

Mississippi State Department of Health

Fiscal Years 2026-2030

Strategic Plan

**Prepared in accordance with the
Building a Better Mississippi Instructions
June 2024**



MISSISSIPPI STATE DEPARTMENT OF HEALTH

Mississippi State Department of Health

Mission Statement

The Mississippi State Department of Health mission is to protect and advance the health, well-being, and safety of everyone in Mississippi.

Agency Philosophy

The Mississippi State Department of Health strives for excellence in government, cultural competence in carrying out its mission, and local solutions to local problems. MSDH identifies its values as:

- **Health Equity**
We believe in achieving the highest level of health for all Mississippians by partnering with communities and other organizations to address avoidable inequalities and equalize the conditions of health.
- **Customer Focused**
To provide an optimal customer experience, we strive to be compassionate and to respond in a timely manner with knowledge and competence.
- **Cultural Sensitivity**
We appreciate and respect cultural differences and strive to ensure our practices, policies, and behaviors are inclusive and meet the needs of our communities. We feel health literacy plays a key role in inclusiveness and health equity.
- **Professionalism**
We believe it is important to treat each other with kindness and respect. Our goal is to be reliable, flexible, and accountable to each other.
- **Teamwork**
We believe we can accomplish more together than individually. To work as a team, we commit to doing what we say we are going to do, seeking to understand different perspectives, and practicing active listening.
- **Results Oriented**
We use data, evidence-based practices, and innovative solutions to achieve the best possible outcome. Quality improvement methods are implemented to achieve the highest standards.
- **Proactive Leadership**
We believe in evaluating the present, planning for the future, and making decisions that will support the public health workforce in creating healthy communities.

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. The following programs are addressed in this plan:

- 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. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutrition education and supplemental foods to eligible women and children and promotes breastfeeding to improve infant health.
- Preventive Health and Health Equity collaborates with other agencies and organizations to improve environments and policies that support and encourage healthful behaviors and promote health equity.
- 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. 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. For some specific diseases, prevention is through treatment of reported cases and investigation of contacts.
- 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.
- 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.

- **Mississippi Medical Cannabis Program** – As the lead agency for the Mississippi Medical Cannabis Program, MSDH is responsible for registering patients, practitioners, and all medical cannabis establishments, with the exception of medical cannabis dispensaries. Additionally, MSDH is required to issue work permits to parties interested in employment in the new medical cannabis industry in the state.

In addition, the agency operates such programs as Early Intervention, which provides services for children with disabilities from birth to age three; Regulatory/Licensure programs, which work to assure that emergency medical services, designated health care facilities, childcare 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 Strategic Planning and Response (formerly known as the 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. Measures for the MSDH Office of Strategic Planning 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 a statewide health assessment and strategic planning process. The State Health Assessment (SHA), conducted in 2014 and again in 2019, is 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 (SHIP), the first of which was developed in 2015, to serve as a comprehensive roadmap for improving the health of Mississippians.

A State Health Assessment and Improvement Committee (SHAIC) advised and assisted MSDH in developing the SHIP to address the state’s greatest health needs on a priority basis. Through this process, MSDH seeks 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. The 2022-2027 SHIP serves as a guide for Mississippi’s health agenda over the next five years and informs the MSDH strategic plan, which is updated every two years.

In December 2021, MSDH leadership met to create the agency's strategic plan for 2022-2024. The goals of the 2022-2024 strategic plan are (1) Capacity Building and Workforce Development, (2) Technology, Data, and Reporting, (3) Program Alignment and Effectiveness, (4) Customer Service and Values Alignment, (5) Central and Regional Alignment. Leadership will continue to move forward to develop and operationalize the agency's strategic plan for 2024-2026 and will once again need to focus on core public health functions and reflect on what and how future public health practice should look.

Core public health includes the surveillance of currently reportable diseases and other emerging infectious diseases, which allows outbreaks to be detected and investigated to implement appropriate mitigation to reduce further transmission. The response to recent public health challenges demonstrated that the agency must be adaptable in addressing emerging health risks, and that investments in public health are essential to maintain capacity and deliver necessary services.

We must also be able to provide those healthcare services that no private provider will take on, such as treatment of tuberculosis (TB) and sexually transmitted infections (STI) patients. MSDH maintains surveillance of tuberculosis, STIs, HIV and other reportable diseases, as well as conducting contact tracing, testing, treatment, and other mitigation activities to decrease spread of communicable diseases. As an example, Tuberculosis case management and treatment with directly observed therapy, in addition to contact tracing, testing, and treatment can reduce overall transmission of TB in Mississippi as well as reducing the risk of drug resistant tuberculosis.

The agency's response to public health challenges also highlighted the importance of community engagement and the leveraging of community partners to address public health disparities. For example, as rates of syphilis and congenital syphilis are rising in MS, MSDH is engaging with healthcare communities and other community partners to develop strategies to promote prevention, testing and treatment. Primary prevention of chronic diseases, communicable diseases, and injuries requires community engagement. Using both existing relationships with community-based organizations and those that were formed during the response, MSDH will continue to address public health disparities. One example of this work is through our Community Health Workers (CHW) initiative. CHWs work in association with MSDH in urban and rural environments to link the gap between providers and community population in need of care. CHWs conduct outreach and education to citizens in their community who suffer from chronic diseases, early childhood diseases, and other health conditions. They make home visits, help patients navigate complex health information systems, advise, and help connect patients to the resources they need. They also work closely with community partners 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.

Over the next few years, MSDH will also identify opportunities and move forward with current initiatives that bring a collaborative approach to public health through the integration of our programmatic, community, and clinical work. These initiatives will further address public health disparities and the social determinants of health. One such initiative is Transportation to Health, which will provide transportation for MSDH patients to county health departments, thereby providing access to care in rural areas. MSDH will also continue utilizing centralized scheduling, interpretation services, translator services, and telehealth to link Mississippians to MSDH services. Another initiative to further integrate public health into communities is MSDH Mobile Units which will be utilized for multiple purposes to include, but not limited to, providing public health services at health fairs, providing special, targeted public health services for certain populations or geographic areas, provide emergency or disaster response clinical services in areas needing temporary service provision. A prime example of integrating programmatic, community, and

clinical work is our Healthy Moms, Healthy Babies (HMHB) program – a program in which efforts are aimed at reducing the increasing rate of maternal and infant mortality in the state. HMHB is a care management and home visiting program for expectant moms and infants. We work with families and communities to help ensure that all Mississippi moms and babies have safe birthing experiences and healthy infant development. The program provides a multidisciplinary support team to assist moms and babies in all 82 Mississippi counties who have identified health risks.

MSDH acquired the Office of Mississippi Physician Workforce (OMPW) in 2024, and MSDH will look to incorporate the office with other areas of the agency when assessing the needs of the state. OMPW includes assessing the current numbers, ages, types of practice, hospital affiliations, and geographic distribution of the state's current and future physician workforce. MSDH will also be encouraging the development of an adequate and geographically distributed physician workforce for the state with an evolving strategic plan as a part of OMPW. The direction of MSDH must be adaptive to the current environment and other factors that affect health in the state. While we understand this necessary flexibility, we also recognize there are public health services that only we provide and important work that we lead. As we strategically adapt to the state's public health needs, we see each change as an opportunity to reprioritize our programs and strategically adapt to what is most important for the health, well-being, and safety of everyone in Mississippi.

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, with historically only about 8.7% of the budget from the state general fund, activities are often driven by funding stream requirements, regardless of the state needs and priorities. Additionally, pass-through funding appropriated in state law requires MSDH to redirect resources to the administration of these pass-through programs.

MSDH is continuously evaluating our programs and strategically directing our resources towards high priority areas. The Department is working to be more efficient at delivering services to those populations most in need to keep our Mississippi communities healthy and safe. MSDH will maximize our federal and state resources and working to reduce costs. As part of our budget request, MSDH is asking for funding to align operations in county health departments to address critical access needs across the state. However, based on historical state support, MSDH Leadership understands that to accomplish our public health objectives, we must also take a deep and critical look at our agency funding from all sources and identify opportunities to become more self-sufficient. We will continue to take a business approach to health department operations, including an in-depth evaluation of the services provided in county health departments. We are continuing to assess our generation of internal revenue through third-party billings. We are reassessing our fees for regulatory work. And we are continuing to make investments in the automation of processes and evaluating how we do everything from the central office to the county health departments to identify opportunities for improvement in efficiencies and business processes.

In order to successfully carry out those core public health functions and the other important work we are charged to do, it is vital that we assess our public health workforce capacity. Through federal funding, MSDH has established the Office of Workforce Development, which will center on three important aspects of investing in our workforce – recruitment, retention, and infrastructure. MSDH must invest in a workforce that champions public health in order to create a healthier and safer Mississippi.

Internal Management

Quality improvement is an essential part of the agency's operations 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 initial QI Plan was finalized during 2016 and is updated annually.

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 appropriate MSDH office for investigation. Coordination with other offices is planned as required by the nature of the complaint, such as Human Resources or the Ethics Advisor Committee.

In addition, Internal Audit staff conducts a variety of audits according to the approved audit plan, which is derived from a risk-based approach. Internal Audit staff evaluates internal controls over accounting, administrative, information technology, and other major processes. As required by MS Code § 25-65 (2013), known as the Mississippi Internal Audit Act, Internal Audit is independent of the Mississippi State Department of Health. The Internal Audit director is hired by and reports directly to the State Board of Health.

Agency Goals, Objectives, Strategies, and Measures by Program

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 the fall 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 known as Healthy Moms/Healthy Babies 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 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 training session provided to assist delivering hospitals in achieving Baby Friendly designation (reported by most recently completed Calendar Year)

Note: This work is now done by CHAMPS, an MSDH partner.

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)

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)

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 the fall 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: 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)

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

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

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

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)

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, and 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, and 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, and 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)

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: 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

Note: Less than 10% of emergency planning and response plans were reviewed during FY 2022 due to 100% of the Planning Section being activated for ongoing COVID-19 response efforts. Emergency preparedness and response plans are on a biennial review cycle. The highest obtainable percentage in this category will always be 50%.

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

Note: Volunteers were not used for emergency response during the COVID-19 pandemic response. Volunteers are typically utilized from other states that are not responding to the same emergency (e.g., Volunteers from Kansas volunteering in Mississippi after a hurricane). Because all states were responding to COVID-19, Mississippi was not able to utilize volunteers from other states.

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: HRSA currently automatically designates all 21 Federally Qualified Community Health Centers and their satellite locations as a HPSA; therefore, these facilities do not receive a designation review by the Mississippi Primary Care Office.

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

Program 9: Mississippi Medical Cannabis Program

Goal A: Provide a safe and accessible program that meets the needs of qualified patients and the public health and safety of all Mississippi residents.

Objective A.1: Oversee (1) The licensing, oversight, and inspection of cannabis testing facilities and cannabis research facilities; (2) The licensing of cannabis cultivation facilities, cannabis processing facilities, cannabis transportation entities, and cannabis disposal entities; (3) The issuing of registry identification cards for qualifying patients and designated caregivers; (d) The registering of practitioners; and (5) The selection, certification, and oversight of the statewide seed-to-sale tracking system

A.1.1. Strategy: Evaluate applications and award licenses in accordance with the *Mississippi Medical Cannabis Act* and MSDH Rules, Title 15, Part 22: Medical Cannabis Program.

Output: Number of qualifying patients approved

Output: Number of designated caregivers approved

Output: Number of Registry Identification Cards revoked

Output: Percentage of applications approved

Output: Number of registered medical practitioners

Output: Number of conditions added to the list of debilitating conditions

Output: Total number of patients with a Registry Identification Card

Output: Number of licensed cannabis cultivation facilities

Output: Number of licensed cannabis processing facilities

Output: Number of licensed cannabis testing facilities

Output: Number of licensed cannabis transportation entities

Output: Number of licensed cannabis waste disposal entities