

# **Mississippi State Department of Health**

**Fiscal Years 2019-2023**

## **Strategic Plan**

**Prepared in Accordance with the  
Building a Better Mississippi Instructions  
July 2017**

# Mississippi State Department of Health

## Mission Statement

The Mississippi State Department of Health mission is to promote and protect the health of the citizens of Mississippi.

## Agency Philosophy

The MSDH strives for excellence in government, cultural competence in carrying out its mission, and local solutions to local problems. The MSDH identifies its values as applied scientific knowledge, teamwork, and customer service.

## Relevant Statewide Goals and Benchmarks

*Statewide Goal #1:* Protect Mississippians from risks to public health and provide them with the health-related information and access to quality health care necessary to increase the length and quality of their lives.

The Mississippi State Department of Health administers more than 200 programs, providing a broad range of services. Programs addressed in this plan include:

- Health Services – Women’s Health and Child/Adolescent Health include programs to reduce maternal and infant mortality and to provide reproductive health services, targeted screening and referral for breast and cervical cancer, and early detection/referral for infants with genetic disorders; WIC provides nutrition education and supplemental foods to eligible women and children and promotes breastfeeding to improve infant health; and Preventive Health collaborates with other agencies and organizations to improve environments and policies that support and encourage healthful behaviors;
- Health Protection – Environmental Health regulates the public water supply, food service and processing establishments, onsite wastewater disposal systems, and other areas of environmental concern to help prevent adverse health effects from environmental hazards; and Mississippi’s Trauma Care System is a coordinated effort to ensure that patients with traumatic injuries are transported as quickly as possible to the hospital most appropriate for their injury;
- Communicable Disease collects and analyzes data regarding reportable diseases, investigates outbreaks, and works to reduce the rate of premature death and the spread of these diseases;
- Tobacco Control administers programs designed to decrease the use of tobacco among youth and adults in Mississippi;
- Public Health Emergency Preparedness and Response develops and tests plans and procedures to respond to any public health threat or emergency;
- Primary Care Development helps to assure access to primary care services for underserved areas of the state;
- Local Governments and Rural Water Systems Improvements Loan Program and Emergency Loan Program use grants from the federal Environmental Protection Agency to offer low-interest loans

to public water systems to help them achieve and maintain compliance with federal and state Safe Drinking Water Acts; and

- Mississippi Burn Care Fund disburses designated funds to burn center hospitals for uncompensated care provided to Mississippi burn victims transferred from a Mississippi licensed hospital.

In addition, the agency operates such programs as Early Intervention, which provides services for children with disabilities from birth to age three; Licensure programs, which work to assure that emergency medical services, designated health care facilities, child care facilities, and certain types of practitioners meet minimum standards and comply with laws and regulations; and Public Health Statistics, which registers and certifies certain vital events and maintains health statistics. The Public Health Laboratory performs testing of samples to identify certain infectious diseases, assure the safety of the public water supply, and identify environmental health concerns.

**Statewide Goal #2:** Protect the public's safety, including providing timely and appropriate responses to emergencies and disasters.

The Mississippi State Department of Health Office of Emergency Preparedness and Response, while focusing on public health threats and emergencies, also coordinates with the Mississippi Emergency Management Agency and integrates its efforts with federal, state, local, and tribal governments; the private sector; and non-governmental organizations. Activities are based on and support the National Response Plan, the National Incident Management System, and the Homeland Security Exercise and Evaluation Program. Use of these systems ensures that all entities required to respond to a mass casualty event are equipped and prepared to do so. The program is responsible for Emergency Support Function 8 in the Governor's State Emergency Response Plan, and provides technical assistance, training, and exercises to ensure the response capabilities for regional, district, and local response teams as well as the Governor's State Emergency Response Team regarding medical response. Measures for the MSDH Office of Emergency Preparedness and Response are included under Statewide Goal #1.

## **Overview of Strategic Plan**

Since 2014, the Mississippi State Department of Health and its partners have engaged in the state's first-ever statewide health assessment and strategic planning process. The State Health Assessment was a year-long collaborative effort that engaged more than 19,000 residents, public health professionals, and community partners across the state. It provided a foundation of knowledge on the health status and quality of life of Mississippians and served as the basis for a State Health Improvement Plan developed in 2015 to serve as a comprehensive roadmap for improving the health of Mississippians.

A State Health Assessment and Improvement Committee advised and assisted MSDH in developing the plan to address the state's greatest health needs on a priority basis. Through this process, MSDH is seeking to: (1) encourage and stimulate quality and performance improvement, (2) promote greater accountability and transparency, (3) identify opportunities, (4) evaluate the allocation of resources, (5) enhance relationships within Mississippi's communities and with other organizations, and (6) increase cooperation and collaboration with other agencies and organizations.

In 2017, MSDH consolidated district administrative functions by reducing the number of Field administrative units from nine Districts to three Regions and realigning funding streams to fund some

district personnel by federal grant funds where possible. Staff paid through federal grants perform the function of the grant and services promoted by the grant. MSDH is now comprised of three regions: the Northern Public Health Region, Central Public Health Region, and Southern Public Health Region. Each region employs a regional administrator, responsible for administrative functions of the county health departments in each region, and a regional health officer who reports to the State Health Officer. These Regions have oversight of all county health department operations.

As the strategic planning process is ongoing, the direction of the MSDH must be adapted to the current community environment and other factors that affect health in the state. MSDH will continue to provide those core public health services that no private provider will take on, such as surveillance for and treatment of all tuberculosis patients and contact tracing, testing, and treatment to assure that TB does not reoccur, and does not come back in a drug resistant form. MSDH has a nationally renowned TB program.

Core public health also includes the surveillance for other infectious diseases, which allows outbreaks to be detected and investigated to prevent continuing spread of the disease and further outbreaks. In addition, while Mississippi public health has provided safety net health care services in clinics for decades, including reproductive health services, well baby care, and TB and STD services, and will continue doing so, MSDH must also look to engaging communities outside the walls of the clinic in activities and adoption of policies that promote healthy behaviors. Community engagement in health and prevention, and the inclusion of health as a consideration in all policies, both locally and statewide, can provide a healthy environment to allow healthy choices to be more easily made. Community Health Teams, directed by Community Health Directors, are employed in all three public health regions to promote these collaborations with community partners.

Primary prevention of chronic diseases, communicable diseases, and injuries will require that community engagement, and MSDH will facilitate community changes to improve health. While this primary prevention strategy is evidence-based and will affect health in the long term, it will take decades to reverse the trends that have led to Mississippi's high rates of chronic disease and to see changes in the death rates due to or even incidence of these chronic diseases. Short term and intermediate term goals will have to include objectives related to the risk factors associated with chronic diseases, such as rates of appropriate exercise and tobacco use.

In conjunction with this effort, MSDH has implemented a performance management system to measure its progress toward meeting targeted goals and objectives. A Vision, Mission, Services, and Goals Performance Dashboard will assist in monitoring results, and quality improvement initiatives will address areas of need as they are identified.

These activities are part of the MSDH's steps toward accreditation by the national Public Health Accreditation Board, which is an effort to improve and protect the health of the public by advancing the quality and performance of the nation's public health departments. Accreditation is a multi-year process. Achieving accreditation in 2018 will document that MSDH meets the standards included in each of 12 public health domains.

As MSDH patient populations decline, and as Medicaid managed care payment methodologies decrease reimbursement to MSDH even further, the Department must refocus its efforts to population-based public health preventive services and regulatory activities. Future requests from the Department will be more focused to cover core public health activities that, in the past, were performed by field staff who were paid out of other sources.

One priority of great concern is Mississippi's infant mortality rate, which remains the highest or among the highest in the country every year. The Legislature provided \$1 million in state general funds in FY 2016 to address the most pertinent drivers of infant mortality: prematurity, which is related to tobacco use in pregnancy, interconception care, low breastfeeding rates, and having a previous preterm delivery, as well as Sudden Infant Death Syndrome and sleep-related deaths. These funds were added to funds from Title V, the Centers for Disease Control Preventive Health block grant, and grants received from the Association of Maternal and Child Health Programs to address infant mortality. While these state funds are no longer available, MSDH intends to maintain as much as possible an ongoing effort to reduce infant mortality in a collaborative effort between the public and private sector.

## External/Internal Assessment

Numerous factors may influence the agency's ability to reach its goals and objectives. MSDH is strongly affected by changes in federal and state laws, regulations, and funding. As MSDH funding is from many sources, and historically only about 11% of the budget is from the state general fund, activities are often driven by funding stream requirements, regardless of the state needs and priorities. In addition, the agency must respond to changes in the healthcare system, an arena that remains volatile. During the 2016 Legislative Session, Senate Bill 2362 diverted monies collected through fines and assessments from special funds designated for Trauma and EMS Systems of Care and Domestic Violence to the State General Fund. This resulted in a reduction of 9.68 million dollars of general fund appropriations to the State Department of Health in 2017 and 2018. However, House Bill 1651 (2016) and House Bill 1511 (2017) included line item funding for Trauma and EMS Systems of Care and Domestic Violence in the amount of 9.68 million, which equates to a diversion of general funds previously appropriated for core public health services to these programs. House Bill 1511 moved funding of the Mississippi Qualified Health Centers from the Health Care Expendable Fund to the Tobacco Control Fund and funding for the Stroke and STEMI system of care from general funds to the Tobacco Control Fund which allowed more funds to be use for core public health services.

During 2014 and 2015 the MSDH, along with numerous partners, conducted a comprehensive statewide assessment of the health and social wellbeing of Mississippians and the issues affecting our public health system. The assessment was a collaborative effort that engaged a diverse range of public health partners, stakeholders, and residents.

The Assessment consisted of four parts: (1) a Health Status Assessment through an epidemiological analysis of demographic, social, and health indicators from a variety of data sources; (2) a State and Community Themes and Strengths Assessment through a statewide survey, community conversations, and focus groups; (3) a Forces of Change Assessment through an advisory council comprising experts, stakeholders, and representatives across the state public health system; and (4) a State Public Health System Assessment through dialog from over 100 representatives of government, business, academic institutions, healthcare providers, and a variety of community-based, non-profit, and advocacy organizations.

The Assessment has resulted in the identification of priority issues in a public health *system*-focused approach rather than an agency-focused approach. Its purpose is a shared understanding of health and quality of life issues, a common vision for a healthy future, and a collective investment in implementing strategies to address priority issues. Improving health and quality of life will require an alignment of efforts throughout the state and the incorporation of health into the culture of Mississippians.

The comprehensive State Health Improvement Plan developed during 2015 establishes priorities for a variety of agencies and organizations to work in concert with MSDH to help address the social determinants of health, strengthen the state's public health infrastructure, improve health status, and promote an environment where everyone has an opportunity to be healthy. The MSDH is only one part of the public health system. Other agencies, private organizations, institutions, volunteers, and informal associations play critical roles in creating conditions in which people can be healthy. Government alone cannot match the collective strength of individuals, communities, and various social institutions working together to improve health.

The State Health Improvement Plan is intended to promote collaboration, coordination, efficiency, and a common agenda among key players in the public health system. The ongoing process of implementing the Plan will bring together these system partners on a periodic, regular basis to coordinate efforts. MSDH efforts and priorities will be re-evaluated and adjusted as necessary.

MSDH developed an agency-focused three-year strategic plan. The following represent a summary of major external factors that the Department must consider in its strategic planning:

### **Demographic**

- High poverty and unemployment rates
- Low education levels in the general population and low health literacy
- Very rural population, creating disparate transportation and service delivery problems
- Poor local tax base; diminishing state dollars, fewer services
- Increasing Spanish-speaking population

### **Health Status**

- Impact of chronic diseases
- High rates of behavioral risk factors
- High teen birth rates

### **Public Health System**

- Insufficient political and financial support of public health, and siloing of funding
- Low capacity and resources to address surveillance and response to long-term problems like chronic diseases
- Health care system infrastructure and access to care – high rates of uninsured and provider gaps
- Environmental and structural barriers to health – limited access to healthy foods and recreational spaces, unsafe neighborhoods
- Impact of disasters, e.g., Hurricane Katrina, the BP oil spill, and tornadoes

### **Internal Management**

Quality improvement is an essential part of the agency's accreditation process and delivery of effective services and will be an ongoing effort to ensure that concepts of quality improvement are a permanent part of all MSDH activities. The Department has developed a performance data management tool and will

begin to actively use it to manage programs in the future and evaluate how well programs are meeting established targets and standards.

The MSDH has established a Quality Improvement Council and drafted a Quality Improvement Plan to guide the development, implementation, monitoring, and evaluation of cross-divisional efforts to build a culture of continuous quality improvement through the agency. It provides a framework for an ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. The QI Plan was finalized during CY 2016.

As a part of performance management and quality improvement, plans are under way to evaluate and revise the MSDH process to monitor program and service delivery activities carried out by local health departments within the centralized organizational structure. Activities will include all dimensions of the agency – counties, districts, programs, disciplines, and related or support units. The desired result is a continuous improvement in the quality of services delivered to the state's citizens.

In addition, state audit and federal program reviews are a significant part of the agency's operations. These reviews assure compliance with federal rules and regulations, as well as quality and performance standards.

Complaints from the public or from staff are relayed to the MSDH Office of Field Services for investigation. Coordination with other offices is planned as required by the nature of the complaint. A written report is filed on each complaint received.

In addition, Internal Audit staff conduct financial, compliance, electronic data processing, and operational and efficiency audits of the agency. Internal Audit staff also evaluate internal controls over accounting systems, administrative systems, electronic data processing systems, and all other major systems to ensure accountability. Internal Audit is independent of the Department of Health; the Internal Audit director is hired by and reports directly to the State Board of Health.

## Program Plans

### Program 1: Health Services

**Note:** Many Health Services measures are reported by Calendar Year – some are the most recently completed Calendar Year and some are one year prior to the most recently completed year because of when the measures are finalized. This plan notes those measures where applicable. If no notation is provided, the measure is reported by State Fiscal Year.

**Goal A:** Reduce maternal and infant mortality, morbidity, and low birthweight; reduce the incidence of unplanned pregnancies; provide assistance to children with special health care needs; and minimize the effects of genetic disorders through early detection and timely medical evaluation, diagnosis, and treatment. [MS Code 1972 Annotated §41-3-15, 41-42-1, 41-21-201, 41-21-203; U.S. Code 106-354, and MCH federal block grant]

**Objective A.1:** Reduce maternal and infant mortality.

*Outcome:* Infant mortality rate (infant deaths per 1,000 live births – reported by Calendar Year)

*Outcome:* Incidence rate of low birthweight births (less than 5 pounds, 8 ounces – reported by Calendar Year)

*Outcome:* Percentage of women who received prenatal care in the first trimester (reported by Calendar Year)

*Outcome:* Percentage of live births delivered prior to 37 weeks of gestation (reported by Calendar Year)

**Note:** The above outcomes are based on Mississippi Vital Statistics data, which is not available for the most recently completed Calendar Year until after publication of the Strategic Plan and performance measures in July of each year.

*Outcome:* Percentage of infants who were ever breastfed (WIC population – reported by most recently completed Calendar Year)

*Outcome:* Percentage of infants breastfed through six months of age (WIC population – reported by most recently completed Calendar Year)

**Note:** MSDH data is available only for the population served by the WIC Program (Supplemental Food Program for Women, Infants, and Children).

**A.1.1. Strategy:** Continue the Perinatal High Risk Management/Infant Services System (PHRM/ISS) to help decrease premature birth, low birthweight, and infant mortality; counsel on birth spacing; and promote healthy pregnancies and beginning of life outcomes. PHRM/ISS provides enhanced services to Medicaid-eligible pregnant/postpartum women with high-risk pregnancies and infants at high risk for health problems. Services include case management; home visits; nursing,



psychosocial, and nutritional counseling; and health education provided through a multi-disciplinary team of a nurse, social worker, and nutritionist.

*Output:* Number of PHRM/ISS maternity patients served and number of professional visits received

*Output:* Number of PHRM/ISS infant patients served and number of professional visits received

*Efficiency:* Cost per patient for PHRM/ISS monthly case management

**A.1.2. Strategy:** Increase breastfeeding initiation and duration rates through the following activities: (1) strengthen partnerships with breastfeeding coalitions and other community organizations that provide services to prenatal, postpartum, and breastfeeding mothers; (2) provide training to increase the number of lactation professionals available in the state; (3) assist delivering hospitals in achieving Baby Friendly designation, and (4) provide peer counselor support to prenatal and breastfeeding mothers.

*Output:* Number of community partnerships with breastfeeding coalitions and other community organizations that provide services to prenatal, postpartum, and breastfeeding mothers (reported by most recently completed Calendar Year)

*Output:* Number of lactation professionals trained (reported by most recently completed Calendar Year)

*Output:* Number of training sessions provided to assist delivering hospitals in achieving Baby Friendly designation (reported by most recently completed Calendar Year)

*Output:* Number of educational sessions provided by peer counselors to prenatal and breastfeeding mothers (reported by most recently completed Calendar Year)

*Efficiency:* Cost per lactation professional trained (reported by most recently completed Calendar Year)

*Efficiency:* Cost per training session provided to assist delivering hospitals in achieving Baby Friendly designation (reported by most recently completed Calendar Year)

*Efficiency:* Cost per educational session provided by peer counselors to prenatal and breastfeeding mothers (reported by most recently completed Calendar Year)

**Objective A.2:** Prevent unintended pregnancies and reduce the incidence of teenage pregnancy.

*Outcome:* Teenage birth rate age 15-19 years (live births per 1,000 women age 15 to 19 – reported by Calendar Year)

*Outcome:* Births to unmarried women as a percentage of total live births (age-adjusted – reported by Calendar Year)

**A.2.1. Strategy:** Work through county MSDH clinics and other local providers under contract with MSDH to maximize and improve the delivery of high quality, evidence-based family planning and related preventive services such as medical exams, education, and counseling (including abstinence) and to ensure that a broad range of acceptable and effective family planning methods are available to clients in the target population (low-income individuals ages 13-44, with priority given to sexually active teenagers [19 and younger] at or below 100% of the federal poverty level).

*Output:* Number of unduplicated Comprehensive Reproductive Health Program users (reported by most recently completed Calendar Year)

*Output:* Number of Comprehensive Reproductive Health Program users age 15-19 (reported by most recently completed Calendar Year)

*Output:* Number of family planning waiver clients served by MSDH (reported by most recently completed Calendar Year)

*Efficiency:* Average cost per patient enrolled in Comprehensive Reproductive Health (reported by most recently completed Calendar Year)

*Efficiency:* Percentage of program funds used for providing comprehensive reproductive health services (reported by most recently completed Calendar Year)

**A.2.2. Strategy:** Increase awareness of and promote the availability of family planning services to the priority population through use of social marketing, promotional strategies, teen focus groups and conferences, and community outreach, as well as educational presentations and materials to the priority population and to providers and community partners who provide services to this population.

*Output:* Number of providers and community partners receiving education on evidence-based Comprehensive Reproductive Health strategies and program services (reported by most recently completed Calendar Year)

*Output:* Number of Comprehensive Reproductive Health educational materials distributed through local providers and community partners (reported by most recently completed Calendar Year)

*Efficiency:* Average cost per Comprehensive Reproductive Health educational material distributed through local providers and community partners (reported by most recently completed Calendar Year)

**Objective A.3:** Prevent premature death and undue illness through early detection and treatment of breast and cervical cancer.

*Outcome:* Female breast cancer incidence rate per 100,000 population (age-adjusted – reported by Calendar Year)

*Outcome:* Rate of female breast cancer deaths per 100,000 population (age-adjusted – reported by Calendar Year)

*Outcome:* Cervical cancer incidence rate per 100,000 population (age-adjusted – reported by Calendar Year)

*Outcome:* Rate of cervical cancer deaths per 100,000 population (age-adjusted – reported by Calendar Year)

*Note:* Breast and cervical cancer death rates are based on Mississippi Vital Statistics data, which is not available for the most recently completed CY until after publication of the Strategic Plan and performance measures in July of each year. Cancer incidence rates are reported from the Mississippi Cancer Registry and are one year behind MSDH Vital Statistics data.

**A.3.1. Strategy:** Use federal funding and non-profit funds to contract with providers to screen eligible women through mammography, clinical breast exams, pelvic exams, and Pap smears, and provide diagnostic testing and treatment for women whose screening exams reflect abnormalities. (Eligible women are those with incomes below 250% of the federal poverty level who are uninsured or under-insured, age 50-64 for mammograms and 40-64 for cervical screenings.)

*Output:* Number of providers contracted to deliver mammography services

*Output:* Number of providers contracted to deliver breast and cervical cancer screening services

*Output:* Number of women screened for breast or cervical cancer

*Output:* Number of women referred to Medicaid for treatment of breast or cervical cancer

*Output:* Number of breast biopsies

*Output:* Number of cervical biopsies

*Output:* Number of colposcopies

*Output:* Number of breast and cervical cancer prevention education programs conducted

*Efficiency:* Cost per screening mammogram

*Efficiency:* Cost per colposcopy/cervical biopsy

*Efficiency:* Percentage of women with abnormal breast findings who received complete follow-up services and diagnosis within 60 days of screening (reported by Calendar Year)

*Efficiency:* Percentage of women with a diagnosis of breast cancer who received treatment within 60 days (reported by Calendar Year)

*Efficiency:* Percentage of women with abnormal cervical findings who received complete follow-up services and diagnosis within 90 days of screening (reported by Calendar Year)

*Efficiency:* Percentage of women with a diagnosis of cervical cancer who received treatment within 90 days (reported by Calendar Year)

**Objective A.4:** Reduce morbidity and mortality of Mississippi newborns with genetic disorders through early detection and treatment, accompanied by counseling and appropriate referrals.

*Outcome:* Percent of newborns screened (reported by most recently completed Calendar Year)  
(Number diagnosed with a genetic disorder – reported by most recently completed CY)

*Outcome:* Percentage of newborns with positive and inconclusive genetic screens who received recommended follow-up (reported by most recently completed Calendar Year)

**A.4.1. Strategy:** Use program fees to contract with laboratory to conduct screening tests and provide training to newborn screening submitters (hospital staff and public health nurses); identify infants with disorders and provide follow-up for evaluation, diagnosis, and treatment.

*Output:* Number of newborns screened for genetic disorders (reported by most recently completed Calendar Year)

*Output:* Number of genetic screens with positive or inconclusive results (reported by most recently completed Calendar Year)

*Efficiency:* Cost per newborn genetic screening (reported by most recently completed Calendar Year)

*Efficiency:* Percentage of newborns who received a repeat genetic screen due to inadequate or rejected specimens (reported by most recently completed Calendar Year)

**Goal B:** Promote healthy lifestyles through population and evidence-based interventions including policy, systems, and environmental changes in worksites, schools, and diverse community settings at the local and statewide level. [MS Code 1972 Annotated §41-3-15 (5) (a); Preventive Health and Health Services Block Grant; CDC 1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors, and Promote School Health (CDC-RFA-DP13-1305)]

**Objective B.1:** Implement population and evidence-based interventions to reduce the incidence, complications, and burden of such diseases as diabetes and cardiovascular disease.

*Outcome:* Percentage of population diagnosed with diabetes (reported by most recently completed Calendar Year)

*Outcome:* Premature death rate due to cardiovascular disease (death less than 75 years, per 100,000 population – reported by Calendar Year)

**B.1.1. Strategy:** Increase access to and promote the use of programs in community settings to help people prevent and manage diabetes and other chronic diseases:

Lifestyle Change Programs (for the primary prevention of Type 2 Diabetes);

“*Motivated to Live a Better Life*”, a Stanford licensed Chronic Disease Self-Management Program for people living with a long-term health condition, and Diabetes Self-Management Program for people living with diabetes, along with their family member or caregiver;

Education courses for Certified Diabetes Educators to teach diabetes self-management to others in the community.

*Output:* Number of Lifestyle Change Programs implemented in the community

*Output:* Number of Chronic Disease Self-Management Program and Diabetes Self-Management Program workshops conducted

*Output:* Number of Certified Diabetes Educator preparation courses conducted

*Efficiency:* Cost per patient enrolled in Lifestyle Change Program

*Efficiency:* Cost per participant of Chronic Disease Self-Management and Diabetes Self-Management Program workshops conducted

*Efficiency:* Cost per participant enrolled in Certified Diabetes Educator preparation course

**B.1.2. Strategy:** Increase use of quality improvement processes, such as electronic health records to manage high blood pressure, among health care providers (federally qualified community health centers, rural health clinics, and private practices); increase use of team-based/multi-disciplinary care for patients with high blood pressure.

*Output:* Number of training sessions conducted for healthcare providers on how to effectively use electronic health records to manage high blood pressure

*Output:* Number of training workshops on team-based care/multi-disciplinary approach to treating patients with high blood pressure

*Efficiency:* Cost per healthcare provider trained on the effective use of electronic health records to manage high blood pressure

**Objective B.2:** Reduce the obesity rate among adults in Mississippi.

*Outcome:* Percentage of adults who are obese (defined as a Body Mass Index of 30 or more, regardless of sex – reported by most recently completed Calendar Year)

*Outcome:* Adult compliance with recommended levels of aerobic physical activity (percentage of adults who report participating in 150 minutes or more of aerobic physical activity per week – reported by most recently completed Calendar Year)

**B.2.1. Strategy:** Provide technical assistance to state agencies on establishing a worksite wellness committee.

*Output:* Number of active state agency worksite wellness committees

*Efficiency:* Average time spent providing technical assistance to state agency worksite wellness committees

**B.2.2. Strategy:** Promote formalized shared-use agreements between schools and community sites to enhance opportunities for physical activity.

*Output:* Number of shared-use agreements between schools and community sites that enhance opportunities for physical activity

*Efficiency:* Average time spent providing technical assistance to schools and communities to implement shared-use agreements that enhance opportunities for physical activity

**B.2.3. Strategy:** Establish mayoral health councils to promote the availability of and access to physical activity opportunities, healthy food options, and tobacco/smoke-free environments.

*Output:* Number of mayoral health councils established

*Efficiency:* Average number of hours spent establishing and providing assistance to mayoral health councils, per month, per council

**Objective B.3:** Reduce deaths and disabilities that occur as a result of non-use or incorrect use of a child restraint device in the event of a motor vehicle crash.

*Outcome:* Deaths of persons ages 0-4 years by motor vehicle injuries (number of deaths and rate per 100,000 population per year – reported by Calendar Year)

*Note:* MSDH has a small grant aimed at increasing the use of child safety seats, but no programs or funding to address other causes of death, such as unintentional injuries or homicide.

**B.3.1. Strategy:** Distribute child safety seats; conduct one-on-one training with parents, guardians, or other individuals on best child passenger safety practices; and conduct checkpoints for the correct usage of child safety seats.

*Output:* Number of child safety seats inspected at child safety checkpoints (reported by most recently completed Calendar Year)

*Output:* Number of child safety seats distributed (reported by most recently completed Calendar Year)

*Efficiency:* Average number of minutes to inspect child safety seats at child safety checkpoints (reported by most recently completed Calendar Year)

*Efficiency:* Cost per child safety seat (reported by most recently completed Calendar Year)

## Program 2: Health Protection

**Goal A:** Prevent adverse health effects from environmental hazards that can spread disease. [MS Code 1972 Annotated §41-26-1 – 103 and 42 U.S.C. § 300(f) et seq]

**Objective A.1:** Assure that public water supplies routinely provide safe drinking water to the citizens of Mississippi.

*Outcome:* Percentage of Mississippi population receiving water from a public water supply

*Outcome:* Percentage of Mississippi population receiving water from a public water supply which has had no water quality violations of the Safe Drinking Water Acts in the past year

**A.1.1. Strategy:** Annually survey/inspect all community public water supplies to eliminate operational and maintenance problems that may potentially affect drinking water quality.

*Output:* Number of public water systems surveyed/inspected annually:  
Community systems  
Non-transient non-community systems  
Transient non-community systems

*Efficiency:* Cost per unit for water system surveys/inspections

*Efficiency:* Percentage of water systems surveyed/inspected

**A.1.2. Strategy:** Monitor drinking water quality for compliance with Safe Drinking Water Acts.

*Output:* Number of water quality samples analyzed for compliance with Safe Drinking Water Acts (SDWA):  
Microbiological  
Radiological  
Chemical

*Efficiency:* Percentage of water quality violations addressed within required time frames

**A.1.3. Strategy:** Negotiate with consulting engineers on the final design of engineering plans and specifications for all new or substantially modified public water supplies.

*Output:* Number of reviews of engineering plans and specifications for new or modified public water supply projects

*Efficiency:* Cost per unit for review of engineering plans and specifications

*Efficiency:* Percentage of engineering plans and specifications reviewed and commented on within 10 working days of receipt

**A.1.4. Strategy:** Enforce standards through issuing mandatory boil water notices when necessary and assisting public water systems with voluntary boil water notices.

*Output:* Number of "Boil Water Notices" issued on public water systems: state issued, self imposed, and state assisted

*Efficiency:* Cost per boil water notice issued

*Efficiency:* Percentage of boil water notices issued within 24 hours of sample results or receipt of a request

**A.1.5. Strategy:** Certify water works operators to ensure operation of the water supply in compliance with Safe Drinking Water Acts.

*Output:* Total number of certified water works operators  
Number of new certified operators  
Number of recertifications issued

*Efficiency:* Cost per water works operator certification

*Efficiency:* Percentage of community public water supplies with an MSDH-certified operator

**Goal B:** Improve the oral health of Mississippians through the proven preventive strategy of community water fluoridation. [MS Code 1972 Annotated §41-26-2]

**Objective B.1:** Increase the proportion of Mississippi's population receiving optimally fluoridated water.

*Outcome:* Percentage of Mississippi population receiving optimally fluoridated water

**B.1.1. Strategy:** Encourage and assist communities to adjust the fluoride content that occurs naturally in a community's water to the best level for preventing tooth decay.

*Output:* Number of public water systems that implemented a new water fluoridation program

*Output:* Number of training presentations conducted by MSDH staff on water fluoridation

*Efficiency:* Percentage of public water systems that fluoridate or have naturally optimal fluoride levels

**Goal C:** Assure that trauma patients arrive at the facility most appropriate for the treatment of their injury as quickly as possible. [MS Code 1972 Annotated §41-59-5 and State Trauma Plan]

**Objective C.1:** Transfer trauma patients from initial receiving hospitals to higher levels of care as rapidly as possible.



*Outcome:* Transfer time (in minutes) from Level III and IV Trauma Centers to appropriate facilities for treatment

**Strategy: C.1.1:** Audit Trauma Registry records annually for Levels I-III trauma centers (including pediatric and burn centers) to ensure accuracy and completeness of data.

*Output:* Number of trauma records audited annually (reported by most recently completed Calendar Year)

*Efficiency:* Cost of Trauma Registry audit per facility (reported by most recently completed Calendar Year)

**Strategy: C.1.2:** Conduct initial and recurring training for at least one Trauma Registrar from each reporting hospital annually.

*Output:* Number of trauma registrars from reporting hospitals receiving training (reported by most recently completed Calendar Year)

*Efficiency:* Cost per quarterly trauma registrar training session (reported by most recently completed Calendar Year)

### **Program 3: Communicable Disease**

**Goal A:** Reduce the morbidity and premature mortality due to communicable diseases among Mississippians. [MS Code 1972 Annotated §41-23-1 – 41-23-5]

*Note: All Communicable Disease data is compiled and reported by Calendar Year except immunization and the number of STD diagnostic, treatment, and follow-up services.*

**Objective A.1:** Reduce the number of outbreaks of reportable diseases by implementing appropriate disease interventions to prevent further spread of secondary cases.

*Outcome:* Number of cases of mosquito-borne illness (West Nile virus) and associated number of deaths (reported by most recently completed Calendar Year)

*Note:* While MSDH provides public information regarding the current occurrence of cases in the state and how to prevent the disease, and this assists in assuring that individuals participate in prevention activities such as using mosquito repellent and getting rid of standing water in which mosquitoes may breed, there is no state funding for mosquito control programs, which are the mainstay of prevention in communities with ongoing West Nile virus transmission. In addition, as West Nile virus illness has been in this country for more than 10 years now, the occurrence in humans in any given year is more affected by the epidemiology of the virus in birds and other hosts than on public health intervention.

*Outcome:* Number of outbreaks of food-borne illness (salmonella) and case rate per 100,000 population (reported by most recently completed Calendar Year)

**A.1.1. Strategy:** Conduct disease surveillance and investigation on reported cases and target prevention messages to the public.

*Output:* Number of mosquito-borne illness reports (West Nile virus) received and investigated (reported by most recently completed Calendar Year)

*Note:* MSDH does not have funding for a mosquito-control program; efforts are directed to disease surveillance and public awareness and prevention messages.

*Efficiency:* Costs of mosquito-borne illness (West Nile virus) per case investigated (estimated staff time plus cost of test – reported by most recently completed Calendar Year)

**A.1.2. Strategy:** Analyze and conduct surveillance of food-borne illness reports for potential outbreak to prevent further spread.

*Output:* Number of food-borne illness (salmonella) case reports investigated (reported by most recently completed Calendar Year)

*Efficiency:* Costs of food-borne illness (salmonella) per case investigated (estimated staff time plus cost of test – reported by most recently completed Calendar Year)

**Objective A.2:** Reduce the incidence of tuberculosis (TB) in Mississippi.

*Outcome:* Number of tuberculosis cases per year and case rate per 100,000 population (reported by most recently completed Calendar Year)

**A.2.1. Strategy:** Conduct surveillance and investigation of tuberculosis (TB) cases and suspects, provide treatment and follow-up through completion of therapy, conduct investigation of exposures, and provide treatment for those found to be infected.

*Note:* TB patients have 12 months to complete therapy. Thus, patients identified in one year have until the corresponding date in the following year, so complete year data will always lag one year behind the most recently completed calendar year. A *TB case* is someone with active TB disease; this person can be infectious and requires multi-drug antibiotic therapy for at least six months. A person with *tuberculosis infection* is not infectious to others and needs preventive antibiotic therapy to prevent progression to active TB.

*Output:* Number of newly-reported verified TB cases starting therapy (reported by year prior to most recently completed Calendar Year)

*Output:* Number of contacts identified to verified smear-positive TB cases (reported by year prior to most recently completed Calendar Year)

*Output:* Number of newly-reported tuberculosis infection patients starting therapy (reported by year prior to most recently completed Calendar Year)

*Output:* Number of TB suspects (reported by year prior to most recently completed Calendar Year)

*Efficiency:* Percentage of newly-reported verified TB cases who completed therapy (reported by year prior to most recently completed Calendar Year)

*Efficiency:* Percentage of identified contacts to verified smear-positive TB cases who are evaluated (reported by year prior to most recently completed Calendar Year)

*Efficiency:* Percentage of newly-reported tuberculosis infection patients who completed therapy (reported by year prior to most recently completed Calendar Year)

**Objective A.3:** Reduce the prevalence and incidence of sexually transmitted disease among Mississippians.

*Outcome:* Number of new cases of chlamydia and case rate per 100,000 population per year (reported by most recently completed Calendar Year)

*Outcome:* Number of new cases of primary and secondary syphilis and case rate per 100,000 population per year (reported by most recently completed Calendar Year)

*Outcome:* Number of new cases of gonorrhea and case rate per 100,000 population per year (reported by most recently completed Calendar Year)

**A.3.1. Strategy:** Interrupt the natural course of STDs in individuals and communities by (1) detecting and preventing new infections through comprehensive epidemiology; (2) interviewing and counseling; (3) screening at-risk populations for asymptomatic STD infections and ensuring that all positive laboratory tests are followed and adequately treated; (4) implementing educational programs directed towards people at risk for STDs; and (5) ensuring that uniform standards of health care are available to all persons in both the public and private medical communities.

*Output:* Number of MSDH patients screened for gonorrhea and chlamydia using DNA technology (reported by most recently completed Calendar Year)

*Output:* Number of STD diagnostic, treatment, and follow-up services (nursing encounters only – this output is reported by most recently completed Fiscal Year rather than Calendar)

*Efficiency:* Percentage of new primary and secondary syphilis cases interviewed within 14 days of specimen collection (reported by most recently completed Calendar Year)

*Efficiency:* Percentage of new primary and secondary syphilis contacts treated within 14 days of interview (reported by most recently completed Calendar Year)

**Objective A.4:** Reduce the incidence of HIV Disease and assist in the provision of care and services to people living with HIV Disease in Mississippi.

*Outcome:* Number of new cases of HIV Disease and case rate per 100,000 per year (reported by most recently completed Calendar Year)

**A.4.1. Strategy:** Reduce HIV infection rates by conducting surveillance activities; providing counseling, testing, referral, and partner notification services; and implementing culturally-competent strategies to modify risk-associated behaviors. Administer funds provided by Part B of the Ryan White CARE Act for care and services to people living with HIV Disease.

*Output:* Number of HIV antibody screening tests conducted by MSDH (reported by most recently completed Calendar Year)

*Output:* Number of persons served by AIDS Drug Program (reported by most recently completed Calendar Year)

*Efficiency:* Average cost of AIDS Drug Program per person served (affected by patient rotation – reported by most recently completed Calendar Year)

*Efficiency:* Percentage of HIV partner notification reports completed and returned within 14 days (reported by most recently completed Calendar Year)

*Efficiency:* HIV Contact Index (number of contacts named divided by number of original patients – reported by most recently completed Calendar Year)

**Objective A.5:** Eliminate morbidity and mortality due to vaccine-preventable diseases in children, adolescents, and adults.

*Note:* This objective depends in large part upon the continuation of the current Mississippi immunization law [Miss. Code Ann. § 41-23-37], which allows for vaccine exemptions for medical reasons, but does not allow religious (found to be unconstitutional in 1979) or philosophical exemptions for immunizations required for school. The current law is very much supported by the scientific evidence regarding the safety and efficacy of vaccines.)

*Outcome:* Number of reported cases of vaccine-preventable communicable diseases and case rates per 100,000 population: hepatitis A, measles, mumps, pertussis (reported by most recently completed Calendar Year)

*Outcome:* Rate of two-year children fully immunized (National Immunization Survey: 4:3:1:3:3:1:4 series, age 19 to 35 months – reported by Calendar Year prior to the most recently completed year)

*Note:* The CDC and the National Immunization Survey report the immunization rates of children 19 to 35 months old as a key benchmark because recommended vaccinations for two year olds may be administered as appropriate at any time during this time frame.

*Outcome:* Adolescent immunization rates (age 13 to 17 years), by recommended vaccine: [meningococcal, combined tetanus, diphtheria, and pertussis (Tdap), human papillomavirus (HPV) (females) – reported by Calendar Year prior to the most recently completed year]

*Note:* Tdap became a required immunization for students entering seventh grade beginning with the 2012-2013 school year. Meningococcal and HPV are not currently required immunizations for Mississippi adolescents.

**A.5.1. Strategy:** Monitor immunization levels, administer vaccinations, distribute education and informational materials, enforce immunization laws, and administer the Vaccines for Children program (VFC). This federally-funded program supplies vaccines to VFC-enrolled public and private providers to immunize eligible children at no cost who might not otherwise be immunized because of a family's inability to pay.

*Output:* Doses of childhood vaccine administered in MSDH clinics to those 0-18 years

*Output:* Number of providers enrolled in Vaccines for Children Program

*Efficiency:* Cost per child of age-appropriate immunizations administered for children 19 to 35 months of age

*Efficiency:* Cost per adolescent of age-appropriate immunizations administered for adolescents 13 to 17 years of age

*Note:* Immunization outputs and efficiency measures are reported by most recently completed Fiscal Year, unlike other Communicable Disease program measures.

**Program 4: Tobacco Control** [MS Code 1972 Annotated §41-113-1 – 41-113-11]

**Goal A:** Reduce the prevalence of tobacco use among youth and adults in Mississippi.

**Objective A.1:** Refine and implement a statewide comprehensive tobacco education, prevention, and cessation program in accordance with the CDC’s “*Best Practices for Comprehensive Tobacco Control Programs*” as periodically amended.

*Outcome:* Percentage of current smokers among public middle school students (reported by most recently completed Calendar Year)

*Outcome:* Percentage of current smokers among public high school students (reported by most recently completed Calendar Year)

*Outcome:* Percentage of current smokers among adults 18 years and older (reported by most recently completed Calendar Year)

**A.1.1 Strategy:** Establish and support tobacco-free coalitions in each Mississippi county to implement evidence-based programs consistent with CDC’s “*Best Practices for Comprehensive Tobacco Control Programs*”.

*Output:* Number of counties with tobacco-free coalitions implementing evidence-based programs consistent with CDC best practice guidelines

*Efficiency:* Per capita funding for community interventions (MS Tobacco Control Program Fund)

**A.1.2 Strategy:** Support organizations that provide tobacco cessation services to Mississippians.

*Output:* Number of unduplicated individuals who contacted Office of Tobacco Control (OTC)-funded tobacco cessation treatment programs

*Output:* Number of unduplicated individuals who have completed the intake process for OTC-funded tobacco cessation treatment programs

*Efficiency:* Per capita funding for cessation interventions (MS Tobacco Control Program Fund)

## **Program 5: Public Health Emergency Preparedness and Response**

**Goal A:** Ensure readiness for any public health threat or emergency at the state and local/regional levels. [MS Code 1972 Annotated §41-3-15 (5) (a); §319-C-1 and 319-C-2, U.S. Public Health Service Act as amended by the Pandemic and All-Hazards Preparedness Act of 2006; Presidential Directive 8]

**Objective A.1:** Establish, maintain, and test plans and procedures to protect Mississippians in the event of natural or human-caused disasters.

*Outcome:* Time required for command staff to report to Emergency Operations Center in response to a natural or man-made disaster

*Outcome:* Mississippi's score on the National Health Security Preparedness Index overall and by domain: health security surveillance, community planning and engagement, incident and information management, healthcare delivery, countermeasure management, and environmental and occupational health.

*Note:* Measure is included in *Building a Better Mississippi* statewide strategic plan. The Office of Public Health Emergency Preparedness and Response does not utilize the National Health Security Preparedness Index as a means of measuring its performance. While the Index provides an overall score for the state, along with individual scores for domains, the individual measures which lead to these scores require data from sources outside of the MSDH and include numerous indicators that are not part of MSDH. CDC and ASPR (Office of the Assistant Secretary for Preparedness and Response) verify that certain performance measures contained in grants funded by these agencies are met each year; however, these measures do not receive scores.

**A.1.1. Strategy:** Review and update emergency operation plans of licensed medical facilities and MSDH emergency preparedness plans and procedures according to established schedule.

*Output:* Number of licensed medical facility emergency operation plans and MSDH emergency response plans and procedures reviewed and updated

*Efficiency:* Percentage of emergency preparedness and response plans and procedures reviewed and approved

**A.1.2. Strategy:** Provide technical assistance, training seminars, workshops, and exercises to improve processes for mass dispensing efforts of Strategic National Stockpile (pharmaceutical supplies) during an incident.

*Output:* Number of emergency preparedness and Strategic National Stockpile (pharmaceutical supplies) training sessions

*Output:* Number of personnel trained to provide mass prophylaxis to the citizens of Mississippi in an emergency

*Output:* Number of Cities Readiness Initiative training sessions

*Output:* Number of people trained through Cities Readiness Initiative

*Output:* Number of Closed Points of Dispensing pre-identified to provide mass prophylaxis during an event (thus increasing the speed of dispensing prophylaxis to all citizens)

*Efficiency:* Percentage of population able to receive mass prophylaxis in closed points of dispensing rather than open points of dispensing during an incident (thus reducing the number of citizens in the general population standing in line to receive prophylaxis and increasing the speed of dispensing to all citizens)

**Note:** This measure is significant because Closed Points of Dispensing (PODs) provide their own staff to dispense prophylaxis. Without the pre-arranged closed PODs, MSDH would need additional open PODs, requiring staff, to serve the same number of people.

**A.1.3. Strategy:** Maintain a statewide volunteer program to support health care organizations with medical preparedness and response to incidents and events.

*Output:* Number of volunteers registered and credentialed in Mississippi Responder Management System to provide additional support when resources at the local and state level are limited during an incident

*Efficiency:* Average cost savings to the state per staff person per day by using volunteers pre-registered and credentialed in Mississippi Responder Management System to support local resources during an incident versus using paid staff

**A.1.4. Strategy:** Plan for the shelter needs of at-risk populations with medical needs during a time of disaster.

*Output:* Number of pre-identified shelters to house individuals with medical needs requiring specialized care not obtainable in a general population shelter during an incident and average number of people these shelters would be able to house based on ADA assessments

*Efficiency:* Average cost savings to the state per individual with medical needs served in a specialized shelter versus hospitalization during an event

**A.1.5. Strategy:** Conduct National Incident Management System and Homeland Security Exercise and Evaluation Program preparedness exercises annually and respond to real-world incidents as necessary; evaluate response and complete after-action report as required by CDC.

*Output:* Number of National Incident Management System and Homeland Security Exercise and Evaluation Program preparedness exercises conducted and real-world incidents responded to

*Efficiency:* Average time required to produce after-action report improvement plan following an exercise or real-world emergency response



## **Program 6: Administrative and Support Services**

**Goal A:** Help assure access to primary care services for underserved areas of the state. [MS Code 1972 Annotated §41-3-15 (5) (a)]

**Objective A.1:** Assist underserved communities to increase the number of primary care, dental, and mental health providers.

*Outcome:* Number of Health Professional Shortage Areas designated: primary care, dental, and mental health

*Outcome:* Number of entire counties designated as Health Professional Shortage Areas for primary care, dental, and mental health

*Outcome:* Percentage of Mississippi population living in an area designated as a Health Professional Shortage Area for primary care, dental, and mental health

*Outcome:* Number of practitioners needed to remove health professional shortage areas, by type of practitioner: primary care, dentists, and core mental health professionals

**Note:** Health Professional Shortage Area (HPSA) designation reviews are conducted to assist the federal government with directing resources to areas of greatest need. HPSA designation qualifies an area for various federal resource incentives, including a 10% Medicare bonus payment for primary care providers, loan repayment programs through the National Health Service Corps, and site approval for J-1 Visa Waiver physicians.

*Outcome:* Number of approved National Health Service Corps sites

**Note:** National Health Service Corps designation provides incentives to help attract physicians, such as federal loan repayment programs.

**A.1.1. Strategy:** Conduct annual health professional shortage area designation (HPSA) updates.

*Output:* Number of Health Professional Shortage Area designation reviews conducted: Primary Care, Dental, and Mental Health

*Efficiency:* Percentage of HPSA designation reviews completed by federal deadline (a calendar date that changes annually)

**Note:** The federal Health Resources and Services Administration (HRSA) suspended HPSA reviews during FY 2015 and 2016 as HRSA transitioned to a new Shortage Designation Management System. The updates will resume in FY 2017. HRSA automatically designates all 21 Federally Qualified Community Health Centers as a HPSA; they do not receive a designation review by the Office of Primary Care Development.

**A.1.2. Strategy:** Coordinate physician recruitment incentive programs to increase the number of health care professionals in areas of need, including the recruitment of physicians for these areas.

*Output:* Number of National Health Service Corps site applications processed

*Output:* Number of J-1 Visa Waiver applications reviewed

*Output:* Number of National Interest Waiver applications processed

*Output:* Number of health care professionals placed in areas of need: Primary Care, Dentists, and Core Mental Health Professionals

*Efficiency:* Percentage of National Health Service Corps site applications processed within 21 days as required by federal Health Resources and Services Administration

*Efficiency:* Percentage of J-1 Visa Waiver physician placements completed within 180 days

*Efficiency:* Percentage of J-1 Visa and National Interest Waiver applications approved by U.S. Department of State

## **Program 7: Local Governments and Rural Water Systems Improvements Loan Program and Emergency Loan Program**

**Goal A:** Ensure that the construction and maintenance of Mississippi's drinking water infrastructure is able to occur in a cost-effective manner to meet the needs of citizens and ensure reliability and sustainability of the state's public water systems. [MS Code 1972 Annotated §41-3-16 and 41-26-1 through 41-26-101; PL 104-182 (federal Safe Drinking Water Act, Section 130 Amended 1996); CFDA 66.468; and 40 CFR Parts 31 and 35 and Subpart L]

**Objective A.1:** Maintain a financially sound loan program; provide loan funds under an approved scoring system to meet drinking water needs as rapidly as funds allow in order of public health importance.

*Outcome:* Percentage of MS water systems receiving funding during the given year that were able to maintain compliance with Safe Drinking Water Act requirements as a result of a low interest loan

*Outcome:* Percentage of MS water systems receiving funding during the given year that corrected a compliance deficiency as a result of low interest loan

*Outcome:* Estimated amount of money saved during the given year by public water systems as a result of low interest rate versus market rate

**A.1.1. Strategy:** Provide loans, on a priority basis, to public water systems that are required or desire to make significant capital improvements to protect public health by complying with the federal and state Safe Drinking Water Acts and provide technical assistance to public water systems through federal set-asides in the loan program.

*Output:* Number of improvement loans made to public water systems

*Output:* Number of emergency loans made to public water systems

*Output:* Number of water systems receiving technical assistance

*Output:* Total amount of loan awards

*Efficiency:* Percentage of loan documents received and commented upon within 10 working days

*Efficiency:* Percentage of available federal capital funds used for water system loans

*Efficiency:* Percentage of funds given to small water systems (those serving populations of 10,000 or less – federal benchmark of at least 25%)

## **Program 8: Mississippi Burn Care Fund**

**Goal A:** Ensure that qualified burn center hospitals receive appropriate reimbursement for uncompensated care provided to Mississippi burn victims [MS Code 1972 Annotated §7-9-70].

**Objective A.1:** Properly disperse designated funds to qualified burn center hospitals that have entered into a cooperative agreement with the State of Mississippi to reimburse those hospitals for uncompensated care provided to qualified Mississippi burn victims transferred from a Mississippi licensed hospital.

*Outcome:* Percentage of eligible Mississippians receiving uncompensated care for burns who have payments made from the Burn Care Fund on their behalf

**A.1.1. Strategy:** Verify the validity of each claim by ensuring that the patient is in the Burn Care Registry; pay valid claims as soon as possible to the extent that funding allows.

*Output:* Number of burn centers under cooperative agreement to care for Mississippi burn victims

*Output:* Number of claims processed for uncompensated care to Mississippi burn victims

*Efficiency:* Percentage of claims audited before payment

*Efficiency:* Percentage of eligible claims paid within 30 days following submission of necessary documents and auditing of claims