before three months of age.
- 76.92% of newborns enrolled in Part C services were enrolled in early intervention before six months of age.

The CLPPP program partnered with 36 Head Start programs and LPHAs during the fall of 2024 to test over 300 children, and 45 children with elevated blood lead levels were identified.

ODH visited all SSDs, screened 413 students, and applied varnish to 273 students. The nurses and DESE expressed appreciation for this program.

Inclusion Specialists reported most of their work centered around services for children with challenging behaviors related to undiagnosed perceived special needs opposed to diagnosed special needs. At this young age, challenging behaviors can be indicators of special needs such as sensory processing disorders, ADHD, autism, etc. Inclusion-related trainings were offered to support child care professionals, families of children with special needs, and the community.

Challenges

An outdated data system and program staff turnover presented barriers to quality data collection and analysis for the Newborn Hearing Screening Program. The Newborn Screening Program experienced limited responses to its survey efforts, hindering comprehensive data collection.

CLPPP saw reduced screening numbers due to several Head Starts having children absent on the day of testing, resulting in only 309/527 that requested testing being tested.

When screening students at the SSDs, ODH sometimes encounters the challenge of students not being present or willing to have the screening done the day the hygienist is at the school, although parents have given consent for a student to receive a screening.

Contractor performance for Inclusion Services reflected an increase in work force challenges, including difficulty recruiting and retaining qualified staff. Statewide training attendance also decreased.

Opportunities

Additional HeadStart programs in rural counties are interested in collaborative testing events with CLPPP.

When a student/parent has given consent for a screening and fluoride varnish, along with instructions, and the student is not present or willing to have a screening performed, ODH provides oral care supplies and fluoride varnish to the nurse in the event the student is willing to allow the nurse to apply the varnish after the hygienist leaves.

Review of trends in usage of Inclusion Services led the program to revise the scope of work to focus more services specifically on children with diagnosed special needs, supporting families throughout their early childhood journey, and educating child care providers on best practices when working with children with special needs. Inclusion Services will collaborate with the Infant Early Childhood Mental Health consultation program to best meet the needs of children and families.

Children with Special Health Care Needs - Application Year

NPM: Medical Home – Family-Centered Care - Access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children with 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.

Some strategies and activities listed below may be relevant for both the Child Health and CSHCN domains.

Special Health Care Needs
The Bureau of Special Health Care Needs (SHCN) in DSDS will maintain active partnerships with several key statewide councils and advisory groups to ensure the needs of cyshcn are represented in systems-level planning and decision-making. Through participation in the Missouri Commission on Autism Spectrum Disorders, SHCN contributes to discussions and recommendations aimed at improving services and supports for individuals with autism and their families. Involvement with the Missouri Developmental Disabilities Council allows SHCN to support efforts that promote integration, independence, and self-determination in every aspect of life for individuals with developmental disabilities. SHCN also plays an important role on the Missouri Assistive Technology Advisory Council, helping to identify and advance strategies that increase access to assistive devices and services that support communication, mobility, and daily functioning. As a member of the Missouri Interagency Transition Team (MITT), SHCN collaborates with other agencies to address data-driven goals for improving employment, independent living, and postsecondary education outcomes for Missouri students with disabilities. Participation in the Missouri Children's Cabinet provides an opportunity for SHCN to engage in cross-agency collaboration to identify and address gaps in services available to Missouri's children. Involvement in the Missouri Newborn Hearing Screening Standing Committee helps guide early identification and intervention strategies for infants with hearing loss. SHCN administers the Missouri Brain Injury Advisory Council, leading development of a collaborative statewide system of prevention, public awareness, and provision of services and supports driven by the needs of individuals with brain injuries and their families. Through these ongoing partnerships, SHCN will ensure the voices and needs of cyshcn and their families are included in broader efforts to improve care coordination, service access, and health outcomes across Missouri. In addition, SHCN will continue to partner with stakeholders to distribute resource materials.

To promote comprehensive access to care, SHCN will collaborate with stakeholders to ensure families of cyshcn are informed about and connected to appropriate insurance coverage. This includes guidance to help families explore coverage options available through the Affordable Care Act, employer-sponsored plans, and private insurance, with the goal of ensuring all cyshcn have access to adequate and continuous health coverage. SHCN will also collaborate with MO Assistive Technology to increase access to assistive technology and related services to enhance healthcare options and supports for cyshcn. SHCN is committed to enhancing health literacy by revising both electronic and printed materials to ensure accessibility and compliance with Section 504 of the Rehabilitation Act (501 compliance).

Service coordination is essential for people with complex conditions and needs. Service Coordinators (SCs) for the Children and Youth with Special Health Care Needs (CYSHCN) and Healthy Children and Youth (HCY) programs will continue to provide service coordination, including resource identification and referrals, and conduct comprehensive assessments for participants/families, regardless of financial status. SCs will complete annual Service Coordination Assessments (SCA) in collaboration with participants/families to address strengths and needs, which drives service plan development and implementation. The SCA incorporates medical home components to evaluate whether participants have a usual source of care when sick or for preventive services, have seen a physician or specialist in the past year, and receive care from providers who communicate and collaborate with one another, including non-medical providers. Additional indicators assess the quality of provider interactions, such as whether providers spend adequate time, listen carefully, respect the family's values and customs, and engage families as partners in care. The assessment determines whether families know whom to contact for services, can access referrals when needed, receive services locally, and have adequate health insurance to meet their child's needs. The SCA also evaluates access to language or mobility accommodations. If it is determined a medical home is not in place, SCs will provide education and guidance to help families understand and establish a medical home, including promoting continuity of care, coordination among providers, and patient-centered practices.

The SCA also includes several components that evaluate the quality and accessibility of services for cyshcn and their families. One element of the SCA assesses whether the participant/family feels like a partner in decision-making with their SHCN SC, reflecting the program's emphasis on family-centered care and collaborative service planning. SCs emphasize the importance of partnering with participants/families throughout the care planning process on a continuous basis. The SCA evaluates if participants/families are satisfied with general health services (physicians, hospitals, therapists), in-home provider agency services, and SHCN services. The SCA includes information regarding medical, dental, and vision insurance. Components related to adequate health insurance for cyshcn assess 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 participants had health coverage for all of the last 12 months. The SCA also includes indicators that assess whether services are organized in a way that makes them easy to use for families of cyshcn, supporting efforts to reduce systemic barriers and improve care coordination.

SHCN Family Partnership

The objectives of the SHCN Family Partnership Program are to provide families with the opportunity to offer each other support and information, give families the opportunity to provide SHCN input on the needs of cyshcn, and build public and community awareness of the unique needs and issues facing families of cyshcn. SHCN employs Family Partners who are parents of cyshcn. Each Family Partner is experienced with navigating options and solutions for the unique needs of individuals with complex medical conditions. Family Partners will continue to provide one-on-one peer support to families, offering resources and referrals guided by their lived experience. They will contact newly enrolled SHCN program participants to inform them of the SHCN Family Partnership Program and 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 and service navigation information, such as the MCH Resource Guide for Missouri Families of Children from Birth to Age 12, through their listservs, resource fairs, virtual speaking opportunities, conferences, and statewide events, including the Parent and Caregiver Retreat. Family Partnership will partner with Missouri Family to Family and the Tri-County Health Department to share information and resources with stakeholders and families. SHCN outreach materials will be reviewed by Family Partners to ensure content is accessible, clear, and actionable.

Dental Home

ODH will conduct oral health screenings at Missouri State Schools for the Severely Disabled (MSSDs). ODH has an agreement with DESE to conduct these screenings and provide fluoride varnish, oral care supplies, oral health education, and referrals as needed. ODH meets with the DESE coordinator to plan the calendar, introduce or re-introduce the program to the nurses, and ensure they understand both the screening process and the importance of preventive oral health care. Consent forms are sent home with the student to inform parents/caregivers about the program and oral health. After a child is screened, school nurses send a note home with any identified oral health concerns, along with guidance on follow-up care. The screenings encourage good oral health and ensure the caregiver understands the importance of oral health. Fluoride varnish is applied by the State Dental Hygienist, if possible. If not possible, the school nurse will apply when the child is agreeable. A second application of fluoride varnish is applied at a later date to help prevent dental decay. A brief report is given to the DESE coordinator to show the oral health of the children at the MSSDs. Feedback from nurses and the DESE coordinator is welcomed.

The Elk's Mobile Dental Program provides free high-quality dental care for children and adults with Intellectual and Developmental Disabilities (I/DD). The three units, staffed with licensed professionals with experience treating individuals with I/DD, have the capacity to provide dental services to 3,000 individuals annually. General Revenue and supplemental funding from the Elk's Benevolent Trust and University Health Truman Medical Center support the Elk's Mobile Dental Program. ODH is the contract monitor for this program and will continue promoting this program at speaking events and health fairs and to the DESE coordinator and MSSD schools.

Newborn Screening

Information about the importance of a medical home for children with and without special health care needs is included in the Newborn Screening booklet produced by the Newborn Screening Program and distributed to new and expectant parents.

Newborn Screening contracts with three tertiary genetic centers and four accredited cystic fibrosis centers affiliated with Missouri children's hospitals, which conduct clinical follow-up on all presumptive positive newborn blood spot screens. The contracts require the centers to have the capacity to provide comprehensive care, including access to multiple subspecialties as appropriate to the diagnosis. The specialists at the contracted centers work in collaboration with primary care to ensure coordinated, family-centered care following screening, additional testing, and diagnosis.

In-service and training events are provided by Newborn Screening for health care providers, hospital staff, midwives, and other entities who collect blood spot samples for newborn screening. Training can be general newborn screening information or tailored to the needs of the audience. All training emphasizes the importance of family involvement in the newborn screening process. Providers are encouraged to explain to families the details of the process, including how the sample is collected and processed, discuss what disorders are screened for in Missouri, and educate parents to ask their baby's health care provider for the screening results.

The Newborn Hearing Screening Program (NHSP) will ensure Missouri families with newborns, infants, and young children up to the age of three who are deaf or hard-of-hearing (DHH) receive appropriate and timely services that include hearing screening, diagnosis, and intervention. NHSP will use the Early Hearing Detection Intervention (EDHI) model recommendations, referred to as the 1-3-6 Benchmarks, that all infants be screened no later than one month of age, infants who did not pass the initial hearing screening and the subsequent rescreening have an audiologic evaluation by three months of age, and all infants diagnosed with a permanent hearing loss receive early intervention by six months of age. NHSP will promote the importance of communicating accurate, comprehensive, up-to-date, evidence-based information to allow families to make important decisions for their children in a timely manner, including decisions with respect to the full range of assistive hearing technologies and communication modalities. Partnerships are in place to support coordinated, family-centered follow-up as part of contracted work with the Missouri State University (MSU) MOHear Project and in collaboration with Early Intervention-First Steps at DESE.

Early Childhood Professionals

The Inclusion Services (IS) program in the Office of Childhood (OOC) at DESE provides inclusion referral services, technical assistance, and training to help families and caregivers of children with special needs, including children who have or are at increased risk for having chronic physical, developmental, behavioral, or emotional conditions and learning disorders requiring more specialized health and educational services in the child care setting. Child care inclusion embodies values, policies, and practices that support the right of every child and his or her family, regardless of ability, to participate in a broad range of activities as full members of families, communities and society. The desired results of inclusive experiences in the child care setting for children with and without special health care needs and their families include a sense of belonging and membership, positive social interactions and friendships, and development and learning to reach their full potential and support their families to navigate child care placement and other supportive services. Inclusion specialists:

- Assist families with locating appropriate child care to support their child's needs successfully. This includes providing families with a list of licensed or regulated childcare facilities that can work with their child. Inclusion specialists want parents to make the choice that best suits their wishes, and by narrowing down who can accommodate a specific need, the specialist can save the families a lot of time and frustration. When the list does not produce a facility that can accommodate a specific need, the specialists contact a program to discuss the requirements of the child in need of care and visit the program to strategize how the facility can make minor adaptations to successfully include the child. The specialists offer technical assistance until the facility is fully equipped to meet the child's needs.
- Provide caregivers with training to develop the necessary knowledge and skills to appropriately meet the child's needs in their care.
- Connect families with other community resources as appropriate.
- Provide general classroom and 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 help develop strategies and offer training to further the caregivers' knowledge and skills, and help the child maintain placement as they grow and develop, thereby reducing preschool expulsion.
- Complete individualized action plans to address environment, relationships, and social-emotional teaching

strategies for children identified as being at-risk.
- Follow-up with the child care program at six weeks and again at three months following the completion of services to determine if additional supports are needed.
- Follow-up with the child's family after the completion of services to determine if their needs were met.

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 recognize the signs of trauma helps providers meet the needs of the children in their care. Inclusion specialists will deliver evidence-based training to child care providers and families 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 will further address the stress placed on children in the foster care system and ways caregivers can support children as they transition between homes. Inclusion services and trainings will be promoted at community events such as child care conferences, at meetings related to early childhood or child care, and through local agencies that support and assist with the placement of children in child care settings.

The Child Care Health Consultation (CCHC) Program will provide consultation and training for child care providers on topics around health and safety, including 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 classroom integration and lesson modification to accommodate children with special health care needs. The CCHC Program will aid in the development of Individualized Health Plans and coordination of other services for young children with special health care needs, with input from other health specialists and parents/guardians, and assist with referrals to outside resources such as MO HealthNet for Kids, immunizations, developmental screening, and WIC.

The CCHC Program will provide developmentally appropriate health promotion presentations for children in child care, including safe interactions with children with food allergies and other topics such as autism spectrum disorder, bullying, positive behavior support, self-esteem, celebrating differences, and empathy. Consultants will provide evidence-based educational materials regarding the physical and emotional care of young children with special health care needs, optimizing the physical, social, and emotional health of all young children in the child care setting and promoting engagement with community-based organizations. CCHC services will be offered to adults and children of all abilities, and family participation and engagement will be encouraged during all program services. Family engagement is now a required element of Health Promotion services. Trainers will be required to provide evidence-based resources related to health and safety for children and families. Future program trajectory, activities, and focus for young children, including those with special health care needs, will be steered with input from Child Care Health Consultants at LPHAs, child care program directors and staff, and identified needs of families and children enrolled in child care programs across the state. Child Care Health Consultants will give input on Child Care Licensing Rule Revisions being completed by the Child Care Compliance and Regulation sections.

Child Lead Poisoning Prevention

Supporting public health relationships involving professionals with various clinical and environmental expertise results in a rapid decline in EBL, preventing undesirable health effects. To strengthen the role of primary care providers within the public health domain, the Childhood Lead Poisoning Prevention Program **(**CLPPP) will work with LPHAs and MO HealthNet Lead Case Managers to coordinate the following clinical and environmental services for families of children with elevated blood lead (EBL) levels:

- Educating health care providers, LPHAs, and WIC programs;
- Organizing community activities and events;
- Documenting the contact information of case managers, physicians, and other health care providers in the records of children with EBL levels;
- Collaborating with Family Partners and representatives from various clinical and environmental disciplines when designing and implementing new program strategies;
- Designing strategies to share and document pertinent case management information and actions across the disciplines and with family/caregiver input to coordinate care more effectively; and
- Working with Family Partners to review program materials and planned activities.

CLPPP will partner with other programs, health care providers, and DESE to provide well-coordinated early evaluation and referrals for services and ongoing monitoring and services for children with lead poisoning. Schools have an early and ongoing role in the appropriate and timely follow-up of children with a history of EBL and can request, collect and record EBL information for all

children in their district. 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 for individualized health planning. DESE programs 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 and the services available to families and children to decrease the potential ongoing exposure and detrimental effects of lead. DESE works with medical providers to ensure initial and ongoing physical, developmental, behavioral, and cognitive assessments are performed. They can perform or refer for various types of child health and developmental evaluations and intervention services needed due to lead exposure before and during the school years.

CLPPP 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 access to services. CLPPP will partner with LPHAs to provide point-of-care testing devices in high-risk counties to increase the identification of children at risk for lead poisoning and reduce the potential for future special health care needs.

Adolescent and School Health

The Adolescent and School Health Program (ASHP) will support school health staff in public, private, and charter schools across Missouri in providing evidence-based management and care to children with complex medical conditions. This will be done through virtual trainings, one-on-one technical assistance, and creation of templates, manuals, and guidance for health office staff use, such as SN CHAT and nebulizer guidance for school nurses. ASHP also contracts with the University of Missouri to provide the Show Me School Health website that includes just-in-time learning modules through a free online library of resources on various health conditions, ranging from mild to complex, that a school nurse may encounter. Additionally, this site includes free online school nurse continuing education courses, providing contact hours and more in-depth training on New School Nurses, Puberty Education for School Nurses, and Comprehensive School Nursing. Other opportunities have been identified and will be added as funding becomes available. ASHP also hosts Health Office Orientation, a one-day workshop offering hands-on orientation for those new to working in a school health office, New Lead Nurse Collaborative, a half-day introduction to the role of being a lead nurse, and Lead Nurse Collaborative, a dedicated space to share updates from public health partners, review best practices, and discuss updates for the new school year. ASHP will encourage school nurses to promote a medical home for every child as part of health-related discussions with parents and families and resource navigation to connect children and families with care and services. ASHP will promote the use of the Care Notebook among partners and school nurses and encourage sharing with families of cyshcn in their communities.

ASHP is partnering with Missouri State University to provide the evidence-based Friendships and Dating Program (FDP). FDP is a comprehensive approach to teaching individuals with intellectual and developmental disabilities the skills needed to develop meaningful relationships and prevent interpersonal violence. This program is also included in the curriculum review currently being done by ASHP to allow for continued and further use of this curriculum with partners across the state. While Missouri State is currently the only agency utilizing this curriculum, discussions have begun with partners serving youth in foster care to explore utilizing the curriculum with their clients.

Additional opportunities for family-to-family and DHH adult-to-family support will be available through family engagement activities utilizing Family Partnership and in collaboration with the Deaf Mentor Project at the Missouri School for the Deaf. This will facilitate sharing strategies and skills with families so they can embed new skills into their daily routines and provide an environment where their child has access to language and can acquire language naturally, regardless of whether the family uses sign language or spoken language or a combination of the two. The goal of NHSP is to build upon and strengthen stakeholder partnerships and establish new partnerships with early childhood entities throughout the state that provide services to infants and toddlers who are DHH. Educational and outreach activities for families will be shared through the Standing Committee, Family Partnership, and MOHear.

Local Public Health Efforts

Tri-County Health Department will work to increase provider knowledge and skills regarding the medical home to ensure coordinated, comprehensive, and ongoing health care services for children with and without special health care needs. Tri-County Health Department will continue to share the Care Notebook they developed and piloted in collaboration with DHSS, SHCN, Family Partners, and families and providers at statewide conferences, such as the annual Family Partner Retreat, Missouri Coordinated School Health Conference, and the Missouri Joint Public Health Conference. Feedback from those utilizing the Care Notebook will be used to guide revisions and updates. The Care Notebook is also available as a fillable PDF.

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 collaborative, BCHW will contract with the University of Missouri Kansas City Institute for Human Development to assist with reviewing and adapting existing nutrition and physical activity strategies to ensure people of all abilities are included. 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, several other initiatives contribute to Missourians receiving coordinated, comprehensive, family-centered, and ongoing health care services. In October 2011, CMS approved Missouri's State Plan Amendment (SPA), establishing Medicaid reimbursement for health homes and making Missouri the first state in the nation to have an approved SPA for health home services. This first SPA established the Community Mental Health Center (CMHC) Healthcare Homes to serve 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 system 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 and addresses community and population-level factors that influence health outcomes for individuals with medically complex needs. One aspect of PCHH includes implementing and evaluating the Patient Centered Medical Home (PCMH) model. PCHH emphasizes integrating primary and behavioral health care 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 comprising a multidisciplinary team, including clinicians, 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 participant in the case management program. Missouri's pediatric hospitals also provide services that support comprehensive, coordinated, and ongoing health care. 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 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 received. SHCN programs include Adult Brain Injury (ABI), CYSHCN, HCY, Family Partnership, and Medically Fragile Adult Waiver (MFAW). Bureau programs that serve cyshcn include CYSHCN, HCY, and Family Partnership. In addition to these programs, SHCN provides funding to Missouri Assistive Technology for the Kids Assistive Technology (KAT) project, which improves access and reduces barriers for cyshcn. SHCN also 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 years, have an eligible special health 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, evaluation, and transition/closure. SHCN maintains contracts with multiple LPHAs to provide service coordination for the CYSHCN Program. CYSHCN SCs 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. SCs 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 Title V funding.

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 SCs 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 funding.

The SHCN Family Partnership Program 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 Program hosts events to benefit families through the 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 Program is funded primarily through Title V funding and secondarily through the HRSA Universal Newborn Hearing Screening and Intervention Program Grant. Additional information about SHCN Family Partnership can be found in the Family Partnership section of the grant application.

MITT, established in accordance with Revised Statutes of Missouri, RSMo Section 162.1000, was formed in 2007 by the Office of Special Education at DESE to increase interagency collaboration at the state, regional, and local levels. MITT meets quarterly to address data-driven goals for improvement and collaboration, with the shared vision of improving employment, independent living, and postsecondary education outcomes for Missouri students with disabilities. The MCH Director and SHCN Nurse Manager are appointed to serve on the MITT, which includes representatives from a various state agencies concerned with transition, to share information, network, and partner to coordinate professional development activities related to transition for students with disabilities.

NOTE: Interagency data-sharing agreements and agreements to strengthen the medical home model of care for cyshcn are linked in Section IV. Title V-Medicaid IAA/MOU.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Percent of children and parents participating in a family skills development and strengthening program who report improvement on program evaluation metrics.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	67.0	69.0	71.0	73.0	75.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Missouri) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Strengths-based services and supports to promote healthy family relationships and functioning, enhance resilience, foster social connections, and support children's social and emotional development.

SPM

SPM 1 - Percent of children and parents participating in a family skills development and strengthening program who report improvement on program evaluation metrics.

Five-Year Objectives

By September 30, 2030, Missouri will increase the percentage of children ages 6-17 years who are flourishing, as evidenced by "usually" or "always" demonstrating self-regulation, showing interest and curiosity in learning, and working to finish tasks, from 56.4% to 60.0% (NSCH 2022-2023).

By September 30, 2030, based on standardized pre- and post-participation survey results, at least 75% of children and parents participating in a family skills development and strengthening program will report improvement on at least 75% of program evaluation metrics.

Strategies
Partner and collaborate with cross-sector stakeholders to implement family strengthening frameworks.
Collaborate with partners to create supportive environments that promote connectedness and healthy and empowered individuals, families, and communities.
Partner and collaborate with cross-sector stakeholders to implement programs/initiatives to promote strong parent-infant relationships, infant and early childhood mental health, and social, emotional, and cognitive well-being across a child's lifespan.
Partner with judicial systems to support families, increase knowledge and skills around parenting, and support completion of family-strengthening curriculum(s) as recommended or court-ordered.
Engage community-based organizations and partners and community members to develop, implement, and maintain community-based educational campaigns, programs, and initiatives to promote healthy family relationships and functioning, enhance resilience, foster social connections, develop knowledge of parenting and child development, and support children’s social and emotional development.
Promote patient/family-centered shared care planning to operationalize core values of family-centered care and ensure families are full partners in health care.
Promote education and awareness of community-based emergency preparedness and recovery programs and resources that prepare families for emergency situations and responses and champion family self-sufficiency.
Engage with partners to implement a whole-person approach that supports and enhances the functioning and resilience of families and considers all aspects of well-being – physical, mental/emotional, social, and spiritual.
Provide health information that is accessible, clear and actionable to enhance health literacy skills for families.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

2021-2025: State Performance Measures

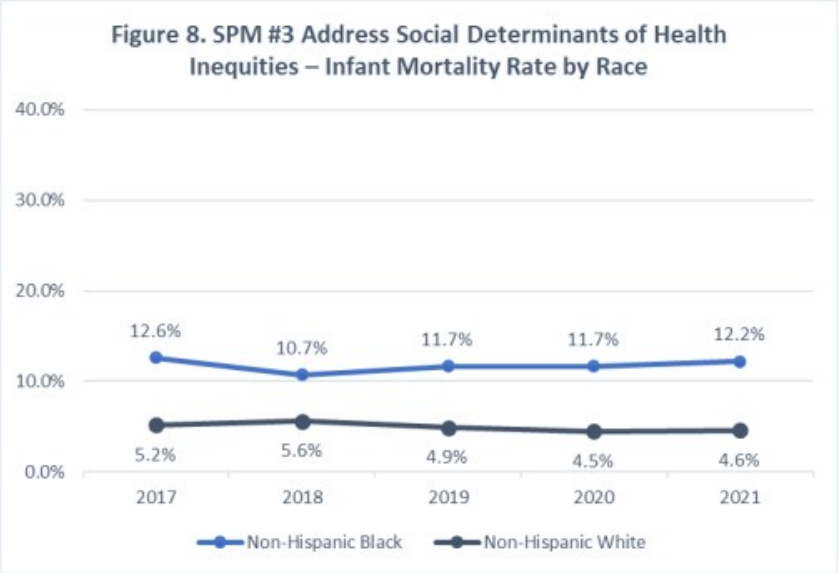
2021-2025: SPM 3 - Number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		20	100		
Annual Indicator		48	90	102	219
Numerator					
Denominator					
Data Source		MO DHSS Internal Survey	MO DHSS MCH Training Log	MO DHSS MCH Training Log	MO DHSS MCH Training Log
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

SPM #3 Address Social Determinants of Health Inequities

Existing economic and health disparities indicate a continuing need for prioritizing efforts to address the community and population-level factors influencing health outcomes. Missouri's poverty rate has declined each year from 14.8% in 2015 to 12.6% in 2023[1], suggesting increasing economic stability for some Missourians. However, additional examination of Missouri's poverty rate indicates poverty is consistently higher among Non-Hispanic Black and Hispanic compared to Non-Hispanic White. In 2023, the poverty rate for Non-Hispanic White Missourians (10.8%) was lower than that of both Non-Hispanic Black (23.0%) and Hispanic (18.7%) Missourians.[2] Geographic disparities in poverty also exist with a 11.5% poverty rate for urban counties in 2023 compared to a 14.9% poverty rate for the rural counties in the same year.

Health care access and quality is also a primary community factor that influences health. Disparities in both infant and maternal mortality indicate a need to explore improvements in health care access and quality. Missouri Vital Statistics data denote the Missouri infant mortality rate for 2023 was 5.9 per 1,000 live births. Though there was an increase in Missouri's overall infant mortality rate from 2021 (5.7) to 2022 (6.5), the infant mortality rate decreased 9% from 2022 to 2023. The disparity between maternal mortality in Non-Hispanic Black women and Non-Hispanic White women persisted since 2017 (Figure 8). The 2019-2023 maternal mortality rate for Non-Hispanic Black women (54.4 per 100,00 live births) was more than double that of Non-Hispanic White women (21.4).



To gain buy-in and build internal awareness and understanding across MCH programs and DHSS overall, MCH Leadership implemented a core MCH training plan, including didactic and interactive experiences for leaders, team members and MCH program staff. MCH workforce development trainings include content related to foundational MCH knowledge and skills, the impact of community and population-level factors that influence health outcomes, and effectively integrating strategies to address community-related health factors and disparities in health outcomes into policies and program services and activities. Additional learning opportunities related to public health, MCH, Life Course Perspective, health disparities, health literacy, and emergent issues of potential import for maternal and child populations are shared with internal and external MCH partners through the MCH Newsletter, monthly virtual MCH Learning Community convenings, and email communication. MCH leadership continues to develop and implement the MCH training plan to establish initial and ongoing training requirements for internal MCH program staff and external contractors.

In alignment with the DHSS *Culturally and Linguistically Appropriate Services Standards* Policy, revised 5-12-

2025, the Culturally and Linguistically Appropriate Services (CLAS) standards are recognized as best practice guidelines to provide a uniform framework for developing and monitoring culturally and linguistically appropriate services. The policy includes the following definitions:

- Marginalized populations are those excluded from mainstream social, economic, cultural, or political life.
- Culturally and Linguistically Appropriate Services are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization (regardless of size) at every point of contact.
- Cultural Competency is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to cultural contexts in communities.
- Linguistic Competency is the capacity of individuals or institutions to communicate effectively at every point of contact. Effective communication includes the ability to convey information – written, oral and digital - in a manner that is easily understood by a variety of groups, including persons of limited English proficiency, those who have low literacy skills or who are not literate, those having low health literacy, those with disabilities, and those who are deaf or hard of hearing.

The complex needs of the maternal and child population are kept in mind during all stages of program and service delivery, with all programs and services culturally and linguistically aware and appropriate during all stages of programmatic and service delivery, to provide effective, impartial, understandable, and respectful quality care and services that are responsive to a variety of cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Special focus is given to marginalized and underrepresented populations and communities to strive towards impartial and optimal health outcomes for all populations.

The person-centered approach 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 funded programs and services 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.

Other Title V MCH Activities Related to the Cross-Cutting & Systems Building Domain

Newborn screening impacts nearly every baby born in Missouri regardless of their socioeconomic status and cultural background. The Newborn Blood Spot Screening Program sought to understand the parents' experience with newborn screening by implementing an improved survey process. The parent survey includes questions assessing barriers to seeking needed repeat screens or additional testing. The survey asked for voluntary demographic information to ensure data was gathered from varied and disparate populations. The program's goal was to determine areas of the newborn screening population where access or information was lacking to help improve outreach strategies and enhance capacity to provide more meaningful education to parents. The newborn screening team worked to seek out and participate in opportunities to further understand ways to provide more culturally and linguistically appropriate services to the geographically and demographically varied population affected by newborn blood spot screening.

The Missouri Newborn Hearing Screening Program (MNHSP) continued striving to ensure all babies born in Missouri received timely hearing screening and appropriate follow-up to increase the likelihood that children with hearing loss achieve speech and language developmental milestones. MNHSP staff, along with Family Partners and MOHears, worked to follow-up with families who may have had missing hearing or diagnostic results to reduce the

number of families lost to follow-up. During calendar year 2023, the MNHSP tracked and followed up on 2,463 newborns who failed to pass their initial newborn hearing screening and 865 newborns who missed their hearing screening. Ultimately, the MNHSP identified 125 newborns with permanent hearing loss and facilitated referral for these newborns to early intervention through Missouri's Part C Program, First Steps.

The TEL-LINK Program collaborated with MO HealthNet to provide 122 referrals for Medicaid services to increase insurance coverage. TEL-LINK collaborated with partners to provide referrals on various 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 various 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 Safe Cribs for Missouri Program continued to ensure culturally and linguistically appropriate resources and educational materials were available to participating agencies for preventing Sudden Unexplained Infant Death and promoting safe sleep practices and environments during initial and follow-up educational sessions provided with crib placements.

The Childhood Lead Poisoning Prevention Program (CLPPP) focused on available data analytics to identify gaps in care and disparities in blood lead testing across the state. Once identified, outreach strategies were implemented and resources distributed to address disparities on a priority basis. CLPPP also worked with national partners to develop and distribute culturally and linguistically appropriate resources related to lead poisoning prevention. CLPPP conducted a health literacy review on several documents and made translated documents accessible online to address populations for whom English is not the primary langauge. Three documents were reviewed for health literacy and translated into other languages based on identified needs. Risk assessment forms provided to families were revised from a baccalaureate reading level an 11th grade reading level (due to including regulatory language).

Through the Inclusion Services (IS) Program, child car inclusion specialists provided referrals to appropriate services, including those provided as a part of child-specific action plans by local public school districts. Specialists helped child care providers identify community factors that influence health, such as housing, food security, poverty, or exposure to violence, as potential factors impacting children's behaviors. This increased child care providers' knowledge and skills on how to better work with and maintain care for children with special needs, resulting in a reduction in preschool expulsions.

The Bureau of Special Health Care Needs (SHCN) Service Coordinators and Family Partners focused on the community factors that influence health for families of children and youth with special health care needs (cyshcn). DHSS SHCN Family Partners provide the unique perspective of parents of cyshcn. 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 and physical environmental factors (such as social inactivity and barriers keeping the individual 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 status, family functioning (such as family stability and availability of a support system for the family), and cultural and belief systems. Both SHCN Service Coordinators and Family Partners frequently connect families with resources for food, housing, utilities, social support, 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 annual application and report.

Leveraging funding from the CDC State Physical Activity and Nutrition (SPAN) grant, DHSS provided an advanced

level 45-hour lactation consultant preparation course. The course was made available to participants from areas of the state with low breastfeeding rates and disparities in breastfeeding practices. 44 individuals from 31 unique sites completed the course. Sites included 20 WIC clinics, 6 hospitals, 2 other clinics, 2 community sites, and 1 family-nurse partnership. 61,686 people were potentially impacted by the lactation education training received. (The total potential population reach is based on WIC caseload data only, to avoid potential count duplication due to dyads receiving services at multiple locations.) In addition to the level 2 lactation training, DHSS provided a level 1 lactation training, providing the 90 hours of lactation specific education needed to sit for the IBCLC exam. Every effort was made to encourage women representing local communities to become peer counselors or International Board Certified Lactation Consultants (IBCLCs) in regions where disparities in breastfeeding support exist. WIC local agencies recruited breastfeeding peer counselors (BFPCs) from the local WIC population in an effort to ensure that BFPCs are culturally congruent with the population served. During FY 2024, the WIC state agency developed a new career ladder for paraprofessionals in WIC, including BFPCs to allow BFPCs to become WIC competent professional authorities (CPAs) by serving in a paraprofessional role for four consecutive years or by attaining the IBCLC certification. This will allow WIC to retain talented, motivated employees with experiential insight and to broaden the experiential background of WIC professional staff, making it easier to recruit and retain representative lactation staff. Policies relating to these changes were approved by the USDA during FY 2025, and training on the changes was provided to local WIC agencies. The changes will be implemented in FY 2026.

The Missouri Physical Activity and Nutrition (MPAN) Program collaborated with the Health Care Work Group/Healthy Weight Advisory Committee, a Missouri Council for Activity and Nutrition (MOCAN) subgroup. 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 supported the committee's efforts to increase workforce capacity to deliver weight management treatments aligned with the available MO HealthNet benefit for children and adults.

The Adolescent and School Health Program (ASHP) implemented the School Nurse Chronic Health Assessment Tool (SN CHAT). The ASHP broadly promoted the tool as a resource for school districts to improve the quality of student health information and plan to address student health and education needs appropriately. The two main components of SN CHAT include 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 to enhance school nurse efficiency in asking pertinent questions in a collaborative approach with parents. It was developed to be used in a face-to-face conversation or by phone with the parent or guardian.

As a member of the Medicaid Advisory Council, the ASHP continued to collaborate and partner with the MO HealthNet Managed Care plans, FQHCs, other state agencies and programs, and supported organizations to provide information, tools, and resources to school nurses. These materials equipped school nurses with information about health care plans and services to aid with assisting parents and families to obtain adequate health insurance coverage and access health plan benefits and health care services. The outreach materials and patient education are available in multiple languages and reviewed by health literacy professionals to ensure the messages are appropriate for targeted audiences and communities. DSS shared data with ASHP to review and identify trends in the number of children enrolled in Medicaid annually. The ASHP also compared this to data on the number of students reported as uninsured from school nurse reporting. With the expansion of Missouri Medicaid eligibility to healthy adults, the ASHP worked with school nurses to provide information and resources to support them in assisting families with Medicaid enrollment.

The ASHP and the MCH Director are part of the steering committee of the *Show-Me School-Based Health Alliance*. The need for students to miss school and/or parents to miss work for medical appointments is a barrier to seeking care. The Alliance worked with partner organizations and community stakeholders to expand the number of school-based clinics and services offered. The number of school-based health centers in Missouri increased from five in 2017 to 106 (not including satellite clinics).

The ASHP collaborated with school health staff in 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 nurses in Missouri schools. The ASHP used the data to monitor the staffing of school health services and identify school districts without designated school health staff. The program offered additional support and technical assistance to ensure the minimum level of health services were available. The database also collected district-level data for students with health insurance. The data is used as an indicator for health care access and is shared with state and local leaders. The ASHP engaged school nurses to utilize the reporting system and investigate options to update the database to improve data collection, access, and sharing.

The ASHP has been undergoing a strategic planning process and plans to re-organize future Council for Adolescent and School Health (CASH) activities and relaunch the council in 2025.

The MCH Services Program supported LPHA efforts to:

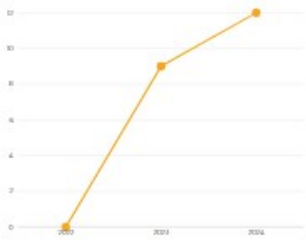
- Increase the number of clients that receive a risk assessment or screening and referral for Medicaid eligibility;
- Assure all women of childbearing age received preconception care services to enable them to enter pregnancy in optimal health; and
- Develop and promote strategies to increase the proportion of women receiving prenatal care beginning in the first trimester.

LPHAs continued 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 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.

MCH Leadership continued 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. The MCH Director facilitated MO HealthNet presenting information about the Notification of Pregnancy portal to LPHAs on one of the regularly scheduled LPHA Update Calls, and the presentation recording and slides were posted on the LPHA website. Informational flyers for MO HealthNet's series of networking meetings for MO HealthNet providers & community partners, "Optimizing Missouri's Managed Care Plan Benefits for Maternal and Infant Health," were shared with the LPHAs and other MCH partners.

The MCH Services Program contracted with 112 LPHAs to address priority MCH issues in their community. The LPHA FY 2022-2026 MCH contract work plans include evidence-based strategies to address their selected local priority health issues, including addressing community and population-level factors that influence MCH outcomes, existing health disparities, and gaps/weaknesses in access to care. Jackson County Public Health changed organizational practices to address health disparities among preconception, prenatal, and postpartum women from a baseline of zero perinatal women in FY 2022 to a total of 12 by the end of FY 2024. After meeting with the Cultural Health Navigator in the Health Services Division and identifying a need for a MCH resource packet in Spanish, the Program & Policy Specialist consulted with CHWs at Jackson County Public Health to compile a packet of local resources, including education and resources, such as resources created and translated by government websites (such as the CDC), on dental and vision services, marketplace insurance enrollment, and childhood nutritional education to share with Spanish-speaking pregnant, postpartum, and parenting clients who requested resources for these types of services. Feedback received from Spanish-speaking families has been positive, showing gratitude for sharing knowledge, especially around clinics and services that are in close proximity, in their own language.



The Child Care Health Consultation (CCHC) Program provided consultation and training for child care providers and health promotions for children in child care at licensed and license-exempt child care programs, including those that contract with the Child Care Subsidy Program. The CCHC Program Coordinator assisted LPHA staff in developing resources for child care providers and families and health promotions for children in child care. CCHC services were inclusive of adults and children of all abilities and addressed the community and population-level factors that influence health outcomes and safety. These services are provided at no cost to the child care provider to ensure everyone has access to program services promoting safe and healthy environments. LPHA staff assessed children in child care for health care access referral needs, including MO HealthNet for Kids, immunizations, health care providers, developmental screening, and WIC. CCHC services assisted child care providers to identify and utilize community-based resources and organizations to address health disparities. In FY 2024, Child Care Health Consultants received in-depth orientation and training on using Missouri Family Resources, a free statewide website and mobile app that can be used by families and early childhood professionals to connect children and families to resources in their communities. Child Care Health Consultants received information about the Office of Childhood Community Leaders, who develop and implement plans to ensure young children and their families can access high-quality programs, services, and resources in their respective communities. Through connection to these resources, more children and families were aware of available resources and had access to health care and proper nutrition. The CCHC Program encouraged family participation in all services and provided consultation and training for child care providers on developing and implementing procedures to promote strong family partnerships for optimal health and safety of children in child care.

The Title V funded Home Visiting Programs' contracted home visitors assessed all clients for insurance status at initial enrollment and periodically throughout enrollment. Home visitors assisted clients/families in the Medicaid enrollment process by linking clients with their nearest FQHC to speak with a trained navigator and obtain eligibility and enrollment assistance. Home Visitors also utilized ParentLink Navigators to assist individuals in completion of enrollment applications. In FY 2024, 80% (217/272) of primary caregivers and 89% (225/252) of enrolled children reported continuous insurance coverage during the program year. Insurance coverage ensures children and primary caregivers can access adequate and responsive preventive health care, including well-child visits. In FY 2024, 97.32% of children enrolled in home visiting (291/299) received the recommended well-child visits based on the AAP periodicity schedule of Recommendations for Preventive Pediatric Health Care.

The Office on Women's Health (OWH) promoted health care access across all programming. The maternal mortality team and Pregnancy Associated Mortality Review (PAMR) Board reviewed all maternal deaths for contributing community and/or population-level factors. The data identified issues and supported recommendations to promote trauma-responsive and culturally and linguistically appropriate care and services. Recommendations in the most recent PAMR report included encouraging health care facilities to utilize social workers, CHWs, and doulas during pregnancy and postpartum to increase continuity of care for referrals, care coordination, communication and addressing community factors influencing health; and requiring all health care staff to undergo training on trauma-informed and impartial care at least annually. With the use of state funds allocated to prevent maternal mortality, the OWH contracted with the Missouri Hospital Association to help hospitals implement these recommendations.

In women's health programming, the OWH ensured materials developed and distributed included evidence-based information to address gaps/weaknesses in access to care and health disparities. This was done through prevention

materials for maternal mortality and the regular updates in the monthly *Women's Health Network Update* newsletter. The violence prevention team worked across topic areas to promote a representative CHW workforce. The OWH partnered with the Missouri Coalition Against Domestic and Sexual Violence to develop and implement a training to educate CHWs on domestic and sexual violence and the overlap with community factors that influence health.

The Office of Dental Health (ODH) promoted accessibility across all programs. Based on responses from LPHAs regarding the primary languages of their community members, ODH had several pieces of oral health literature translated into seven different languages and placed online for download or printing.

To continue building a comprehensive maternal-child public health system to address the priority needs of Missouri's MCH population, the MCH Director and leadership team continued 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 community and population-level factors that influence health outcomes, health literacy, disparities in MCH outcomes, and promoting impartial and optimal health outcomes for MCH populations;
- Promote trauma-responsive and culturally and linguistically appropriate MCH programs and services;
- 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, representative, and well-trained MCH workforce.

Additional Performance Analysis

The Newborn Screening Program distributed 2,573 electronic parent surveys. The surveys included the following voluntary questions with responses as indicated:

- *How old are you?*
  - 108 responses received
    - Under 18 years = 3.70%
    - 19-29 years = 49.07%
    - 30-39 years = 42.59%
    - 40 years or older = 4.63%
- *What is the highest level of school you have completed or the highest degree you have earned?*
  - 107 responses received
    - Did not graduate high school = 8.41%
    - High school graduate or diploma = 34.58%
    - Associate or bachelor's degree = 36.45%
    - Graduate or professional degree = 20.56%
- *What ethnicity do you identify as?*
  - 107 responses received
    - Hispanic/Latino = 5.61%
    - Not Hispanic/Latino = 94.39%
- *What race do you identify as?*
  - 110 responses received
    - White = 80.91%
    - Black or African American = 10.00%
    - American Indian or Alaska Native = 0.91%
    - Asian = 1.82%

        - Native Hawaiian or Pacific Islander = 3.64%
        - Other = 2.79%
- *What is your [sex]?*
    - 107 responses received
        - Male = 6.67%
        - Female = 93.46%

Overall, survey results indicated parents responding identified as females between the ages of 19-39 years old, not Hispanic/Latino, white, and with some level of post high school education. The parents who responded to the question about barriers to obtaining a repeat screen when needed overwhelmingly reported untimely communication or no communication at all from their primary care providers regarding screening results. Prior to collation of the survey results, the program updated an information insert sent out in parent notification letters to include information in English on one side and Spanish on the other side. In addition, literature and presentation materials have been updated with more current photos of families representing local communities.

CLPPP identified lack of resources as a barrier to successful mitigation of lead hazards in the homes of children with elevated blood lead levels. Cleaning supplies and HEPA (High-Efficiency Particulate Air) certified vacuums were provided to families that engaged in the risk assessment process. Cleaning supplies, including buckets, wet mops, cleaning rags, and painting supplies, were provided to over 50 families, and 8 vacuums were distributed to families with significant lead dust hazards. Two families drastically reduced lead dust hazards in their home, and additional data is pending for the other families.

LPHAs anecdotally expressed gratitude to ODH team members for creating educational materials with oral health information available in several languages in response to LPHAs expressing the need for materials in other languages to meet the needs of their community members.

CCHC Program trends show an increased number of LPHAs participating in the program, resulting in an increased number of counties that are eligible to receive services and an increase in the number of service hours provided annually. LPHA jurisdictions with CCHC Program coverage increased from 96 to 102 from October 1, 2022 to September 30, 2024.

Challenging behaviors can be indicators of special needs such as sensory processing disorders, ADHD, autism, etc., and Inclusion Specialists reported the majority of their work centered around services for children with challenging behaviors related to undiagnosed perceived special needs opposed to diagnosed special needs. Inclusion-related trainings were offered to support child care professionals, families of children with special needs, and the community.

<u>Challenges</u>
The Newborn Screening Program experienced limited responses to survey efforts, difficulty developing and maintaining communication with the vast number of pediatric primary care providers, and limited program staff and resources. Data reported by the Newborn Hearing Screening Program for the rate of families lost to follow-up in calendar year 2023 showed:

- Loss to follow-up following birth = 0.58%.
- Loss to follow-up following final hearing screening = 18.93%.
- Loss to follow-up following diagnosis = 10.96%.

CLPPP experienced difficulties getting families to allow risk assessors back into the home for follow-up testing to ensure lead hazards had been reduced to meet EPA recommended levels.

Limited DHSS, LPHA, and partner workforce capacity, workforce turnover, difficulty recruiting and retaining qualified workforce members, shifting priorities, and financial constraints limit the scope of existing program activities and services and prevent implementation of new program activities and services to prioritize efforts to address

disparities in health outcomes and community and population-level factors that influence health outcomes. Workforce limitations correlated with decreased contractor participation in training and professional development opportunities. DHSS programs also report challenges in providing hard copy informational/educational materials due to insufficient funding to support printing costs, and the new investments in resources, training, technical savvy, and creativity required by the new federal accessibility requirements for online materials.

LPHA workforce turnover and limited capacity are obstacles to accomplishing the deliverables of the MCH Services contract. Historically and pre-COVID, the MCH Services Program provided New MCH Coordinator Orientation to approximately nine new LPHA MCH Coordinators annually. In FY 2024, the MCH Services Program provided New MCH Coordinator Orientations to 62 new LPHA MCH Coordinators. MCH Coordinators often left the role abruptly or with little time to share knowledge related to the contract work plan, and in many instances, the person assuming the role of MCH Coordinator had limited public health experience or experience managing grants/contracts. Recognized the opportunity to increase knowledge and skills for LPHA MCH Coordinators, the MCH Services Program developed additional MCH professional development opportunities for LPHA team members.

Home visitors faced challenges in maintaining current information for eligibility for health care services and changing processes for enrollment in health care coverage. Home Visitors were encouraged to utilize resources such as ParentLink Navigators and FQHCs. Home visitors also frequently educate families that the purpose of periodic well child visits is much more than only updating immunizations and also includes development screening, assessing for and addressing possible emerging health or development concerns, answering parent/caregiver questions, and reassuring parents/caregivers the child is developing and behaving as expected for age. Many parents do not understand the importance of well child visits until the home visitor provides the information.

Opportunities

The Newborn Screening Program will use the electronic parent survey results to determine if questions can be redesigned to encourage a broader population of parents to respond. The program will continue to seek ways to better collaborate with providers to educate on the importance of communicating test results and any follow-up actions needed to parents.

CLPPP will use the information collected during risk assessments to determine future resources needed by families. Families often requested paint to assist with home repairs, and the program is researching ways to provide this resource, including paint recycling centers and purchasing paint in special circumstances (for example, bitter paint for children with pica).

ODH is exploring alternative ways to make translated materials available and accessible for LPHAs.

In the annual MCH Services Program survey, disseminated to 112 LPHAs, 92% (100/109) agreed the following program initiatives and activities helped increased awareness of resources, opportunities to network with others, and overall knowledge and skills related to maternal child health issues.

- Virtual Contract Opening Meeting, hosted annually in October, to provide technical assistance on the contract Scope of Work: All LPHA staff working with the MCH Services contract in any capacity are invited to attend. The webinar recording is shared for those unable to attend the live meeting.

- MCH Services Contract Work Plan toolkit is a compilation of activities completed by LPHAs within the previous contract year. The toolkit increases the visibility of LPHA efforts, peer-to-peer sharing, and knowledge of evidence-based strategies.

- Virtual MCH LPHA Networking Meetings, hosted annually in the winter months and guided by feedback received from LPHAs on the annual program evaluation survey, feature a content expert speaker and a facilitated networking session.

- The MCH HUDDLE is held quarterly to encourage individuals to work together rather than alone. Participants

discuss issues they are struggling with, compare notes about possible solutions, and make a commitment to work toward improvements, specifically working to achieve MCH Services contract deliverables and outcomes. Each MCH HUDDLE hosts a content expert on a MCH issue, followed by a LPHA Success Story, and closing with a facilitated discussion by the MCH District Nurse Consultants (DNCs).

- The MCH Exclusive, a monthly email to LPHAs, includes resources and answers to frequently asked questions and facilitates rapport between the DNC and LPHA MCH Coordinator/Administrator. The DNCs share the responsibility of compiling and reviewing MCH Exclusive content.

- New MCH Coordinator Orientation training is provided to all new LPHA staff working with the MCH Services contract to ensure staff understand the Scope of Work and have the knowledge and skills to carry out the work plan.

Based on evaluation of trends in usage of services for Inclusion Services, the Program will be changing the scope of work to focus more services specifically with children with diagnosed special needs, supporting families throughout their early childhood journey, and continuing to educate child care providers on best practices when working with children with special needs. There will be new opportunity to collaborate with the Infant Early Childhood Mental Health Consultation Program to best meet the needs of the community.

Due to the implementation of the new Missouri Professional Development (MOPD) System for clock hour trainings and professional development for child care providers, the CCHC Program team has provided additional technical assistance, training sessions, and training guides on using the MOPD System for Child Care Health Consultants. The CCHC Program team also incorporates feedback from guest speaker presentations, feedback from the annual program evaluation survey, and suggestions for new trainings and health promotions from Child Care Health Consultants and child care providers into annual program planning and development.

Cross-Cutting/Systems Building - Application Year

SPM: Strengthening Families - Strengths-based services and supports to promote healthy family relationships and functioning, enhance resilience, foster social connections, develop knowledge of parenting and child development, and support children's social and emotional development.

Prevention, Connection, and Education/Skill Development
OWH will develop partnerships with community-based organizations to implement strategies that build community connectedness and strengthen economic security for families. OWH will collaborate across programs, including Adolescent and School Health (ASHP), MCH Services, and the Center for Local Public Health Services, to identify partners for a new violence prevention initiative that will also address multiple risk and protective factors for family health. Partners will work collaboratively to build community connectedness in non-traditional third spaces, such as libraries and laundromats, to encourage community gathering. Partner organizations will identify strengths and opportunities for connection and additional venues/locations to host community gatherings. Examples of work that could be accomplished include sponsoring health fairs, developing mentoring programs, sharing early literacy information, hosting parenting classes, and other identified relevant strategies. OWH will leverage other federal funding sources to sponsor kick-off events to alert the communities to these new partnerships. Examples include sponsoring a health fair, a free laundry day at a laundromat, or a car tune-up event. Laundromats are disproportionately used by Medicaid-eligible populations and have disproportionately high levels of unmet needs, making laundromats a great place to begin outreach efforts for low-income and/or uninsured families with more health-related social needs. Community connectedness will be strengthened by cross-sector partnerships to sponsor ongoing events. OWH will provide technical assistance and resources to the local organizations. This combined effort will meet multiple goals, including enhanced community connection to prevent sexual violence, more partnerships for sharing health information, improved parental understanding of child development, and reduced economic strain for families. OWH will share the success of these initiatives, partner organization resources, training, and funding opportunities for improved family health with community partners through the Women's Health Network Update.

ASHP aims to contract with a juvenile justice partner in central Missouri to pilot the evidence-based curriculum, Making Proud Choices, intended to reduce the risk of unintended pregnancy, HIV, and other STIs and increase knowledge and perception of personal vulnerability, develop positive attitudes toward safer sex, and build skills and confidence to abstain successfully or to use safer sex practices willingly and effectively. Through this partnership, ASHP will expand and grow partnership to reach additional at-risk youth and support protective factors that contribute to stronger short- and long-term youth and family outcomes.

ASHP will partner with LPHAs, school districts, and community partners to provide an evidence-based curriculum for adolescent females ages 14-24 years, focused on healthy decision-making about relationships, pregnancy, partnering, and more. Each session includes additional time to facilitate guest presentations on a variety of topics related to pregnant and parenting teen mothers. Additional topics (navigating support as a young person, engaging trusted adults, and accessing resources that promote well-being, resilience, connection within families, etc.), partnerships, and areas for improvement will be identified and considered through performance improvement monitoring as the program pilot is implemented.

32 LPHAs will complete year five contract work plan activities to promote protective factors for youth and families and achieve targeted system outcomes outlined in FY 2022-2026 contract work plans. A contract outcomes report will be completed, evaluating performance trends and providing conclusions across the five-year contract work plan cycle.

The MCH Services Program plans to increase educational and technical assistance opportunities to increase LPHA knowledge and skills to develop FY 2026-2030 contract work plans utilizing the MCH Evidence *What Works Evidence Accelerators*, including the following evidence-based strategies to increase the percentage of children and parents participating in a family skills development and strengthening program who report improvement on program evaluation metrics:

- Partner and collaborate with cross-sector stakeholders to implement family strengthening frameworks, and
- Create supportive environments that promote connectedness and healthy and empowered individuals, families, and communities.

The Bureau of Special Health Care Needs (SHCN) will partner and collaborate with cross-sector stakeholders to implement family-strengthening frameworks and promote health and well-being across the lifespan. SHCN will participate in statewide workgroups, councils, outreach events, and public education opportunities to inform others about SHCN programs and services, emphasizing the

role these services play in supporting families. Examples of workgroups and councils include the Missouri Commission on Autism Spectrum Disorders, Developmental Disabilities Council, Assistive Technology Advisory Council, Interagency Transition Team, Children's Cabinet, Newborn Hearing Standing Committee, and Brain Injury Advisory Council. SHCN Family Partners and Children and Youth with Special Health Care Needs (CYSHCN) and Healthy Children and Youth (HCY) Service Coordinators (SCs) will prioritize the development of strong, healthy family relationships by empowering caregivers in their role(s). Both Family Partners and SCs play a key role in fostering empowered families by connecting families to programs, services, and community resources that promote healthy living. Through service coordination and the Family Partnership Program, SHCN will connect participants and families to community resources, such as accessible parks, recreational activities with accessible facilities, and other supports that promote active, healthy lifestyles for individuals with special health care needs.

SHCN will promote family preparedness by connecting families with community-based emergency preparedness resources, including the STARS (Special Needs Tracking and Awareness Response System) program. SCs and Family Partners will help families understand the importance of emergency planning and provide them with resources to be prepared for emergency situations. SHCN supports comprehensive and coordinated systems of care by promoting patient and family-centered shared care planning. Annual Service Coordination Assessments (SCAs) will be conducted collaboratively with participants and families, and include unmet needs, goals, and plans identified by the family. The SCA also assesses whether the participant/family feels like a partner in decision-making with their SC. SHCN is committed to enhancing health literacy by revising both electronic and printed materials to ensure accessibility and compliance with Section 504 of the Rehabilitation Act (501 compliance). Family Partners will contribute to the review of SHCN outreach materials to ensure content is accessible, clear, and actionable. By continuing to connect families with supportive services, accessible environments, and opportunities for engagement, SHCN will ensure individuals and families are supported and empowered to thrive.

ODH will work closely with the Missouri Coalition for Oral Health and MO Healthnet to increase the number of Medicaid-enrolled providers and the number of dental visits among the entire population, including the MCH population. Through separate funding, ODH supports teledentistry services in schools, allowing dental providers to offer preventive dental services to children during school hours. This supports the family unit by reducing the need for parents to miss work or coordinate transportation for dental visits, while ensuring children receive timely oral health care.

The Prenatal Substance Use Prevention (PSUP) Program will promote healthy pregnancy and childbirth by engaging families on the importance of prenatal substance use prevention. 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 and explain the importance of a healthy pregnancy and childbirth. The PSUP Program maintains 33 sets of substance-exposed infant manikins and reallocates the sets based on requests by community partners.

As part of the Preventing ACEs (adverse childhood experiences) for Families Impacted by SUD initiative, the SUD Grant Program allows grantees to collaborate with partners to enhance socioeconomic support for families. Overall family health is promoted by improving access to essential needs and resources such as housing, food, and healthcare. The program aims to foster economic stability for individuals with substance use disorders (SUD) and their families through education and coaching and to implement family-friendly policies that focus on reducing ACEs. This proactive approach can help break the cycle of addiction and adversity, encourage healthier lifestyles, and reduce the risk of substance use-related harm within families and the community.

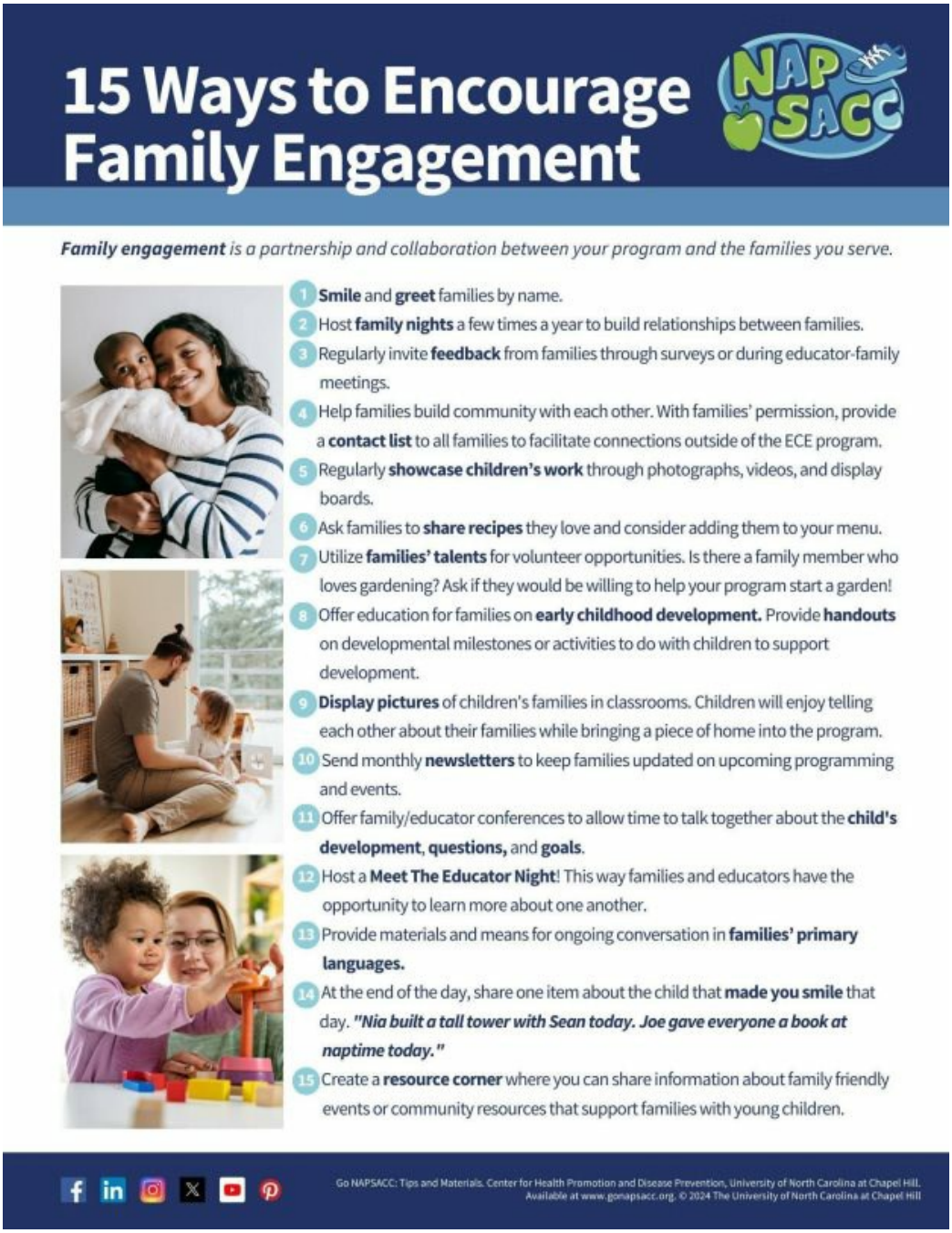
Early Care and Education

BCHW will partner with DESE, the Department of Agriculture (MDA), and the University of Missouri Extension to advance Farm to School/Farm to Early Care and Education (ECE) efforts. Many partnerships are made with local producers to incorporate local food production into school and ECE meals and learning curriculums. BCHW resources are accessible to ECE providers to enhance classroom learning and create opportunities for family engagement. For example, one provider is using Growing with MO resources to highlight a fruit or vegetable of the month and encourage families to participate at home by sharing photos showing family members engaging with the featured fruit/vegetable, connecting nutrition education between the classroom and the environment. BCHW will support ECE providers with nutrition, physical activity, and breastfeeding resources that can be utilized and adapted to extend healthy practices into families' daily routines. BCHW conducted a produce prescription/food is medicine landscape review to identify existing produce prescription programs throughout Missouri. Findings will help connect existing programs and identify successful approaches utilized in Missouri, including the funding framework, partners, and more. BCHW will support innovative fruit/vegetable program

efforts to increase community access to fresh produce, including fruit/vegetable boxes for WIC/senior participants as part of the MDA Farmers Market Nutrition Program, and mobile food markets in conjunction with voucher benefits, such as SNAP.

BCHW will support ECE provider implementation of policies and practices supportive of nutrition/Farm to ECE, physical activity, and breastfeeding best practices. Support will include providing training, resources, and technical assistance to achieve criteria for recognition as a Missouri MOve Smart Child Care and Missouri Breastfeeding Friendly Child Care. Additional Missouri breastfeeding initiatives include the Missouri Breastfeeding Friendly Worksite program and the Breastfeeding Welcome Here campaign. Collectively, these initiatives help create consistent, supportive environments that promote early parent-child bonding, reduce stress for caregivers, and reinforce protective factors that contribute to stronger, healthier families. Additional information on these initiatives can be found in the Perinatal/Infant Health domain.

As funding permits, BCHW 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 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 in achieving best practices for nutrition, physical activity, and breastfeeding within the early care setting. GoNAPSACC includes modules and action planning for nutrition, farm to ECE, physical activity, and breastfeeding. Child care clock hours are available to child care providers who complete GoNAPSACC training modules. As funding permits, the Physical Activity Learning Sessions (PALS) resources will be made available for ECE providers by technical assistants trained for each respective resource. Child Care Health Consultants at LPHAs can be trained as technical assistants/trainers for one or both GoNAPSACC and PALS, equipping them with the tools and resources needed to provide the training to ECE providers within their jurisdiction. PALS is focused on physical activity and utilizes the NAPSACC assessment modules for physical activity as part of its training curriculum. Completion of the trainings/modules prepares ECE providers to meet the policies and best practices aligned with the ECE recognition programs, including the Missouri Move Smart Child Care Program and the Missouri Breastfeeding Friendly Child Care Program. GoNAPSACC uses the 15 Ways to Encourage Family Engagement resource (inserted below) to encourage ECE providers to involve families in nutrition and physical activity initiatives and support children's health inside and outside of the early care and education setting.



Health and Wellness Initiatives

BCHW will promote built environments and community resources that support healthy and active living and clinical-community integration/coordination of service delivery to address nutrition/food security, physical activity and breastfeeding supports throughout community engagement with community-based organizations and providing technical assistance to enhance cross-sector collaboration among local businesses, worksites, health care, ECE, schools, food banks/pantries, farmers markets/local producers, local government entities, and other community partners. Addressing obesity requires collaboration among multiple organizations. Missouri brings partners together through the Missouri Council for Activity and Nutrition (MOCAN), the statewide obesity prevention council facilitated by the University of Missouri Extension. MOCAN's member organizations are structured into workgroups specific to settings or topics: Schools, Child Care, Physical Activity, Worksites, Food Systems, Health Care, and Healthy Aging. Supported by Title V funding, BCHW actively participates in MOCAN workgroups to support statewide improvements for physical activity and nutrition, including workgroup input and collaboration for the Missouri MOve Smart Child Care program, Missouri Breastfeeding

Friendly Child Care program, Missouri Complete Streets, Farm to ECE, and other food access initiatives that help strengthen the conditions in which families live, learn, work, and care for children. Partnership with MOCAN and its workgroups facilitate connections with Missouri stakeholders for promotion of Missouri's nutrition, physical activity, and breastfeeding initiatives.

Developing a healthier community involves creating a culture that promotes the benefits of healthful nutrition and physical activity and supports access to nutritious foods and safe places to be physically active. Public policy is essential in supporting opportunities for children, youth, and families to develop healthy nutrition and physical activity practices. Strategies to promote policy and environmental changes that can foster healthier communities in which opportunities for access to healthy foods and safe places to be physically active abound include collaboration with internal partners, LPHAs, youth, and statewide and community organizations with similar goals. 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 promote the toolkit and partner with other organizations assisting businesses in the state to improve employee health.

The MOCAN Physical Activity Workgroup additionally supports Missouri Complete Streets initiatives. Through partnership with the Missouri Complete Streets (MOCS) Advisory Committee, Missourians for Responsible Transportation (MRT), and other community partner organizations for community engagement and development of active transportation plans, BCHW aims to increase statewide partnerships to incorporate Complete Streets design and policies as part of community engagement and planning efforts. Through the development of local-level active transportation plans and Complete Streets policies, and training of Regional Planning Commission planners on how to incorporate active transportation into their planning efforts, the goal is regional-level active transportation plans and Complete Streets policies to help lead statewide active transportation efforts and increase safer, more accessible communities for families. MoDOT recently disseminated a statewide survey to identify Missouri's priorities for its Long Range Transportation Plan, which will inform MoDOT's efforts for next steps in the development of a statewide active transportation plan.

Safe and Healthy Environments

The SBC will train WIC local agency (LA) staff in child development concepts related to breastfeeding, including normal infant and young child behavior, feeding and satiety cues, and normal sleep patterns. WIC training also emphasizes motivational interviewing, participant-centered education, and giving parents evidence-based information to empower them to make informed decisions about how they will feed their children. These practices are utilized in all 116 WIC LAs. Missouri WIC also offers extra funding to WIC LAs that offer enhanced breastfeeding services and apply to be recognized as a Breastfeeding Friendly WIC Clinic. Enhanced services are best practices that are not required by USDA but are encouraged and include participating in the Breastfeeding Peer Counseling program, having a breastfeeding expert on staff, participating in a local breastfeeding coalition, and offering in-person group prenatal breastfeeding classes and an in-person breastfeeding support group. 53 WIC Las, serving 87.3% of the pregnant and breastfeeding women in Missouri WIC, qualify for this program and will receive funding for personnel time to support these services. Offering group classes, support groups, and peer support fosters social connections between pregnant women and breastfeeding mothers, helps to develop knowledge of parenting and child development, and promotes healthy family relationships. WIC LAs participate in local breastfeeding coalitions and partner with other stakeholders in the community to promote DHSS breastfeeding initiatives to hospitals and businesses, provide breastfeeding information directly to families at health fairs and "baby showers," and build robust referral networks in their communities to ensure families are referred for necessary care.

The Childhood Lead Poisoning Prevention Program (CLPPP) will partner with various community providers to raise awareness of common lead hazards that impact children in Missouri. The implementation of the new data and surveillance system (SMWC) will provide greater flexibility in data analysis and additional opportunities to track program goals and milestones. As funding permits, CLPPP will work to increase the number of risk assessments accepted by families across the state and distribute cleaning equipment to families in need to help reduce lead hazards in the home. SMWC will allow the program to track the number of outreach attempts, mailings, and risk assessments.

CLPPP will continue to offer in-person and online educational opportunities statewide to ensure families are provided education that is consistent across the state. To help evaluate impact, coordinated efforts to support case managers and providers will be tracked through the number of trainings offered, people trained, and information shared. CLPPP participates in public outreach events and creates updated materials annually to increase awareness of lead within the state of Missouri.

The Tobacco Prevention and Control Program (TPCP) will partner with schools, prevention resource centers, and other youth-serving organizations to support policies that prevent youth from using tobacco, protect families from secondhand smoke, and increase access to cessation services. Beginning in FY 2026, TPCP will provide a Community of Practice for K-12 schools and community partners to address youth vaping through implementation of comprehensive tobacco-free policies, including access to cessation, supportive discipline, and evidence-based prevention. TPCP facilitates a statewide youth prevention workgroup with engagement of multisectoral stakeholders. TPCP will partner with local coalitions and LPHAs to increase the number of workplaces and communities with comprehensive tobacco-free and smoke-free policies and with the American Lung Association to increase the number of multiunit housing properties with comprehensive smoke-free policies. Children who grow up in smoke-free and tobacco-free environments are less likely to begin using tobacco. Parents living in smoke-free buildings and communities are more likely to make their own homes smoke-free and are also more likely to quit using tobacco.

Special Supports

The Newborn Screening Program strengthens families by reducing the risk of mortality and morbidity related to undiagnosed and untreated metabolic, genetic, and endocrine disorders. Many conditions on the Missouri screening panel do not show obvious symptoms until irreversible damage has already occurred. Early diagnosis and intervention before illness develops can help a child live their healthiest life, which can also reduce stress and health care costs for families. Through educational materials and media, the program empowers families with the information they need to support their baby's health from birth. Additionally, the program aims to inform health care providers about the importance of newborn screening so they can better support families with accurate, current information. The parent survey distributed by the program results in some families choosing to share their lived experience related to newborn screening. Sharing families' experiences with stakeholders, health care providers, and other community health workers is one of the program's most impactful tools.

The Newborn Hearing Screening Program (NHSP) will work to decrease the number of infants reported as Loss to Follow-up Documentation (LTF/D) by educating families on the importance of rescreening, providing a parent survey to inform programmatic activities and disseminate resources, and providing support for families. The MOHear Project will be utilized to educate and provide technical assistance and training to hearing screening programs and audiology practices to improve reporting practices. The MOHear Project will solicit cooperation from and make arrangements with physicians/offices, hospitals, audiology practices, and other health care providers to consult on current reporting and documentation practices to build trust and respect for family decision making.

The Family Partnership (FP) is a family-based organization, made up of parents of children who are deaf or hard of hearing (DHH), contracted with DHSS to offer parent-to-parent support for families with an infant newly diagnosed as DHH. FP-DHH provides resource information, the opportunity to network with other families through trainings and workshops, and emotional support. The MOHear Project and FP meet semi-annually to discuss additional resources or support families may need across each region of the state. This collaborative effort helps meet the needs of families and provides hearing screening programs with information to improve data collection for LTF/D prevention.

The updated NHSP surveillance and data monitoring system currently being developed will allow NHSP to meet state statutory requirements of and help streamline and improve data collection, while maintaining quality data to inform and support other state agencies, such as Early Intervention, First Steps Part C of Individualized with Disabilities Education Act (IDEA), and Part B Early Childhood Special Education (ECSE), who report state and federal data, along with physicians/offices, hospitals, audiology practices, and other health care providers and programs working with DHH children and families. At the state level, NHSP's streamlined data collection will also assist with information reported annually by DESE for Language Equality and Acquisition for Deaf Kids (LEAD-K) (RSMo Section 161.396) regarding the number of newborns screened for hearing loss, newborns rescreened, and newborns referred to early intervention services. This also provides data to promote language acquisition and kindergarten-readiness for children birth to five years of age who are DHH.

The Newborn Health Program will partner with various community providers, including hospitals, women's health clinics, and local WIC agencies, to distribute the *Pregnancy and Beyond* book and other free educational resources. *Pregnancy and Beyond* contains information covering a wide range of topics, including parent-child bonding and child development.

The TEL-LINK Program will help family health by providing health care service referrals to increase access to care for any

childbearing woman, mother, or family member needing assistance. TEL-LINK is promoted through search engine campaigns to reach underserved populations. TEL-LINK will partner with tobacco control programs, WIC clinics, and dental care providers to provide referrals to services, such as smoking cessation, dental care providers, mental health treatment centers, health insurance providers, and many more.

MCH Leadership will convene a group of subject matter experts in home visiting, group care models, MCH, and curriculum development, including the Children's Trust Fund, to research group family visiting models and develop a curriculum for piloting implementation of group family visiting.

Strategic planning and stakeholder engagement to strengthen families through strengths-based services and supports to promote healthy family relationships and functioning, enhance resilience, foster social connections, develop knowledge of parenting and child development, and support children's social and emotional development will be ongoing, with FY 2026 serving as a planning and development period. Planning and development will be informed by:

- The Life Course Perspective;
- The Center for the Study of Social Policy *Strengthening Families* framework*;*
- The *Strengthening Families Protective Factor* framework; and
- The Health Outcomes from Positive Experiences (HOPE) framework.

NOTE: Content and strategies relevant to strengthening families is also contained throughout the other population domain application narratives.

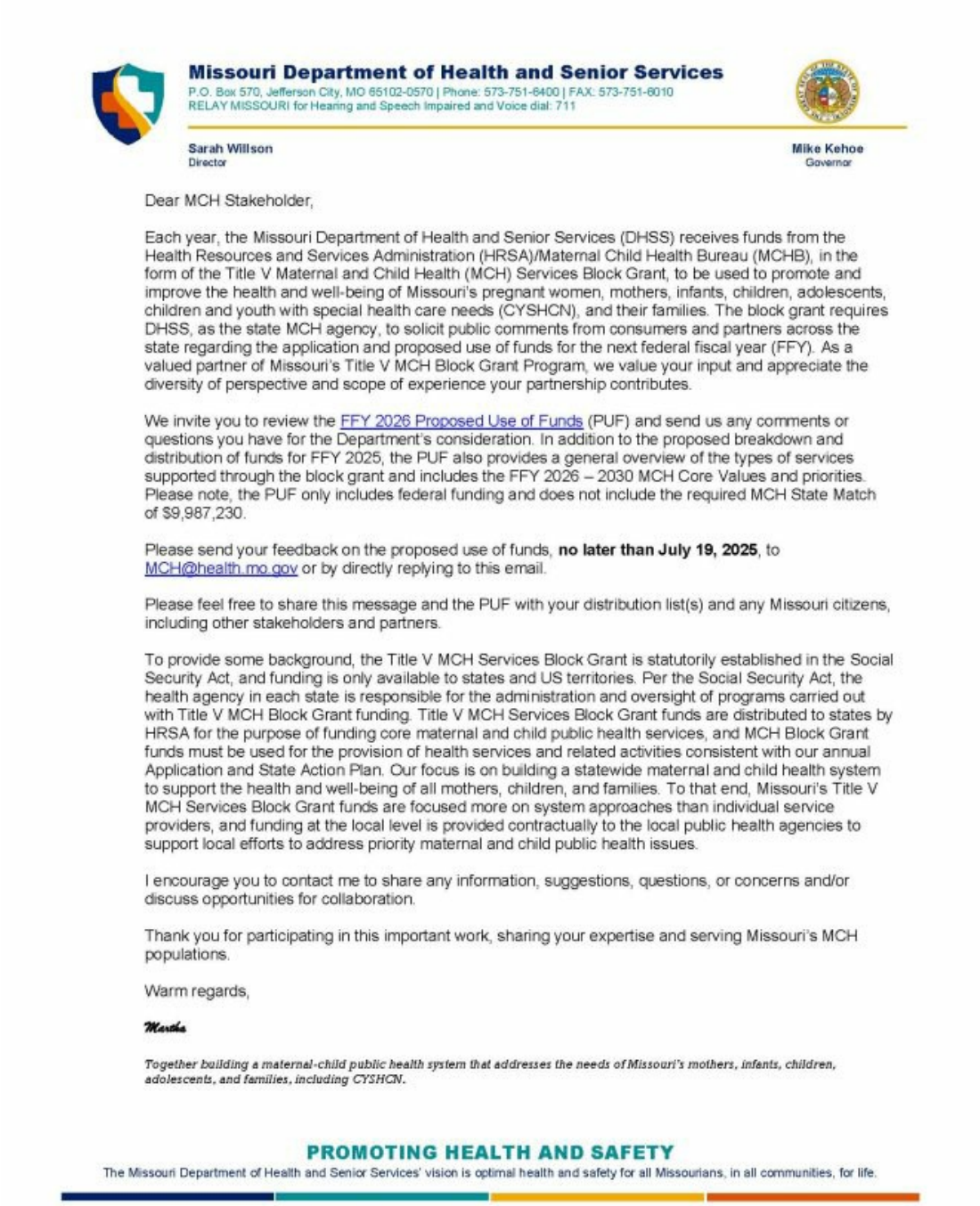
III.F. Public Input

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 MCH stakeholders and implementing partners. MCH Leadership engages and solicits input from LPHAs, community-based organizations, clinical and safety-net providers, community members, and families and family-serving organizations 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 FFY 2026 Title V MCH Block Grant application and proposed use of funds (PUF), the PUF document was posted on the DHSS Public Comment webpage, published in the LPHA weekly newsletter, the *Friday Facts*, and disseminated via email to a multidisciplinary group of MCH stakeholders. This included administrators from the 115 LPHAs, other LPHA team members, healthcare providers, hospitals and health systems, non-profit and other community-based organizations, other government agencies, community members, and families and family-serving organizations.

The MCH Director sent the email message below to over 1,800 MCH partners statewide, including representatives of MCH Training grantees in Missouri (Center of Excellence in MCH Education, Science, and Practice at Saint Louis University, Missouri Child Psychiatry Access Project, and Missouri Leadership Education in Neurodevelopmental and Related Disabilities). Missouri Family Voices, Family Connects, and Wyman Center are key partners in connecting MCH efforts to families and youth. The email was also shared by partners with their contacts and via several listservs, including the Special Health Care Needs Family Partner listserve, School Nurse Listserv, CHW Listserv, PHN Listserv, and MPHA SPHN Membership.



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

Sarah Willson
Director

Mike Kehoe
Governor

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 FFY 2026 Proposed Use of Funds (PUF) 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 2025, the PUF also provides a general overview of the types of services supported through the block grant and includes the FFY 2026 – 2030 MCH Core Values and priorities. Please note, the PUF only includes federal funding and does not include the required MCH State Match of $9,987,230.

Please send your feedback on the proposed use of funds, **no later than July 19, 2025**, to MCH@health.mo.gov or by directly replying to this email.

Please feel free to share this message and the PUF with your distribution list(s) and any Missouri citizens, including other stakeholders and partners.

To provide some background, the Title V MCH Services Block Grant is statutorily established in the Social Security Act, and funding is only available to states and US territories. Per the Social Security Act, the health agency in each state is responsible for the administration and oversight of programs carried out with Title V MCH Block Grant funding. Title V MCH Services Block Grant funds are distributed to states by HRSA for the purpose of funding core maternal and child public health services, and MCH Block Grant funds must be used for the provision of health services and related activities consistent with our annual Application and State Action Plan. Our focus is on building a statewide maternal and child health system to support the health and well-being of all mothers, children, and families. To that end, Missouri's Title V MCH Services Block Grant funds are focused more on system approaches than individual service providers, and funding at the local level is provided contractually to the local public health agencies to support local efforts to address priority maternal and child public health issues.

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.

Warm regards,

Marsha

Together building a maternal-child public health system that addresses the needs of Missouri's mothers, infants, children, adolescents, and families, including CYSHCN.

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.

Public Input on Proposed Use of Funds

A total of 19 responses, summarized below, were received, representing four DHSS team members, 13 external partners/stakeholders, and two family/community members.

- "I see major opportunity to collaborate in the rural areas. I would love to discuss synergy/a pilot in certain areas where we have the largest GAPS. In rural settings without resources, teams are utilizing telehealth to access services for adults. I don't see a reason why we couldn't do so for youth as well. I love all of this and helping the youth to "break the cycle."
- "Years of data, global research, and lived experience demonstrate the profound impact that community-based

birth and postpartum doulas, along with perinatal community health workers, have on improving maternal health outcomes, especially for vulnerable and underserved populations. We respectfully request the opportunity to partner with DHSS in utilizing this funding to expand access to case management, home visitation, education, and care coordination services for expectant families throughout pregnancy, childbirth, and up to 12 months postpartum. We look forward to potential collaboration to improve maternal and child health outcomes across our state."

- "The Missouri Dental Association, as a leading oral health advocate representing dental professionals in Missouri, offers our input on the importance of oral health deliverables from use of Title V MCH Block Grant proposed funds. We feel it is imperative that oral health be a priority in Missouri and within the MCH grant. Oral health significantly impacts overall health. Poor oral health can lead to or worsen many systemic conditions and in children can cause pain, difficulty eating and speaking and impact academic performance and overall well-being. Since the MCH grant is geared toward the maternal, child and family unit, funding oral health initiatives, education and programs is imperative to give the child a foundation of oral health services and knowledge that can carry on into adulthood and throughout their lifetime."
- "Historically these dollars have been utilized to support evidenced-based home visiting programs such as Healthy Families America and Nurse-Family Partnership which are strong models of home visiting that are research -backed and have shown many positive impacts on mothers, children and their families. I would like to advocate for these programs to continue to have ongoing support through this MCH grant so these programs can continue to support and positively impact Missouri families."
- "It does appear that there is room for consolidation around priority areas. For example, in our department no one was aware of Parentlink, could several of these line items be collapsed into a few pots? Could this be re-imagined and any MCH dollars going towards contract services be applied to replication of the Family Connects Program? Sort of a regional approach to maternal child health. It makes sense to utilize funding to the fullest capacity and what has the biggest impact. Then hopefully additional funding could be leveraged."
- "[We] would like to respond positively to the proposed plan to use this block grant to improve the health status of women and children in Missouri. We see an increase in maternal mortality in Missouri and nationwide. Mental health issues and social determinants contribute to this trend. Missouri has a high rate of mental illness and limited access to care compared to most states. Half of Missouri counties are classified as maternity care deserts. There is a definite problem in Missouri with . . . access to basic healthcare and a need to embrace change that can occur with this block grant. This block grant could be an important financial support to our mission for mothers and infants and improving health access for mothers in Missouri. Thank you for your consideration and service to healthcare in Missouri."
- Thank you for your consideration and everything you are doing to ensure Missouri's families are thriving!
- "Thanks for including the LPHAs in the proposed use of the funds. I hope this area of the funds can possibly grow as well."
- "I have read through the assessment presentation slides and compared the new priority areas with the previous selection. This is a comprehensive list and my input is only that I support the selected areas."
- " [The] County Health Department appreciates the Department's continued focus on systems-level improvements that support maternal and child health across Missouri. At the local level, we support prioritization of: strengthening access to care for underserved families, especially in rural areas, expanding mental and behavioral health resources for adolescents and caregivers, and supporting workforce development for local public health and MCH professionals. We value being part of this statewide effort and look forward to continued collaboration to meet the needs of Missouri's mothers, children, and families."
- "I appreciate the opportunity to review the FFY 2026 Proposed Use of Funds and the transparency around how these dollars are being considered for allocation."
- "Huge thanks to DHSS for getting this info out to the public!"

- "Thank you for the very important work you do for Missouri's families. A redistribution of the $341,000 budgeted for oral health should be considered, to specifically provide more equal funding across oral health, obesity prevention, adolescent and school health, and nutrition projects."
- "I had just a few comments on the Title V proposal…thank you for the opportunity to review.
    - Does *comprehensive postpartum care* include mental health and substance use screenings? Is there any guidance, or intent to provide guidance, around Plans of Safe Care?
    - Would there be interest/intent in connecting non-parental adults with Youth Mental Health First Aid? Youth « Mental Health First Aid or additional behavioral health training?
    - Is there an interest for education around transitional-age youth from a behavioral health perspective?
    - The Missouri Behavioral Health Council is offering training around DC:0-5 (early childhood behavioral health assessment). There may be a potential for overlap with maternal and child health efforts?
    - MCH WarmLine and MCH Navigators (ParentLink): Is there an intent to include behavioral health training to the MCH Navigators and those answering the WarmLine?"

Requests for clarification were received regarding the following topics:

- Specific programs, staffing, and activities included in Coordination and Systems Development line item.
- Ways MCH will engage dentists in its oral health priority goals.
- Evaluation methods for investment in the MCH Warmline and MCH Navigators, with a request for a link to past reports on the activities and success of this line item.

The MCH Director personally responded 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 MCH 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: MO HealthNet Maternal Health Coordination, Missouri Perinatal Quality Collaborative/Maternal Child Learning Action Network, ParentLink Advisory Board, Genetics Advisory Committee, Missouri Injury and Violence Prevention Advisory Committee (MIVPAC), Pregnancy Associated Mortality Review (PAMR) Board, Women's Health Committee, 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 statewide Five-Year MCH Needs Assessment and in the development of this application and ongoing development and implementation of the MCH 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 MCH 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 MCH funding, priorities, action plans, and/or any other topic related to MCH. The FY 2026 Application and FY 2024 Annual Report, including the 2025 Five Year MCH Needs Assessment Summary, will be added to this webpage once the final document is available and will remain available throughout the duration of the grant. MCH stakeholders, community and family partners, and program participants will be notified of these and other publicly available information via the quarterly MCH Newsletter. A link is also currently available on the webpage to direct the public to resources and information accessible on the Title V Information System (TVIS) website.

III.G. Technical Assistance

As Missouri concludes implementation of the FY 2021-2025 MCH State Action Plan and transitions to the FY 2026-2030 MCH State Action Plan, areas of needed technical assistance have been identified. Several current and ongoing topics for possible technical assistance have been discussed among MCH Leadership and programs. 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.

- Exploration of group family visiting models and development of a group family visiting curriculum and implementation plan.

- Systematic implementation of Continuous Quality Assurance and Performance Improvement (QAPI) initiatives, including integration and alignment with broader MCH goals and priorities at local and state levels, to continuously improve the quality and safety of services, effectively address unique needs and priorities within populations and communities, and achieve sustained improvements in the health and well-being of mothers, children, and families.

- State adolescent and young adult leadership capacity building to actively engage youth leaders and elevate youth voices.

- Return on Investment (RoI) and Economic Impact (EI) analyses of programs and initiatives receiving Title V MCH Block Grant funding to evaluate the short- and long-term value and impact of Title V funding allocations, inform fiscal decision-making, and ensure the best possible use of scarce resources.

- Integration of processes, findings, and recommendations from the new Statewide Fetal and Infant Mortality Review (FIMR) Network with the Child Fatality Review at the Department of Social Services to align efforts for consistent messaging, collaborative action steps, and unified policy initiatives.

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 - DHSS-Related Acronyms.pdf

Supporting Document #02 - MO DHSS Strategic Map.pdf

Supporting Document #03 - References-Resources-Data Sources_Final.pdf

Supporting Document #04 - DHSS Title V MCHBG Contract_DESE Office of Childhood_FFY 2025_Final.pdf

Supporting Document #05 - FFY 2025 MCH Services Contract Scope of Work.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DHSS-DCPH-DSDS-DESE Org Charts_July2025.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Missouri

	FY 26 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,934,797	
A. Preventive and Primary Care for Children	$ 4,065,948	(31.4%)
B. Children with Special Health Care Needs	$ 4,248,638	(32.8%)
C. Title V Administrative Costs	$ 1,060,397	(8.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 9,374,983	
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)	$ 22,922,027	
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)	$ 22,922,027	

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
No Other Federal Programs were provided by the State on Form 2 Line 9.	

	FY 24 Annual Report Budgeted		FY 24 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 13,186,864 (FY 24 Federal Award: $ 12,742,189)		$ 10,941,680	
A. Preventive and Primary Care for Children	$ 4,175,109	(31.7%)	$ 3,462,627	(31.6%)
B. Children with Special Health Care Needs	$ 4,022,725	(30.5%)	$ 3,522,376	(32.1%)
C. Title V Administrative Costs	$ 1,098,528	(8.3%)	$ 928,541	(8.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 9,296,362		$ 7,913,544	
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)	$ 23,174,094		$ 20,928,910	
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)	$ 23,174,094		$ 20,928,910	

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 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:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Missouri is applying for $12,934,797, which is higher than the amount the state received in FY 2024. 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. Any budget needs not covered by the FY 2026 Title V MCH Block Grant award will be funded with FY 2025 Year 2 funding. If the FY 2026 funding received and/or FY 2025 Year 2 funding is less than anticipated and/or needed, MCH Leadership will prioritize FY 2026 activities and initiatives, while maintaining core services for the MCH populations.	
2.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Missouri is committed to meeting the mandated 4:3 ratio of federal to non-federal funds, based on actual FY 2026 federal expenditures, with $9,987,230 as the state's FY 1989 maintenance of effort minimum amount required.	
3.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: As of 7/11/2025, $10,941,680 of the total FY 24 award amount ($12,742,189) had been expended. The remaining FY 24 funds ($1,800,509) have been allocated for planned expenditures between 7/11 - 9/30/2025, and plans are in place to ensure the full award amount is expended by the end of the two-year grant cycle ending September 30, 2025. The FFR will include final expenditure data and the total amount expended at grant closeout.	
4.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount for Preventive and Primary Care for Children as of July 11,2025. Based on the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, at least $360,030 of the remaining FY 24 funds to be expended will be expended for Preventive and Primary Care for Children to meet the minimum of 30% ($3,822,657) of the Federal Allocation. The FFR will include final expenditure data and the total amount expended at grant closeout.	

5.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount for Children with Special Health Care Needs as of July 11, 2025. Based on the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, at least $300,281 of the remaining FY 24 funds to be expended will be expended for Children with Special Health Care Needs to meet the minimum of 30% ($3,822,657) of the Federal Allocation. The FFR will include final expenditure data and the total amount expended at grant closeout.	
6.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount for Administrative Costs as of July 11, 2025. Based on the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, no more than $345,678 of the remaining FY 24 funds to be expended will be expended for Administrative Costs, so as not to exceed the allowable 10% maximum ($1,274,219) of the Federal Allocation. 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 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 1,739,368	$ 1,583,571
2. Infants < 1 year	$ 1,815,098	$ 1,437,666
3. Children 1 through 21 Years	$ 4,065,948	$ 3,462,627
4. CSHCN	$ 4,248,638	$ 3,522,376
5. All Others	$ 5,348	$ 6,899
Federal Total of Individuals Served	$ 11,874,400	$ 10,013,139

IB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 2,314,180	$ 2,288,600
2. Infants < 1 year	$ 869,680	$ 765,634
3. Children 1 through 21 Years	$ 435,088	$ 495,646
4. CSHCN	$ 6,042,374	$ 6,437,350
5. All Others	$ 325,908	$ 0
Non-Federal Total of Individuals Served	$ 9,987,230	$ 9,987,230
Federal State MCH Block Grant Partnership Total	$ 21,861,630	$ 20,000,369

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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through July 11, 2025 for Pregnant Women. With the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, the total expenditure amount through September 30, 2025 for Pregnant Women is expected to be higher.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is an estimated total expenditure amount through July 11, 2025 for Infants < 1 year. With the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, the total expenditure amount through September 30, 2025 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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is an estimated total expenditure amount through July 11, 2025 for Children 1 through 21 years. With the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, the total expenditure amount through September 30, 2025 for Children 1 through 21 years is expected to be higher.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through July 11, 2025 for CYSHCN. With the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, the total expenditure amount through September 30, 2025 for CYSHCN is expected to be higher.	
5.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2024**

Column Name:	Annual Report Expended

Field Note:
This is the total expenditure amount for all individuals served through July 11, 2025. With the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, the total expenditure amount through September 30, 2025 for all individuals served 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 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 276,697	$ 299,340
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 32,062	$ 42,498
B. Preventive and Primary Care Services for Children	$ 92,144	$ 76,363
C. Services for CSHCN	$ 152,491	$ 180,479
2. Enabling Services	$ 4,290,301	$ 3,410,382
3. Public Health Services and Systems	$ 8,367,799	$ 7,231,958
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)		$ 157,349
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
CYSHCN		$ 125,000
Blood Lead Testing		$ 16,991
Direct Services Line 4 Expended Total		$ 299,340
Federal Total	$ 12,934,797	$ 10,941,680

IIB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 2,714,201	$ 2,615,118
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 2,089,532	$ 1,772,371
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 624,669	$ 842,747
2. Enabling Services	$ 365,785	$ 428,281
3. Public Health Services and Systems	$ 6,907,244	$ 6,943,831
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		$ 1,748,521
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		
CYSHCN Direct Care Payments		$ 842,747
SIDS Payments		$ 23,850
Direct Services Line 4 Expended Total		$ 2,615,118
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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through July 11, 2025 for Direct Services. Based on the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, the total expenditure amount through September 30, 2025 for Direct Services is expected to be higher.	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through July 11, 2025 for Enabling Services. Based on the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, the total expenditure amount through September 30, 2025 for Enabling Services is expected to be higher.	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: This is the total expenditure amount through July 11, 2025 for Public Health Services and Systems. Based on the expectation that all remaining FY 24 funds will be expended by the end of the two-year grant cycle ending September 30, 2025, the total expenditure amount through September 30, 2025 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: 68,441 **Data Source Year: 2024**

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	67,600 (98.8%)	1,620	290	290 (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
Fabry disease	67,600 (98.8%)	32	13	13 (100.0%)
Gaucher disease	67,600 (98.8%)	11	1	1 (100.0%)
Arginemia	67,600 (98.8%)	0	0	0 (0%)
Citrullinemia type II	67,600 (98.8%)	0	0	0 (0%)
Defects of biopterin cofactor biosynthesis*	67,600 (98.8%)	0	0	0 (0%)
Defects of biopterin cofactor regeneration*	67,600 (98.8%)	0	0	0 (0%)
Hyperphenylalaninemia*	67,600 (98.8%)	3	3	3 (100.0%)
Hypermethioninemia*	67,600 (98.8%)	1	1	1 (100.0%)
Tyrosinemia type II*	67,600 (98.8%)	0	0	0 (0%)
Tyrosinemia type III*	67,600 (98.8%)	0	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	67,600 (98.8%)	0	0	0 (0%)
Carnitine palmitoyl transferase deficiency I	67,600 (98.8%)	0	0	0 (0%)
Carnitine palmitoyl transferase deficiency II*	67,600 (98.8%)	0	0	0 (0%)
Dienoyl-CoA reductase deficiency	67,600 (98.8%)	0	0	0 (0%)
Glutaric acidemia type II	67,600 (98.8%)	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
Medium-chain ketoacyl-CoA thiolase deficiency	67,600 (98.8%)	0	0	0 (0%)
Medium/Short chain L-3-hydroxy axyl-CoA dehydrogenase deficiency	67,600 (98.8%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	67,600 (98.8%)	3	3	3 (100.0%)
2-Methyl-3-hydroxybutyric aciduria	67,600 (98.8%)	0	0	0 (0%)
2-Methylbutyryl-CoA dehydrogenase deficiency	67,600 (98.8%)	0	0	0 (0%)
2-Methylbutyrylglycinuria	67,600 (98.8%)	0	0	0 (0%)
3-Methylglutaconic aciduria	67,600 (98.8%)	0	0	0 (0%)
Isobutyryl-CoA dehydrogenase deficiency*	67,600 (98.8%)	0	0	0 (0%)
Malonic acidemia	67,600 (98.8%)	0	0	0 (0%)
Various other hemoglobinopathies	67,600 (98.8%)	3	3	3 (100.0%)
CFTR-Related Metabolic Syndrome*	67,600 (98.8%)	7	7	7 (100.0%)
T-cell related lymphocyte deficiencies*	67,600 (98.8%)	10	10	10 (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:**	**Data Source Year**
	Fiscal Year:	**2024**
	Column Name:	**Data Source Year Notes**
	Field Note: Data Source Year: CY 2024	
2.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: Presumptive Positive Screens CY 2024: Blood Spot Screening: 466 Newborn Hearing Screening: 1,099* CCHD: 55** Total CY 2024 Presumptive Positive Core Conditions: 1,620 *Newborn hearing screening numbers are provisional. There is a large increase in presumptive positive hearing screens for CY 2024 compared to CY 2023 due to a recently discovered data collection error last year. **Missouri conducts passive surveillance only for CCHD screening.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**

	Field Note: Confirmed Cases CY 2024: Core Blood Spot: 144 Hearing: 146* CCHD: Unknown** Total CY 2024 Confirmed Positive Core Conditions: 290 *Newborn hearing screening numbers are provisional. There is a large increase in presumptive positive hearing screens for CY 2024 compared to CY 2023 due to a recently discovered data collection error last year. **Missouri conducts passive surveillance only for CCHD screening.	
4.	**Field Name:**	**Defects of biopterin cofactor biosynthesis* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	
5.	**Field Name:**	**Defects of biopterin cofactor regeneration* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	
6.	**Field Name:**	**Hyperphenylalaninemia* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	
7.	**Field Name:**	**Hypermethioninemia* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**

	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	
8.	**Field Name:**	**Tyrosinemia type II* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	
9.	**Field Name:**	**Tyrosinemia type III* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	
10.	**Field Name:**	**Carnitine palmitoyl transferase deficiency II* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	
11.	**Field Name:**	**Isobutyryl-CoA dehydrogenase deficiency* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	

12.	**Field Name:**	**CFTR-Related Metabolic Syndrome* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	
13.	**Field Name:**	**T-cell related lymphocyte deficiencies* - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: *These disorders have the same screening markers and are referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.	

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 2024

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	2,843	38.4	0.0	60.6	0.0	1.0
2. Infants < 1 Year of Age	16,044	38.4	0.0	60.6	0.0	1.0
3. Children 1 through 21 Years of Age	86,823	33.0	0.0	60.0	7.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	23,805	96.5	0.0	1.7	1.8	0.0
4. Others	17,980	12.0	0.0	80.0	8.0	0.0
Total	123,690					

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	67,123	No	67,863	71.2	48,318	2,843
2. Infants < 1 Year of Age	67,445	No	67,863	99.6	67,592	16,044
3. Children 1 through 21 Years of Age	1,626,208	Yes	1,626,208	24.0	390,290	86,823
3a. Children with Special Health Care Needs 0 through 21 years of age^	525,203	Yes	525,203	24.4	128,150	23,805
4. Others	4,501,952	Yes	4,501,952	1.7	76,533	17,980

^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:	**2024**
	Field Note: Fiscal Year: 2024 Expectant moms downloading the Count the Kicks App, FFY 2024: 478 Mothers receiving home visiting services through Building Blocks, FFY 2024: 291 Mothers served by Healthy Families Missouri Home Visiting Program, FFY 2024: 41 Prenatal care services through Local Public Health Agencies, FFY 2024: 1,840 Total FFY 2024: 2,843	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2024**
	Field Note: Fiscal Year: 2024 Infants receiving home visiting services through Building Blocks FFY 2024: 86 Education for families with infants with elevated blood lead levels FFY 2024: 243 Infants served by Healthy Families Missouri Home Visiting Program FFY 2024: 14 Portable cribs and Safe Sleep education delivered through Missouri’s Department of Elementary and Secondary Education (DESE) to low-income families FFY 2024: 1,074 Infants receiving services through Local Public Health Agencies, FFY 2024: 14,627 Total FFY 2024: 16,044	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2024**

	Field Note: Fiscal Year: 2024 Sexual Risk Avoidance Education FFY 2024: 636 Other Teen Pregnancy Prevention Education (through PREP), FFY 2024: 309 CARE (Physical Abuse) Exams, FFY 2024: 1,686 SAFE-Exams, FFY 2024: 3,431 Child Regulation (Child Care Services) FFY 2024: 145 Education for families with children (age 1 to 6 years) with elevated blood lead level FFY 2024: 7,383 Oral Health (PSP) Non-CSHCN FFY 2024: 49,428 CSHCN Served by Direct Services, FY 2024: 23,805** Total FFY 2024: 86,823* *AAP, EAP, IHP services from previous reports are not included due to the loss of and expenditure of different funding streams, we were not able to offer the School Nurse Supervision and Support contract as we had in previous years. This contract is where the data was collected for the 2023 submission. **CSHCN Served by Direct Services will be expanded upon in 3a notes.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: Fiscal Year: 2024 Children and Youth with Special Health Care Needs Program SFY 2024: 536 Healthy Children and Youth Program SFY 2024: 1,032 Oral Health (PSP) CSHCN FFY 2024: 22,027* Total FFY 2024: 23,805 *This number is from taking the total number of children 0-21 served by Oral Health PSP and dividing it by the percent of SHCN in the state. Oral Health (PSP) Total: 71,635 Percent of CSHCN (NSCH Data): 31% Oral Health (PSP) CSHCN: 22,027	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2024**

Field Note:
Fiscal Year: 2024

Number of Child Passenger Safety (CPS) technicians trained through CPS training FFY 2024: 357
Nurse Training Program Participants FFY 2024: 372*
Lead School Nurse Learning Community FFY 2024: 125
Health Office Orientation FFY 2024: 68
Nurse Education Webinar Series (N.E.W.S.) FFY 2024: 13,739
Child Care Providers Served FFY 2024: 156
Child Care Referrals for families of CYSHCN FFY 2024: 176
Teachers trained on inclusion services FFY 2024: 446
Health care providers, foster parents training on current adolescent health issues FFY 2024: 446
School Health 1:1 Technical Assistance FFY 2024: 365
Trained in Home Visiting programs FFY 2024: 226
Childhood lead poisoning prevention in-home risk assessments FFY 2024: 140

Total FFY 2024: 17,980

*Due to changes in staff and funding, we were not able to present at as many in person conferences as we had in years past so more webinars were provided

6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2024**

Field Note:
Fiscal Year: 2024

Pregnant Women FFY 2024: 2,843
Infants < 1 Year Age FFY 2024: 16,044
Children 1 through 21 Years of Age FFY 2024: 86,823
Children with Special Health Care Needs (Subtotal Children of 0-21 Years of Age) SFY 2024: 23,805
Others FFY 2024: 17,980

Individuals Served Total FFY 2023: 123,690

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2024**

Field Note:
Fiscal Year: 2024

5A Total FFY 2024: 2,843
Pregnancy and Beyond Books distributed FFY 2024: 20,460
MIECHV Home Visiting Program FFY 2024: 296
Oral Health Education Materials FFY 2024: 24,674

Numerator: Total FFY 2024: 48,273
Denominator: MODHSS Vital Statics File - Missouri Resident Deliveries, 2024: 68,207

2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2024**
	Field Note: MODHSS Vital Statics File - Provisional Live Births, 2024: 67,863	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2024**
	Field Note: Fiscal Year: 2024 Newborn Metabolic Screenings CY 2024: 67,600 Numerator: Total CY 2024: 67,600 Denominator: MODHSS Vital Statics File - Provisional Live Births, 2024: 67,863	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2024**
	Field Note: MODHSS Vital Statics File - Provisional Live Births, 2024: 67,863	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: Fiscal Year: 2024 5A Total FFY 2024: 86,823 Children obesity prevention program FFY 2024: 636* Safe Kids FFY 2024: 121,154 Safe Ride Cards Distribution FFY 2024: 8,831 Children (age 1 to 6 years) receiving blood lead testing FFY 2024: 62,840 CSHCN Direct, Enabling, and Public Health Services Systems Total FFY 2024: 128,375** Numerator: Total FFY 2024: 389,000 Denominator: US Census Bureau Population Estimates, 2023: 1,626,208 *Compared to FFY 2023increased number of LPHAs that completed the PALS (Physical Activity Learning Sessions) training of trainers in FY24 and provided the PALS trainings to ECEs **CSHCN Served by Direct, Enabling, and Public Health Services Systems will be expanded upon in 3a notes. ***Due to the loss of federal funding related to the ELC Grant received by DHSS, we did not have funding to support participation of schools in this work as we had done prior, TEAMS School Districts is not reported. ****Due to the loss of and expenditure of different funding streams, we were not able to offer the School Nurse Supervision and Support contract as we had in previous years, School Health Participants is not reported.	

6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**

Field Note:
Fiscal Year: 2024

5A Total FFY 2024: 23,805
Brain Injury (Outreach with the Traumatic Brain Injury Grant) SFY 2024: 17,936
Bureau of Special Health Care Needs community outreach, and printed materials SFY 2024: 33,398
CYSHCN Program community Outreach and printed materials SFY 2024: 14,885
Healthy Children and Youth, Non-Accepted Referrals SFY 2024: 164
Special Health Services Web Inquiries SFY 2024: 38,187

Numerator: Total FFY 2024: 128,375
Denominator: National Survey of Children's Health CSHCN Prevalence Estimates 0-17 (2022-2023) multiplied by US Census Bureau Population Estimates 0-21, 2023: 525,203

7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2024**

Field Note:
Fiscal Year: 2024

5A Total FFY 2024: 17,980
Distribution of 10 Ways to Be a Better Dad FFY 2024: 12,710
Number of Child Care Regulation On-Site Technical Assistance Visits FFY 2024: 21
Community Outreach Contacts FFY 2024: 8,528
Oral Health FFY 2024: 38,908*
MIECHV Trained in Home Visiting Programs FFY 2024: 479

Numerator: Total FFY 2024: 78,626
Denominator: US Census Bureau Population Estimates, 2023: 4,501,952

*There is a large decrease due to the Community Water Fluoridation Campaign that took place in FFY 2023 was a one-time campaign.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Missouri

Annual Report Year 2024

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	68,207	48,722	8,312	6,295	179	1,801	241	2,181	476
Title V Served	26,176	15,122	5,170	3,835	97	426	146	1,122	258
Eligible for Title XIX	26,176	15,122	5,170	3,835	97	426	146	1,122	258
2. Total Infants in State	67,863	48,496	8,246	6,268	178	1,795	239	2,173	468
Title V Served	26,034	15,046	5,136	3,817	97	425	144	1,116	253
Eligible for Title XIX	26,034	15,046	5,136	3,817	97	425	144	1,116	253

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
Title V Program Workforce

State: Missouri

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	161.08
1a. Total Number of FTEs (State Level)	49.08
1b. Total Number of FTEs (Local Level)	112
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	8.54
3. Total Number of FTEs eliminated in the past 12 months	0
4. Total Number of Current Vacant FTEs	1.55
4a. Total Number of Vacant MCH Epidemiology FTEs	0.70
5. Total Number of FTEs onboarded in the past 12 months	10.20

B. Training Needs (Optional)	
1	Outcome measurement at local, state and program levels
2	Resilience
3	Change Management
4	

Form Notes for Form 7:

Excerpted from Email conversation with DSCH/MCHB/HRSA (EJ) 5/28-30:

MCH Director
Based on your response, for this year's report, we will plan to provide the level of FTE detail we currently have access to for all the FTEs covered by federal Title V funds, not including FTEs covered with State Match. Over the next year, we plan to work with our budget and fiscal support team to determine a plan / methodology for obtaining the full scope of details for the FTEs covered with State Match, with the goal of year-to-year incremental progress in our capacity to collect and report the full scope of details for FTEs supported with combined Federal-State Title V MCH Block Grant Partnership funding. We will strive to provide detailed notes on Form 7 to explain what was/was not included in our calculations.

EJ
I understand your concerns as a detail-oriented person with the disparate opinions/understandings revolving around what funding sources constitute "Title V-Funded Positions", and the Form 7 instructions not specifically indicating the calculation of Title V-Funded FTEs would include the Total Federal-State Title V MCH Block Grant Partnership Funding.
I saw you indicated Missouri classified state match as GR-funded and therefore any FTEs fully or partially funded by State Match you would not consider Title V-funded. I also noted in your email your explanation that it would be a labor-intensive effort to obtain FTE information at that granular level for FTEs funded under State Match in addition to providing explanations in the notes field.
The Form 7 FAQ is intended to provide "clarifying instructions" that followed the model we did years ago with "clarifying instructions" for Form 5 to help states incrementally report on Form 5 as we were able to officially update/revise the Form 5 instructions in the guidance itself which you know is on a 3-year cadence. I really appreciate your feedback on the new Form 7 that will be invaluable for us to further update/review instructions for Form 7 in the next iteration of the guidance as well as reviewing the usage of terms in the guidance and outside of the guidance.
We do recognize and understand every state has their own unique scenario as it relates to what FTE/position information they have access to or would be able to obtain, but we do not want the data collection to be overly burdensome as reporting on this form is still in its infancy.
Yes, the FAQ clarifies what was meant as the funding source for "Title V-Funded", but states should report what they are comfortable reporting and/or have access to where a similar path as Form 5 reporting with incremental progress in the capacity to collect and report is the overall goal. The key will be that states provide detailed notes explaining the calculation and what was included even if the reported FTEs do not include FTEs covered with State Match, because this is still valuable information for us to understand how funds are supporting state and local staff.

Field Level Notes for Form 7:

Form 7 Field Level Notes Table

1.	**Field Name:**	**Total Number of FTEs**
	Field Note: Missouri has not historically tracked the number Title V funded FTEs at the local level and does not have local level workforce data for the past 12 months. Missouri is developing a system to track FTEs supported through local contracts and will provide more comprehensive granular data on the total Title V Program Workforce, inclusive of both state and local levels, in the FFY 2027 application/report.	
2.	**Field Name:**	**Total Number of FTEs (State Level)**

	Field Note: 118 positions (not including ITSD or administrative positions or local-level FTEs) are funded in part or whole with Title V funding. In total, Title V funding supports 49.08 state-level FTEs.	
3.	**Field Name:**	**Total Number of FTEs (Local Level)**
	Field Note: 112 LPHAs receive funding through the Title V funded MCH Services contract, supporting an additional 112 MCH Coordinator positions. Missouri has not historically tracked the number Title V funded FTEs at the local level and does not have local level workforce data for the past 12 months. The "112" entered in 1b. represents the number of local MCH Coordinator positions supported by Title V funding and is not a Total Number of FTEs. Missouri is developing a system to track FTEs supported through local contracts and will provide more comprehensive granular data on the total Title V Program Workforce, inclusive of both state and local levels, in the FFY 2027 application/report.	
4.	**Field Name:**	**Total Number of MCH Epidemiology FTEs**
	Field Note: This is the total number of state-level MCH Epidemiology FTEs supported in part or whole with Title V funding, representing 16 different positions. There are additional MCH Epidemiology FTEs/positions that are not supported with any Title V funding. 112 LPHAs receive funding through the Title V funded MCH Services contract, supporting additional MCH epidemiology positions. Missouri is developing a system to track FTE supported through contracts and will provide more comprehensive granular data on the total Title V Program Workforce, inclusive of both state and local levels, in the FFY 2027 application/report.	
5.	**Field Name:**	**Total Number of Current Vacant FTEs**
	Field Note: This is the total number of state level Vacant FTEs supported in part or whole with Title V funding (not including ITSD or administrative positions), representing 2 vacant positions. There are currently 6 vacant MCH Coordinator positions at the local level, but the exact number of FTEs for those 6 positions is not known. Missouri has not historically tracked the total number of Title V funded vacant FTEs at the local level. Missouri is developing a system to track FTEs supported through local contracts and will provide more comprehensive granular data on the total Title V Program Workforce, inclusive of both state and local levels, in the FFY 2027 application/report.	
6.	**Field Name:**	**Total Number of Vacant MCH Epidemiology FTEs**
	Field Note: This is the total number of state level Vacant MCH Epidemiology FTEs supported in part or whole with Title V funding, representing 1 position. 112 LPHAs receive funding through the Title V funded MCH Services contract, supporting additional MCH epidemiology positions, however the number of local level vacant MCH Epidemiology positions or FTEs is not known. Missouri is developing a system to track FTE supported through contracts and will provide more comprehensive granular data on the total Title V Program Workforce, inclusive of both state and local levels, in the FFY 2027 application/report.	
7.	**Field Name:**	**Total Number of FTEs onboarded in the past 12 months**

	Field Note: 10.2 state level FTEs, representing 19 different positions, funded in part or whole with Title V funding were onboarded in the past 12 months (not including ITSD or administrative positions). Approximately 60 local level positions funded in part of whole with Title V funding were onboarded in the past 12 months. Missouri has not historically tracked the number of Title V funded FTEs at the local level and does not have local level workforce data for the past 12 months. Missouri is developing a system to track FTEs supported through local contracts and will provide more comprehensive granular data on the total Title V Program Workforce, inclusive of both state and local levels, in the FFY 2027 application/report.	
8.	**Field Name:**	**Training Needs Line 1**
	Field Note: Understanding the difference between process measurement and outcome measurement varies greatly across programs, team members, and contractors. Current financial constraints and ongoing fiscal management require the ability to measure and evaluate the true impact of programs, services, and initiatives to ensure limited funding is allocated to efforts with the greatest return on investment in terms of improvements in MCH outcomes and the MCH system of care and services.	

Form 8
State MCH and CSHCN Directors Contact Information

State: Missouri

1. Title V Maternal and Child Health (MCH) Director	
Name	Martha Smith, MSN, RN
Title	State Director, Maternal Child Health | State Lead, Public Health Nursing
Address 1	P.O. Box 570
Address 2	930 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102-0570
Telephone	5737516435
Extension	
Email	Martha.Smith@health.mo.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Andrea Tray, MPH
Title	CYSHCN Director
Address 1	P.O. Box 570
Address 2	930 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102-0570
Telephone	(573) 751-5448
Extension	
Email	Andrea.Tray@health.mo.gov

3. State Family Leader (Optional)	
Name	Jada Turley-Winchester, MPH
Title	MCH Program Associate | MCH Family Leader
Address 1	P.O. Box 570
Address 2	930 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102-0570
Telephone	(573) 522-4620
Extension	
Email	Jada.TurleyWinchester@health.mo.gov

4. State Youth Leader (Optional)	
Name	Katrina Fernandez, MPH,
Title	MCH Coordinator | State Adolescent Health Leader
Address 1	P.O. Box 570
Address 2	930 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102-0570
Telephone	(573) 751-8338
Extension	
Email	Katrina.Fernandez@health.mo.gov

5. SSDI Project Director	
Name	Venkata Garikapaty, PhD, MPH
Title	Assistant Deputy Director, Division of Community and Public Health
Address 1	P.O. Box 570
Address 2	930 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102-0570
Telephone	(573) 751-0452
Extension	
Email	Venkata.Garikapaty@health.mo.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(800) 835-5465

Form Notes for Form 8:

None

Form 9
List of Priority Needs – Needs Assessment Year

State: Missouri

Application Year 2026

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Access to patient-centered, coordinated, and comprehensive postpartum care.	New
2.	Preventive oral health care services during pregnancy.	New
3.	Safe infant sleep practices and environments to promote safe infant sleep and reduce sleep-related infant deaths.	New
4.	Access to holistic oral health care services for children.	New
5.	A stable and supportive relationship with a caring non-parental adult to enhance adolescent psychological well-being and empower youth with the tools and training to reach their full potential.	New
6.	Smooth and successful transition from child-centered to adult-oriented healthcare, promoting continuity of care, improving health outcomes, and empowering youth to manage their own health.	New
7.	Access to family-centered, coordinated, comprehensive, and community-based health care services and supports for children with and without special health care needs.	New
8.	Strengths-based services and supports to promote healthy family relationships and functioning, enhance resilience, foster social connections, and support children's social and emotional development.	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Missouri

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	95.1	3.8	622	65,427
2021	102.5	4.0	677	66,025
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 SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2023	25.4	2.7	88	346,973
2018_2022	23.8	2.6	84	353,119
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 MM - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	15.9	0.3	3,166	198,616
2022	16.9	0.3	3,270	194,045
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 TB - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	8.9 %	0.1 %	5,972	67,084
2022	9.1 %	0.1 %	6,285	68,951
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 LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks gestation) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	11.0 %	0.1 %	7,402	67,061
2022	11.3 %	0.1 %	7,792	68,914
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 PTB - Notes:

None

Data Alerts: None

NOM - Stillbirth rate per 1,000 live births plus fetal deaths - SB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.2	0.3	358	69,343
2021	5.6	0.3	388	69,841
2020	6.2	0.3	431	69,716
2019	5.5	0.3	402	72,529
2018	5.4	0.3	400	73,669
2017	5.9	0.3	430	73,464
2016	6.2	0.3	463	75,168
2015	6.1	0.3	458	75,519
2014	5.2	0.3	392	75,752
2013	5.4	0.3	411	75,707
2012	5.6	0.3	422	75,868
2011	5.1	0.3	387	76,504
2010	5.2	0.3	400	77,159
2009	5.4	0.3	432	79,337

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SB - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.9	0.3	406	69,174
2021	5.8	0.3	406	69,666
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 PNM - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.8	0.3	467	68,985
2021	5.8	0.3	406	69,453
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 IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	4.0	0.2	276	68,985
2021	3.5	0.2	241	69,453
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 IM-Neonatal - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	2.8	0.2	191	68,985
2021	2.4	0.2	165	69,453
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 IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	202.9	17.2	140	68,985
2021	167.0	15.5	116	69,453
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 IM-Preterm Related - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	124.7	13.5	86	68,985
2021	108.0	12.5	75	69,453
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 IM-SUID - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.7	0.3	375	65,664
2021	6.2	0.3	408	66,068
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 NAS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness - SR

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	66.1 %	3.8 %	158,929	240,325

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 SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	13.8 %	1.3 %	179,774	1,301,887
2021_2022	14.2 %	1.2 %	185,477	1,304,173
2020_2021	12.4 %	1.2 %	161,281	1,296,012
2019_2020	10.9 %	1.2 %	140,124	1,280,097
2018_2019	13.5 %	1.4 %	173,693	1,288,245
2017_2018	12.4 %	1.5 %	162,030	1,306,548
2016_2017	11.2 %	1.3 %	145,021	1,296,176

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 TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	23.0	1.9	153	664,248
2022	23.8	1.9	157	660,353
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 CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	49.5	2.5	396	800,223
2022	54.8	2.6	434	791,866
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 AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021-2023	20.2	1.3	244	1,208,565
2020_2022	19.4	1.3	231	1,188,001
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 AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 10 through 19 per 100,000 - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	7.8	0.6	187	2,392,616
2020_2022	7.8	0.6	185	2,370,821
2019_2021	7.8	0.6	185	2,359,741
2018_2020	8.9	0.6	208	2,342,541
2017_2019	9.8	0.7	230	2,348,041
2016_2018	10.3	0.7	242	2,352,278
2015_2017	9.0	0.6	211	2,355,319
2014_2016	7.8	0.6	183	2,358,547
2013_2015	6.5	0.5	154	2,363,931
2012_2014	5.7	0.5	135	2,375,753
2011_2013	5.5	0.5	131	2,399,320
2010_2012	5.4	0.5	131	2,429,624
2009_2011	5.2	0.5	128	2,457,480

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	17.1	0.9	410	2,392,616
2020_2022	16.9	0.8	401	2,370,821
2019_2021	15.4	0.8	363	2,359,741
2018_2020	14.4	0.8	337	2,342,541
2017_2019	13.8	0.8	324	2,348,041
2016_2018	12.6	0.7	297	2,352,278
2015_2017	11.4	0.7	268	2,355,319
2014_2016	9.7	0.6	228	2,358,547
2013_2015	8.2	0.6	195	2,363,931
2012_2014	8.3	0.6	196	2,375,753
2011_2013	8.1	0.6	194	2,399,320
2010_2012	9.2	0.6	224	2,429,624
2009_2011	10.0	0.6	246	2,457,480
2008_2010	11.1	0.7	275	2,476,455
2007_2009	10.9	0.7	271	2,487,691

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Firearm - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	129.0	4.2	941	729,362
2021	134.5	4.3	995	739,766
2020	127.2	4.1	950	746,714
2019	142.9	4.4	1,067	746,505
2018	126.4	4.1	949	750,660
2017	135.8	4.2	1,026	755,578
2016	134.2	4.2	1,018	758,643
2015	146.0	5.1	835	571,754
2014	143.4	4.3	1,096	764,073
2013	144.8	4.3	1,113	768,823
2012	154.9	4.5	1,193	770,235
2011	166.2	4.6	1,285	772,992
2010	180.2	4.8	1,407	780,700
2009	182.4	4.8	1,419	777,932
2008	196.1	5.0	1,520	774,919

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Child - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	261.7	5.8	2,072	791,866
2021	290.1	6.0	2,322	800,527
2020	304.6	6.3	2,371	778,428
2019	278.6	6.0	2,175	780,786
2018	271.9	5.9	2,130	783,327
2017	284.0	6.0	2,226	783,928
2016	281.6	6.0	2,211	785,023
2015	291.3	7.0	1,718	589,776
2014	276.9	5.9	2,180	787,156
2013	288.8	6.1	2,283	790,407
2012	310.1	6.2	2,475	798,190
2011	328.1	6.4	2,660	810,723
2010	332.6	6.4	2,730	820,711
2009	373.2	6.7	3,083	826,046
2008	376.0	6.7	3,120	829,698

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	48.2 %	2.0 %	520,702	1,080,649
2022	53.4 %	1.9 %	568,709	1,064,425
2021	57.3 %	1.7 %	610,370	1,065,003
2020	60.5 %	1.6 %	642,215	1,061,380
2019	56.2 %	2.0 %	595,398	1,058,849
2018	55.4 %	2.4 %	584,656	1,055,678
2017	54.7 %	2.0 %	579,506	1,058,636
2017	54.7 %	2.0 %	579,506	1,058,636
2016	61.3 %	2.3 %	646,203	1,054,724
2015	58.6 %	2.0 %	619,178	1,055,788
2014	55.2 %	2.2 %	581,235	1,052,815
2013	59.4 %	2.0 %	623,812	1,049,928
2012	56.3 %	2.1 %	589,053	1,045,826

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM WHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	88.4 %	1.2 %	1,205,897	1,364,122
2021_2022	91.0 %	1.0 %	1,248,907	1,372,474
2020_2021	91.9 %	1.1 %	1,248,430	1,358,456
2019_2020	90.7 %	1.2 %	1,229,762	1,356,225
2018_2019	88.5 %	1.3 %	1,213,340	1,371,708
2017_2018	89.6 %	1.3 %	1,236,841	1,381,125
2016_2017	91.2 %	1.2 %	1,259,105	1,381,074

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 CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile) - OBS

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: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	15.2 %	1.6 %	135,847	893,548
2021_2022	16.1 %	1.6 %	140,453	872,513
2020_2021	19.0 %	1.8 %	162,656	857,455
2019_2020	19.2 %	1.8 %	166,834	869,198
2018_2019	16.3 %	1.7 %	142,702	875,301
2017_2018	12.7 %	1.5 %	111,102	873,116
2016_2017	13.6 %	1.5 %	117,044	861,004

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 OBS - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	13.9 %	1.4 %	8,326	60,097
2022	15.6 %	1.4 %	9,963	63,706
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 PPD - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum anxiety symptoms - PPA

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	24.6 %	1.8 %	14,728	59,980

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 PPA - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	11.3 %	2.0 %	51,158	451,839
2021_2022	9.1 %	1.7 %	41,645	459,641
2020_2021	8.0 %	1.5 %	36,746	458,803
2019_2020	8.6 %	1.5 %	39,576	459,821
2018_2019	10.7 %	2.1 %	49,099	460,436
2017_2018	11.0 %	2.6 %	51,144	463,930
2016_2017	9.4 %	2.2 %	44,124	470,066

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 BCD - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	23.6 %	2.4 %	115,061	486,901
2021_2022	17.2 %	1.9 %	81,776	476,318
2020_2021	14.1 %	1.7 %	65,266	463,927
2019_2020	13.8 %	1.7 %	64,029	465,018
2018_2019	13.8 %	1.8 %	64,700	469,131
2017_2018	12.8 %	2.1 %	60,727	472,591
2016_2017	11.9 %	2.0 %	55,444	466,653

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 ADA - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system - SOC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	12.3 %	2.0 %	52,015	423,819
2021_2022	13.3 %	2.3 %	49,674	373,182
2020_2021	15.7 %	2.3 %	52,877	336,318
2019_2020	18.2 %	2.5 %	65,269	358,730
2018_2019	14.4 %	2.2 %	57,769	402,454
2017_2018	16.3 %	2.9 %	67,968	415,945
2016_2017	19.6 %	3.1 %	75,708	385,453

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 SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 5, who are flourishing - FL-YC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	77.7 %	2.7 %	312,626	402,193
2021_2022	80.8 %	2.4 %	325,595	402,811
2020_2021	82.6 %	2.5 %	337,079	407,930
2019_2020	84.3 %	2.6 %	342,037	405,553
2018_2019	83.3 %	3.1 %	336,665	404,086

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 FL-YC - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA

Data Source: National Survey of Children's Health (NSCH)-CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	38.6 %	3.4 %	127,298	329,481
2021_2022	37.2 %	3.3 %	110,965	298,320
2020_2021	39.9 %	3.3 %	110,071	275,790
2019_2020	46.6 %	3.5 %	135,237	290,411
2018_2019	48.3 %	3.8 %	151,668	314,164

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 FL-CA - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent

Data Source: National Survey of Children's Health (NSCH)-All Children

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	57.0 %	2.1 %	529,543	929,201
2021_2022	57.5 %	2.1 %	534,467	930,182
2020_2021	61.8 %	2.0 %	563,820	912,757
2019_2020	66.4 %	2.0 %	605,999	912,165
2018_2019	66.1 %	2.1 %	613,931	928,698

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 FL-Child Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	20.8 %	1.5 %	281,237	1,350,340
2021_2022	19.3 %	1.4 %	260,554	1,350,545
2020_2021	19.9 %	1.5 %	266,485	1,340,567
2019_2020	17.2 %	1.4 %	230,188	1,341,019
2018_2019	16.5 %	1.4 %	225,069	1,361,558
2017_2018	21.8 %	1.9 %	297,641	1,362,383
2016_2017	25.4 %	1.9 %	340,010	1,341,090

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 ACE - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Missouri

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	89.3	89.1
Numerator	56,979	53,527
Denominator	63,820	60,097
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	90.1	90.6	91.0	91.5	92.0

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	79.7	75.3
Numerator	45,011	39,863
Denominator	56,476	52,960
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	76.9	77.7	78.4	79.2	80.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		85.2	86.4	87.6	88.8
Annual Indicator	83.1	84.8	82.9	82.8	72.9
Numerator	54,118	53,369	51,856	51,597	42,851
Denominator	65,137	62,925	62,533	62,314	58,773
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	90.9	91.9	92.9	94.0	95.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		41.9	43.9	46	48
Annual Indicator	40.3	37.1	36.6	35.5	28.9
Numerator	25,609	23,096	22,467	21,574	16,786
Denominator	63,599	62,314	61,451	60,782	58,181
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	49.7	50.5	51.3	52.2	53.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		49	49.2	49.5	49.7
Annual Indicator	55.0	54.6	58.9	60.1	73.7
Numerator	35,105	33,976	36,271	36,443	43,433
Denominator	63,808	62,273	61,579	60,621	58,900
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	51.5	52.4	53.2	54.1	55.0

Field Level Notes for Form 10 NPMs:

None

NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	80.2
Numerator	47,479
Denominator	59,177
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	81.8	82.6	83.4	84.2	85.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who had a dental visit during pregnancy - PDV-Pregnancy

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	46.7
Numerator	28,824
Denominator	61,731
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	47.1	47.4	47.6	47.8	48.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child - Child Health

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	75.0
Numerator	976,851
Denominator	1,303,086
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	75.7	76.0	76.3	76.7	77.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance - ADM

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	91.8
Numerator	438,703
Denominator	477,900
Data Source	NSCH
Data Source Year	2022_2023

Federally Available Data	
Data Source: National Survey of Drug Use and Health	
	2024
Annual Objective	
Annual Indicator	28.8
Numerator	136,000
Denominator	470,000
Data Source	NSDUH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	92.9	93.4	93.9	94.5	95.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	49.8	50.6	51.4	52.2	53
Annual Indicator	46.9	51.9	48.5	44.0	42.4
Numerator	141,727	149,881	135,203	126,340	179,643
Denominator	301,956	288,780	278,712	287,294	423,301
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	54.3	55.0	55.7	56.3	57.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	49.2	49.6
Numerator	675,506	678,140
Denominator	1,374,264	1,368,115
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	51.4	52.3	53.2	54.1	55.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Adolescent Health - All Adolescents

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Adolescents	
	2024
Annual Objective	
Annual Indicator	18.3
Numerator	88,936
Denominator	486,513
Data Source	NSCH-All Adolescents
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	19.2	19.7	20.1	20.6	21.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

State: Missouri

2021-2025: NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		37.6	37.8	38.2	38.4
Annual Indicator	32.8	31.2	34.3	32.4	24.6
Numerator	156,884	145,507	154,430	147,004	110,011
Denominator	477,809	465,671	450,203	453,355	446,508
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	70.1	70.5	71	71.5	72
Annual Indicator	72.6	72.5	72.4	71.8	76.3
Numerator	754,373	755,016	751,551	751,176	814,079
Denominator	1,039,355	1,041,255	1,038,345	1,046,558	1,066,748
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	275.1	275	274.9	274.8	274.8
Annual Indicator	271.9	278.6	304.6	290.1	261.7
Numerator	2,130	2,175	2,371	2,322	2,072
Denominator	783,327	780,786	778,428	800,527	791,866
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2018	2019	2020	2021	2022

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Missouri

SPM 1 - Percent of children and parents participating in a family skills development and strengthening program who report improvement on program evaluation metrics.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	67.0	69.0	71.0	73.0	75.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

2021-2025: 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					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	71.9	72.1	72.3	72.5	72.7
Annual Indicator	72.5	72.5	69.8	72.5	75
Numerator	928,942	928,942	905,262	948,407	976,851
Denominator	1,280,625	1,280,625	1,296,180	1,308,148	1,303,087
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2019_2020	2020_2021	2021_2022	2022_2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**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)	
2.	**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)	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2020-2021 data not available	
4.	**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)	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Note: Annual objectives based on percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year. Data Source: National Survey of Children's Health (NSCH) years 2021-2022	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Note: Annual objectives based on percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year. Data Source: National Survey of Children's Health (NSCH) years 2022-2023	

2021-2025: SPM 2 - Suicide and self-harm rate among youth ages 10 through 19

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		17.4	16.8	16.2	15.5
Annual Indicator		17.4	29	25.6	25.6
Numerator		1,200	274	151	151
Denominator		6,897	945	590	590
Data Source		YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year		2019	2021	2023	2023
Provisional or Final ?		Final	Final	Final	Final

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.

YRBSS conducted on odd numbered years. 2022 data reflects final survey data from 2021.
Updated data to reflect YRBSS weighting.
Numerator: 274
Denominator: 889

Weighted Numerator: 78,792
Weighted Denominator: 271,436
Weighted Percent: 29%

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Updated data to reflect YRBSS weighting.
Numerator: 151
Denominator: 659

Weighted Numerator: 69,610
Weighted Denominator: 271,915
Weighted Percent: 25.6%

4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
YRBSS conducted on odd numbered years. 2024 data reflects final survey data from 2023.
Updated data to reflect YRBSS weighting.
Numerator: 151
Denominator: 659

Weighted Numerator: 69,610
Weighted Denominator: 271,915
Weighted Percent: 25.6%

2021-2025: 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					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		20	100		
Annual Indicator		48	90	102	219
Numerator					
Denominator					
Data Source		MO DHSS Internal Survey	MO DHSS MCH Training Log	MO DHSS MCH Training Log	MO DHSS MCH Training Log
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
FFY 23, 102 out of 113 Title V MCH-funded staff completed a series of videos and article reviews on the medical home approach and the strengthening families framework from the American Academy of Pediatrics (AAP) and the Center for the Study of Social Policy.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Missouri

ESM PPV.1 - Number of postpartum care providers who participate in training through the Missouri PQC on implementing standardized and comprehensive postpartum care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

ESM SS.1 - Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bedsharing or soft bedding (aligned with MIECHV performance measure).

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		83.6	83.8	84	84.6
Annual Indicator		76.6	99.4	97.8	97.5
Numerator		108	166	264	427
Denominator		141	167	270	438
Data Source		MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program	MO DHSS DESE Safe Cribs Program	MO DHSS DESE Safe Cribs Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	80.3	82.0	83.7	85.3	87.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Available data information is current for July 1, 2022 to June 30, 2023. Provided by Missouri DESE - Safe Cribs for Missouri Program, Follow up Assessment Survey.	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: This measure has been changed for FY25-30. Data is not comparable with the previous measure.	

ESM PDV-Pregnancy.1 - Number of oral health care providers who participate in training on providing respectful, whole-person, and person-centered care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

ESM PDV-Child.1 - Number of students referred to an oral health care provider as a result of participating in the Preventive Services Program (PSP).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	14,000.0	14,000.0	14,000.0	14,000.0	14,000.0

Field Level Notes for Form 10 ESMs:

None

ESM ADM.1 - Number of LPHAs contracted to develop adolescent youth leadership initiatives to ensure youth engagement in decision-making, program planning, service delivery, and quality improvement activities at local and state levels.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM MH.1 - Number of school health staff educated on the importance and benefits of a medical home for children with and without special health care needs.

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		1,800	2,000		
Annual Indicator	1,822	1,057	637	193	193
Numerator					
Denominator					
Data Source	MO DHSS Programs	MO DHSS Programs	MO DSS Programs	MO SHCN Family Partnership	MO SHCN Family Partnership
Data Source Year	2020	2021	2022	2023	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	125.0	125.0	75.0	75.0	75.0

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.

4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
SHCN Family Partnership hosted a session on the Medical Home Approach for parents and caregivers, who attended the 2023 Navigating Uncharted Waters Retreat. The Missouri Medical Home brochure was shared by SHCN Family Partners during two outreach events.

Note: SHCN Family Partnership did not have a consistent full-time manager in place during the reviewed grant period, which led to some of the projects/initiatives not being completed as intended.

5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
2024 data was not available at the time of reporting.

This measure has been changed for FY25-30. Data is not comparable with the previous measure.

ESM TAHC.1 - Number of school health staff educated on supporting high school students' development of health self-advocacy skills.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	200.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM PA-Child.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	100	200	300
Annual Indicator	33	352	486	559	559
Numerator					
Denominator					
Data Source	MO DHSS Go NAPSACC data	MOPHIRS Report -CLPHS Service Log	MO DESE CCHC program	MO DESE CCHC program	MO DESE CCHC program
Data Source Year	2019	2021	2022	2023	2023
Provisional or Final ?	Final	Final	Final	Final	Final

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.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Annual indicator are logged hours of training for FY 2023 as kept by Child Care Health Consultation (CCHC) Program in DESE.	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 2024 data was not available at the time of reporting.	

2021-2025: ESM WWV.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		85.8	86.2	86.8	87.2
Annual Indicator	83.7	86.7	86.6	85.4	87.6
Numerator	1,001	1,204	1,573	1,014	969
Denominator	1,196	1,388	1,816	1,187	1,106
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2021-2025: ESM IH-Adolescent.1 - Percentage of high school students who reported distracted driving.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		45	44.2	43.5	42.5
Annual Indicator	45.8	45.8	42.5	49.2	49.2
Numerator	722	722	197	122	122
Denominator	1,576	1,576	464	248	248
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2019	2019	2021	2023	2023
Provisional or Final ?	Final	Final	Final	Final	Final

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. Updated data to reflect YRBSS weighting. Numerator: 197 Denominator: 518 Weighted Numerator: 73,318 Weighted Denominator: 172,558 Weighted Percent: 42.5%	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Updated data to reflect YRBSS weighting. Numerator: 122 Denominator: 318 Weighted Numerator: 73,057 Weighted Denominator: 148,444 Weighted Percent: 49.2%	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: YRBSS data only released on odd numbered years. YRBSS conducted on odd numbered years. 2024 data reflects final survey data from 2023. Updated data to reflect YRBSS weighting. Numerator: 122 Denominator: 318 Weighted Numerator: 73,057 Weighted Denominator: 148,444 Weighted Percent: 49.2%	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Missouri

SPM 1 - Percent of children and parents participating in a family skills development and strengthening program who report improvement on program evaluation metrics.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the number of children and parents who report improvement or strengthening in family skills
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of participants in family skills development and strengthening programs reporting improvement on at least 75% of program evaluation metrics **Denominator:** Number of participants in family skills development and strengthening programs
Healthy People 2030 Objective:	By September 30, 2030, based on standardized pre- and post-participation survey results, at least 75% of children and parents participating in a family skills development and strengthening program will report improvement on at least 75% of program evaluation metrics.
Data Sources and Data Issues:	MO DHSS Family Skills Development and Strengthening Program Surveys
Significance:	Strengths-based services and supports to promote healthy family relationships and functioning, enhance resilience, foster social connections, develop knowledge of parenting and child development, and support children's social and emotional development.

Form 10
State Performance Measure (SPM) Detail Sheets (2021-2025 Needs Assessment Cycle)

2021-2025: 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of children, ages 1-17 years, who had a preventive dental visit in the last year.</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>Children, ages 1-17, who had a preventive dental visit in the last year.</td></tr>
<tr><td>Denominator:</td><td>All children ages 1 through 17 years.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Related to Oral Health (OH) Objective 7. Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year. (Baseline: 44.5%, Target: 49.0%).
Related to Oral Health (OH) Objective 8. Increase the proportion of low-income children and adolescents who receive any preventive dental service during the past year. (Baseline: 30.2%, Target: 33.2%).</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>National Survey of Children's Health (NSCH)</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2021-2025: SPM 2 - Suicide and self-harm rate among youth ages 10 through 19
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	By 2025, reduce the suicide death rate among youths 10-19 years from 7.8% per 100,000 (CY 2019 Vital Statistics).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of high school kids who seriously considered attempting suicide in the past year (YRBS) **Denominator:** Number of adolescents in grades 9 through 12 (YRBS)
Healthy People 2030 Objective:	Related to Mental Health and Mental Disorders (MHMD) Objective 1: Reduce the suicide rate. (Baseline: 11.3 suicides per 100,000 in 2007, Target: 10.2 suicides per 100,000) Related to Mental Health and Mental Disorders (MHMD) Objective 2: Reduce suicide attempts by adolescents. (Baseline: 1.9 suicide attempts per 100 occurred in 2009, Target: 1.7 suicide attempts per 100)
Data Sources and Data Issues:	YRBS
Significance:	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).

2021-2025: 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:** 219 **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:**
Healthy People 2030 Objective:	No Healthy People 2020 Objective.
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 a health 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 PPV.1 - Number of postpartum care providers who participate in training through the Missouri PQC on implementing standardized and comprehensive postpartum care.
NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Measure Status:	Active
Goal:	At least 100 providers will be trained in FY26.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of postpartum care providers who participate in training through the Missouri PQC on implementing standardized and comprehensive postpartum care. **Denominator:**
Data Sources and Data Issues:	Missouri PQC
Evidence-based/informed strategy:	The ESM is based on the evidence-based strategy of guideline adherence protocol per the MCHbest database. https://www.mchevidence.org/tools/strategies/details.php?postpartum-visit-10 Per the MCH Evidence Center, "Adherence to comprehensive postpartum care guidelines—as recommended by the American College of Obstetricians and Gynecologists and endorsed by multiple health professional organizations—can help ensure consistent quality of care for all postpartum patients." This training, which is guided by the ACOG framework and consists of a postpartum plan of care toolkit developed by the PQC, covering number of visits, mental health and SUD screening, a warm handoff to a primary care provider, and more, will assure consistent, evidence-based, patient-centered, coordinated, and comprehensive care for postpartum women in Missouri.
Significance:	The PAMR Board identified the need for a standardized postpartum plan of care, with an emphasis on the number of visits, mental and SUD screening, a warm handoff to a primary care provider, and more. As prioritized and guided by ACOG, the PQC training addresses strategies of providing training for all types of providers, implementing the Maternal Mortality Prevention Plan, and promoting and supporting traditional and nontraditional provider roles and community-based models of perinatal care to reduce maternal mortality and assure consistent, evidence-based, person-centered, coordinated, and comprehensive care to postpartum women in Missouri.

ESM SS.1 - Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bedsharing or soft bedding (aligned with MIECHV performance measure).
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 D) Percent of infants room-sharing with an adult during sleep - SS

Measure Status:	Active
Goal:	By September 30, 2030, Missouri will increase the percent of infants enrolled in home visiting that are always placed to sleep on their backs without bedsharing or soft bedding from 77% to 87%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Infants enrolled in home visiting that are always placed to sleep on their backs without bedsharing or soft bedding **Denominator:** Infants enrolled in home visiting
Data Sources and Data Issues:	MIECHV
Evidence-based/informed strategy:	Evidence-based home visiting programs as assessed by the Home Visiting Evidence of Effectiveness (HomVEE) study. The ESM is based on the caregiver/parent education and education per the MCHbest database. https://www.mchevidence.org/tools/strategies/details.php?safe-sleep-01. Cross-sector collaboration to address social drivers contributing to disparities in infant health and mortality and promote overall infant health must include strategies to address unsafe infant sleep practices and environments as a leading cause of infant mortality.
Significance:	Home visiting programs play a crucial role in educating families about safe sleep practices for infants. Through partnership and collaboration with cross-sector stakeholders, person-centered guidance and a nuanced approach in taking family needs into account will be promoted in the implementation and spread of community-based safe infant sleep education campaigns and evidence-based infant health promotion programs to ensure safe infant sleep practices and environments and reduce sleep-related infant deaths.

ESM PDV-Pregnancy.1 - Number of oral health care providers who participate in training on providing respectful, whole-person, and person-centered care.
NPM – Percent of women who had a dental visit during pregnancy - PDV-Pregnancy

Measure Status:	Active
Goal:	At least 50 oral health care providers will be trained in FY26.
Definition:	**Unit Type:** Count **Unit Number:** 50 **Numerator:** Number of oral health care providers who participate in training on providing respectful, whole-person, and person-centered care. **Denominator:**
Data Sources and Data Issues:	DHSS Oral Health program
Evidence-based/informed strategy:	The literature emphasizes the value of integrating oral, physical, and behavioral health through whole-person, team-based approaches that engage families and communities. Sources: Integration of Oral Health and Primary Care: Communication, Coordinati
Significance:	Oral health is an important part of prenatal care. Pregnant women are susceptible to a range of oral health conditions that can lead to poor health outcomes for the mother and baby. This ESM measures the number of oral health care providers, inclusive of broader maternal health care providers, who receive appropriate training on providing respectful, whole person, and person-centered care. These trainings, which will be conducted by and in partnership with MHA and MU through the Maternal Mortality Prevention Plan and with other partners, including the Office of Dental Health, to provide education and professional development that targets all providers working with the perinatal population. Through providing education/training to oral care providers, inclusive of maternal care providers, on respectful, whole person, person-centered care for pregnant and postpartum women, we assure an integrated and coordinated approach to perinatal health and well-being.

ESM PDV-Child.1 - Number of students referred to an oral health care provider as a result of participating in the Preventive Services Program (PSP).
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child

Measure Status:	Active
Goal:	At least 14,000 students will be referred to a oral health care provider as a result of participating in the Preventive Services Program (PSP) in FY26.
Definition:	**Unit Type:** Count **Unit Number:** 14,000 **Numerator:** Number of students referred to a oral health care provider as a result of participating in the Preventive Services Program (PSP). **Denominator:**
Data Sources and Data Issues:	DHSS Oral Health program
Evidence-based/informed strategy:	The ESM is based on the evidence-based strategy of school-based dental programs per the MCHbest database. https://www.mchevidence.org/tools/strategies/details.php?dental-visit-child-wwfh-01. Oral health problems in children may result in pain and discomfort; sleep and appetite issues; low self-esteem, confidence and social skills; and reduced academic performance. The Preventive Services Program (PSP) is dedicated to improving healthy smiles for all of Missouri's children through education and preventive treatment. The goal of PSP is to review Missouri children's oral health and provide a public health intervention called fluoride varnish.
Significance:	Oral health is an integral part of overall physical, emotional, and social wellbeing, and a crucial aspect of youth development. Oral health is deeply connected to nutrition, speech, self-esteem, chronic disease, and quality of life. Oral health problems in children may result in pain and discomfort; sleep and appetite issues; low self-esteem, confidence and social skills; and reduced academic performance. When oral health care providers take a whole-person approach, they can better identify underlying issues and offer care and navigation/coordination/referrals that are preventative, respectful, and meet the needs of the child. Through promotion and support of the delivery of preventive oral health care by oral health professionals and implementation of the Preventive Services Program, which provides an oral health review, oral health education, application of fluoride varnish, oral health supplies, and referral to an oral health care provider, children and families are positioned to access holistic oral health services.

ESM ADM.1 - Number of LPHAs contracted to develop adolescent youth leadership initiatives to ensure youth engagement in decision-making, program planning, service delivery, and quality improvement activities at local and state levels.
NPM – Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance - ADM

Measure Status:	Active
Goal:	4 LPHAs contracted in FY26 (FY26 will be a planning and implementation year for this new initiative. In future years, this strategy will transition to measuring outcomes.)
Definition:	**Unit Type:** Count **Unit Number:** 4 **Numerator:** Number of LPHAs contracted to develop adolescent youth leadership initiatives to ensure youth engagement in decision-making, program planning, service delivery, and quality improvement activities at local and state levels. **Denominator:**
Data Sources and Data Issues:	DHSS Title V program
Evidence-based/informed strategy:	By embedding youth voices into MCH decision-making and improvement processes, programs become more relevant, optimal, and effective—ultimately increasing adolescent satisfaction, access to services, and health outcomes. "Youth-Adult Partnerships in Work with Youth: An Overview," Journal of Youth Development https://open.clemson.edu/jyd/vol12/iss4/3; For youth involved in this initiative through the LPHAs, they will gain trusted guidance in decision-making. By being involved as a youth leader, embedded in local and state level decision-making initiatives, youths will be empowered build life skills and reach their full potential.
Significance:	Adult mentoring provides youth with guidance, support, and encouragement during a critical period of development. Mentorship also fosters skill development and positive youth development, improves health and social outcomes, and provides a trusted adult for navigating challenges and systems. Through a collaborative youth leadership and voice initiative, local public health agencies can provide mentorship to youth, including establishing and conducting training across their team and with partners, embedding youth-driven goal setting, and collaborating with cross-sector stakeholders to promote youth leadership and youth voice in the broader public health system, thereby promoting adolescent psychological well-being and empowering youth with the tools and training to reach their full potential.

ESM MH.1 - Number of school health staff educated on the importance and benefits of a medical home 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 - MH

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>At least 250 school health staff will be trained by the end of FY27.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>Number of school health staff educated on the importance and benefits of a medical home for children with and without special health care needs.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>DHSS School Health program</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The ESM is based on the evidence-based strategy of healthcare provider training and education per the MCHbest database. https://www.mchevidence.org/tools/strategies/details.php?medical-home-fcc-01. Children spend a majority of their time in the school setting, from early childhood through the adolescent years. School health staff are well positioned to promote medical home with children and their families through day-to-day interactions as well as broader community health promotion activities. School health staff may also function as a child's medical home in certain circumstances, like in rural areas without a primary health care provider/setting.</td></tr>
<tr><td>Significance:</td><td>School health staff are well positioned to promote medical home with children and their families through day-to-day interactions as well as broader community health promotion activities, as children spend a majority of time in the school setting. Through partnership and collaboration with cross-sector stakeholders, education on the medical home and implementation of care coordination will be promoted among school health staff and in school settings to enhance access to a medical home and assure facilitation of linking children with and without special health care needs and their families to appropriate services and resources.</td></tr>
</table>

ESM TAHC.1 - Number of school health staff educated on supporting high school students' development of health self-advocacy skills.
NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>At least 200 school health staff will be trained by the end of FY27.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of school health staff educated on supporting high school students' development of health self-advocacy skills.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>DHSS School Health program</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The ESM is based on the evidence-based strategy of provider training/workforce development per the MCHbest database. https://www.mchevidence.org/tools/strategies/details.php?transition-01. Children spend the majority of their time in the school setting, from early childhood through the adolescent years. School health staff are well-positioned to promote the transition into adult health care and adulthood with adolescents and their families through day-to-day interactions as well as broader community health promotion activities. School counselors, as part of school health staff, work with high school students to plan for life after high school, and are also well-positioned to plan the transition of care from child-centered to adult-oriented.</td></tr>
<tr><td>Significance:</td><td>The 2018 clinical report, developed jointly by the AAP, American Academy of Family Physicians, and American College of Physicians, demonstrates the need to improve transitions to adult health care for all youth and families. Youth and young adults' academic and employment outcomes may be negatively impacted by poor health and well-being. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college, or be employed. Addressing the transition to adult health care prevents lapse in care and services, supports youth in developing crucial skills, including learning how to navigate health systems, manage their own care, and make informed decisions, improves long-term outcomes, and helps both caregivers and providers plan proactively, supporting families and systems. Through partnership with cross-sector stakeholders to provide training for providers, including school health staff, on the transition from child-centered to adult-oriented care, as well as encouragement of the adoption of evidence-driven health care transition practices and policies, adolescents and families are empowered to manage their health and are positioned to have a smooth and successful transition to adult health care.</td></tr>
</table>

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM PA-Child.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.
2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>5,000</td></tr>
<tr><td>Numerator:</td><td>Number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MO DESE CCHC data</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2021-2025: ESM WWV.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

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.

2021-2025: ESM IH-Adolescent.1 - Percentage of high school students who reported distracted driving.
2021-2025: NPM – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

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.

Form 11
Other State Data

State: Missouri

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Missouri

Annual Report Year 2024

	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	1		
2) Vital Records Death	Yes	Yes	Daily	1	Yes	
3) Medicaid	Yes	Yes	Daily	1	Yes	
4) WIC	Yes	Yes	Daily	1	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

Form 12
Part 2 – Products and Publications (Optional)

State: Missouri

Annual Report Year 2024

Products and Publications information has not been provided by the State.