Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

A Review of the Mississippi State Department of Health

Although the Mississippi State Department of Health (MSDH) is the lead agency on public health issues in the state, hundreds of entities in both the public and private sectors carry out activities that directly impact the protection and promotion of public health. Protecting and promoting public health in Mississippi is particularly challenging, given the state's demographics, which are associated with behaviors linked to greater risk of disease, high incidences of disease, and poor access to healthcare.

While Mississippi continues to rank poorly on several major public health indicators in comparison to the rest of the country (e.g., years lost by premature death, infant mortality rate, death rates by motor vehicle accidents, incidence of sexually transmitted diseases, teenage birth rate), the state has made progress on a few indicators during the 1990s (e.g., reduction in syphilis and infant mortality rates) and ranks well on other important public health measures, such as the percentage of children who are immunized.

PEER reviewed three MSDH regulatory programs and found deficiencies in enforcement which compromise the ability of these programs to protect the public from associated health risks. Also, PEER determined that MSDH could improve the timeliness and comprehensiveness of its data collection efforts.

July 11, 2000

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A standing joint committee, the PEER Committee is composed of five members of the House of Representatives appointed by the Speaker and five members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of three Representatives and three Senators voting in the affirmative.

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PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

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The Mississippi Legislature

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PEER Committee

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July 11, 2000

Honorable Ronnie Musgrove, Governor
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On July 11, 2000, the PEER Committee authorized release of the report entitled **A Review of the Mississippi State Department of Health.**

William Canon

Senator William Canon, Chairman

This report does not recommend increased funding or additional staff.

Table of Contents

List of Exhibits

A Review of the Mississippi State Department of Health

Executive Summary

Protecting and promoting public health in Mississippi is challenging given the state's demographics (e.g., a high percentage of the population which is low-income, rural, and undereducated). These demographics are associated with behaviors linked to greater risk of disease, high incidences of disease, and poor access to healthcare.

In FY 1999, the State Department of Health expended $175.4 million on public health programs. The majority of revenues (51.2%) consisted of federal funds and the sub-program receiving the greatest total funding ($53.3 million) was the supplemental food program for Women, Infants, and Children (WIC). Between FY 1990 and FY 1999, state funds expended by MSDH nearly doubled, from $20.3 million to $37.5 million.

In addition to the State Department of Health, hundreds of entities in both the public and private sectors carry out activities that directly impact the protection and promotion of public health in Mississippi. In terms of broad health indicators, while Mississippi continues to rank poorly on several major public health indicators in comparison to the rest of the country (e.g., years lost by premature death, infant mortality rate, death rates by motor vehicle accidents, incidence of sexually transmitted diseases, teenage birth rate), the state has made progress on a few indicators during the decade of the 1990s (e.g., reduction in syphilis and infant mortality rates) and ranks well on other important public health measures, such as the percentage of children who are immunized.

PEER reviewed three MSDH regulatory programs and found deficiencies in enforcement which compromise the ability of these programs to protect the public from associated health risks. Also, PEER determined that MSDH could improve the timeliness and comprehensiveness of its data collection efforts.

Recommendations

Collection and Analysis of Public Health Data

1. To improve accuracy and timeliness in the reporting of communicable disease data, MSDH should:

   -- facilitate reporting by printing the phone number, fax number, and MSDH's mailing address on Form 135, the form used to report communicable diseases;

   -- investigate the possibility of online reporting of data;

   -- add to Form 135 the date that the laboratory results were available, as this is a more accurate date to assess timeliness;

   -- track, document, and send educational material to every physician who reports more than seven days after the stated deadline for all classes of communicable diseases to encourage more timely reporting; and,

   -- identify physicians who rarely report communicable diseases and pro-actively contact a specified number per month to inform them of the reportable diseases and proper reporting procedures.

2. The Legislature should consider amending MISS. CODE ANN. § 41-23-1 to provide for several levels of penalties for late reporting and failure to report communicable diseases (e.g., suspension of license, revocation of license, $100 for the first violation, $500 for the second violation).

3. MSDH should add streptococcus disease and toxic-shock syndrome to its list of reportable diseases, since these diseases are on the Centers for Disease Control's nationally notifiable list and are not regional diseases.

4. To address the problem of MSDH not having comprehensive chronic disease data, the Legislature should consider mandating hospitals to report discharge data to MSDH.

5. MSDH should explore ways of improving the accuracy of reporting causes of death. For example, the

department might consider changing the death report form to allow for more than one cause of death and should train doctors, funeral home directors, hospitals, and coroners in the importance of accurate reporting.

6. In order to improve the timeliness of vital statistics reporting, the Legislature should consider imposing penalties parallel to those established for the reporting of communicable diseases (see recommendation 2).

Food Protection

7. MSDH should establish a maximum number of inspections a food establishment can fail within a given time frame, regardless of whether it passes follow-up inspections, before suspending its permit for a specified period.

8. MSDH should inspect food establishments with the frequency required by regulation and more strictly enforce policies governing the Certified Food Manager Program.

9. When conducting internal audits of the food protection sub-program, MSDH internal auditors, not the district, should select the counties to be evaluated and the files within the county offices to be reviewed.

10. MSDH internal auditors should ensure correction of deficiencies cited in internal audit reports by continuing to follow up until the deficiencies are corrected.

Milk Sanitation

11. MSDH should update its milk plant inspection form to correspond with the Grade A Pasteurized Milk Ordinance.

Child Care Facility Licensure

12. MSDH should reallocate staffing resources in order to meet the National Association for the Education of Young Children's staffing standard for child care facility inspectors of a maximum of seventy-five facilities per inspector.

13. MSDH should formalize its hearing process for violations of child care facility licensure regulations and make a record in all child care cases, including all findings and conclusions.

14. MSDH should implement its planned quality assurance function in order to ensure that child care facility inspectors uniformly enforce regulations.

For More Information or Clarification, Contact:

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A Review of the Mississippi State Department of Health

Introduction

Authority

The PEER Committee authorized a program evaluation of the Mississippi State Department of Health (MSDH) pursuant to the authority granted by MISS. CODE ANN. § 5-3-57 et seq. (1972). This review is a "cycle review," which is PEER's determination of the effectiveness of a randomly selected budget unit in achieving its statutory purpose. Cycle reviews are not driven by specific complaints or allegations of misconduct.

Scope and Purpose

This review begins with a discussion of the meaning of "public health," the role of state governments in protecting and promoting public health, the added challenge of meeting this objective in a relatively low-income state such as Mississippi, and the public resources which the state has committed to its public health programs.

PEER assessed MSDH's effectiveness in addressing the state's public health needs by reviewing:

- the adequacy of the department's collection and analysis of public health data to determine public health needs;
- the state's performance on public health indicators; and,
- three MSDH regulatory programs (Food Protection, Milk Sanitation [and bottled water] Program, and Child Care Facility Licensure).

Method

In conducting this study, PEER reviewed information from the State Personnel Board and state laws, regulations, policies and procedures, and other management documents related to the Mississippi Department of Health. PEER reviewed public-health-related information from the federal government and from other states. PEER likewise interviewed Department of Health personnel, legislative staff, and federal officials with regulatory programs and the Centers for Disease Control. PEER also surveyed current literature related to public health issues.

The Public Health Environment in Mississippi

Protecting and promoting public health in Mississippi is challenging, given the state's demographics (e.g., high percentage of the population which is low-income, rural, and undereducated). These demographics are associated with behaviors linked to greater risk of disease, high incidences of disease, and poor access to healthcare.

Health vs. Public Health

Health is a state of complete physical, social, and mental well-being.

According to the World Health Organization, "health" is "a state of complete well-being, physical, social, and mental, and not merely the absence of disease or infirmity."

A seminal work on "public health" is the Institute of Medicine's report entitled ***The Future of Public Health***, published in 1988. As noted in this book, public health is what society does collectively to assure the conditions in which people can be healthy. Public health focuses on communitywide concerns rather than health interests of particular individuals or groups.

Public health entails communitywide efforts focused on communitywide health concerns.

The primary objective of the public health system is to make progress against disease, disability, and premature death. Historically, public health agencies have prevented illness and death through efforts such as water quality control, food inspections, and immunizations. An effective public health system identifies and addresses continuing and emerging threats to the health of the public such as injuries and chronic illness, the spread of AIDS, and access to health care for the medically indigent.

Also, as noted by the Institute of Medicine, the line between public and private responsibilities in the area of public health has never been distinct. The health of a community is a shared responsibility of many entities, organizations, and interests in the community, including health service delivery organizations, public health agencies, other public and private entities, and the people of a community.

For example, public health includes the actions of:

- government officials, to pass laws and ordinances to protect the public, such as programs to regulate child care and commercial food handling;
- the medical community, who are key to assuring that primary care is provided to individuals and to reporting communicable diseases to public health authorities and who help to implement public health practices;
- the public and community leaders, for their support of public health initiatives such as changes in behaviors which help avert health threats (e.g., smoking, diet, exercise); and,
- public health agencies (see discussion of their role in the section which follows).

Appendix A on page 87 contains a list of public and private entities with major health-related responsibilities in Mississippi and a brief description of their relationship with MSDH.

Role of the Mississippi State Department of Health in Protecting and Promoting Public Health in Mississippi

As is true in state public health agencies nationwide, Mississippi's State Department of Health is responsible for taking the lead in assessing public health problems, informing public policy debates and planning, and assuring that needed health services are provided by either external providers or, in the absence of such providers, by the department itself.

MSDH is responsible for taking the lead in assessing public health problems, informing public policy debates and planning, and assuring that needed health services are provided.

State departments of public health vary widely in the specific public health services for which they are directly responsible. For example, some states include traditional public health functions such as water and air pollution control in their state departments of health, while others relegate these responsibilities to separate departments of environmental quality. Also, in some states, mental health is a responsibility of the state department of health. Some states have even created "super-agencies" which include all social and health-related services under one director, following the federal model of the U.S. Department of Health and Human Services.

In Mississippi, while MSDH is the lead agency on public health issues, public health responsibilities are

departmentally fragmented. As shown on Appendix A on page 87, other state agencies administering public health functions include the Department of Mental Health, the Department of Human Services, the Division of Medicaid of the Office of the Governor, the Department of Environmental Quality, the Mississippi Cooperative Extension Service, and some regulatory boards for health service occupations, such as nurses, physicians, and chiropractors. Appendix B on page 99 indicates the state departments with which MSDH has a written agreement and the nature of the agreements.

Although MSDH is the lead agency on public health issues, other agencies, such as the Department of Mental Health and the Department of Human Services, have public health responsibilities.

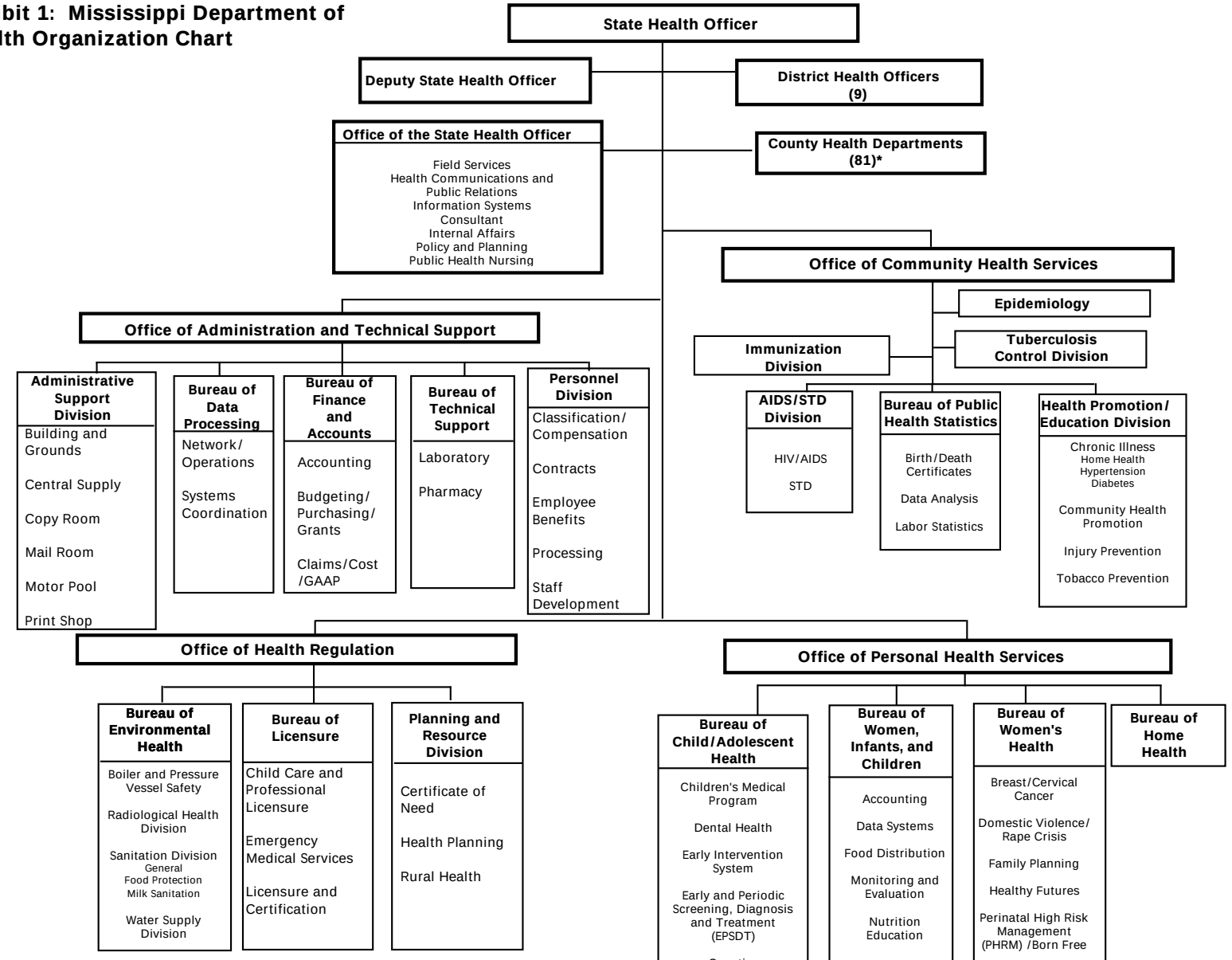
As shown in Appendix C on page 101, Mississippi statutes require MSDH to carry out numerous specific health functions and allow the department to carry out additional health functions at the department's discretion.

MSDH has historically devoted a significant percentage of its resources to providing direct patient medical care as a last-resort provider to the state's uninsured, underinsured, and Medicaid clients. In FY 1999, MSDH's 100 clinics, operating out of MSDH's eighty-one county health departments (Sharkey and Issaquena counties share a county health department; see Exhibit 3 on page 8), directly served 524,803 patients (based on an unduplicated patient count, by program). As shown in Exhibit 1 on page 6, MSDH operates an Office of Personal Health Services, heavily focusing on direct health services to women and children. Provision of these personal health services consumes resources that could otherwise be used for services affecting a larger portion of the population, such as collection and analysis of public health data, disease prevention, and health promotion. However, recent changes in the medical care market requiring recipients to receive direct care services from a primary care physician are reducing the demand on the department to provide such services.

In FY 1999, MSDH's clinics directly served 524,803 patients.

As shown in Exhibit 1 on page 6, in addition to its Office of Personal Health Services, MSDH operates two other major programmatic divisions: the Office of Community Health Services, whose responsibilities include epidemiology, immunization, public health statistics, public health promotion/education and divisions targeted to HIV/AIDS, STDs, and tuberculosis; and the Office of Health Regulation, which is responsible for licensure and certification of health care providers and services (including services potentially affecting public health such as food services, milk and bottled water plants, and child care), regulation of selected environmental risks, such as water supplies, radiological health, and health care planning, including implementation of the state's Certificate of Need program. Exhibit 2 on page 7 lists MSDH's major programs and sub-programs. Appendix C

Exhibit 1: Mississippi Department of Health Organization Chart



SOURCE: MS Department of Health FY 2001 Budget Request; 1999 Annual Report.

*Sharkey and Issaquena counties share a county health department.

Exhibit 2: MSDH Programs and Sub-Programs

Chronic Illness
Home Health Hypertension Treatment Diabetes Treatment

Maternal and Child Health
Family Planning Maternity/Perinatal Services Child Health WIC Genetics Early Intervention for Infants and Toddlers Children's Medical Program

Environmental Health
General Sanitation Food Protection Milk Sanitation Public Water Supply Radiation Control Boiler and Pressure Vessel Safety

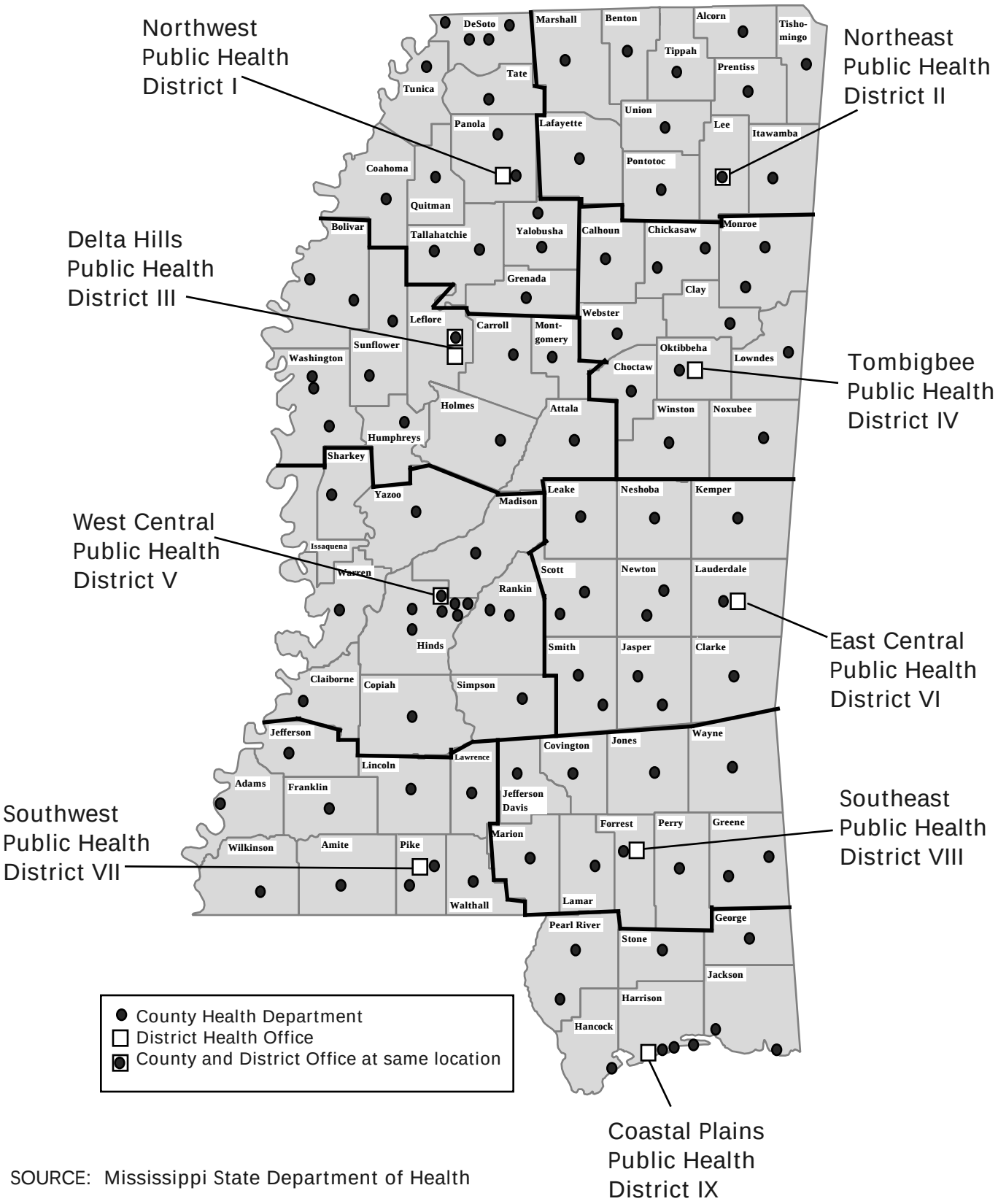
Disease Prevention and Health Promotion
Epidemiology Immunization HIV/ AIDS Sexually Transmitted Diseases Tuberculosis Cancer Prevention Domestic Violence/Rape Prevention and Crisis Intervention Public Health Statistics Health Promotion/Education

Health Care Planning, Systems Development, and Licensure
Health Planning and Certificate of Need Primary Care Development Rural Health Care Development Emergency Medical Services Health Facilities Licensure Professional Licensure Child Care Facility Licensure

Support Services

SOURCE: MSDH FY 2001 budget request and PEER interview with MSDH staff.

Exhibit 3: MSDH Public Health Districts and County Health Departments



SOURCE: Mississippi State Department of Health

on page 101 contains a brief description of each of these programs.

For purposes of program delivery, MSDH's eighty-one county health departments are organized into nine districts, each headed by a district health officer, who is a physician (refer to Exhibit 3 on page 8). As of the close of FY 1999, 71% of MSDH's 2,822 total budgeted positions were allocated to district offices, with the remaining 29% allocated to MSDH's central office in Jackson.

According to the Institute of Medicine, "effective public health actions must be based on accurate knowledge of health problem causation, distribution, and the effectiveness of intervention." Because effective public health policy must be grounded in technical expertise, it is important for the director of a state public health agency to possess a knowledge and understanding of the technical aspects of public health. The Institute of Medicine recommended that the directors of departments of health have a doctoral-level education in medicine or another health profession and have education in public health and public-sector administrative experience.

MSDH is managed and its programs administered by a professional State Health Officer appointed by the State Board of Health for six-year terms. MSDH's current Executive Director is a physician with a specialty in Epidemiology--the core science of public health. He is board certified in Public Health and General Preventive Medicine and has a master's degree in public health.

Further, the Institute of Medicine notes that continuity of leadership is important to the development of rational public health policy. Mississippi's current director has been in the position for seven years.

Mississippi's Challenging Public Health Environment

Mississippi's demographics as a state with a significant percentage of the population that is low-income, rural, and undereducated presents a significant public health challenge. According to Mississippi's FY 2000 ***State Health Plan***:

> ***Although Mississippi has achieved significant improvement in income, education, and housing, the state remains well below national averages in these areas. Each of these factors affects the health status of the population. Therefore, any strategy to elevate the quality of health care in the state***

should take the poorly educated, low-income, and ill-housed people into consideration.

Mississippi ranks at the bottom nationally on major indicators of income and education.

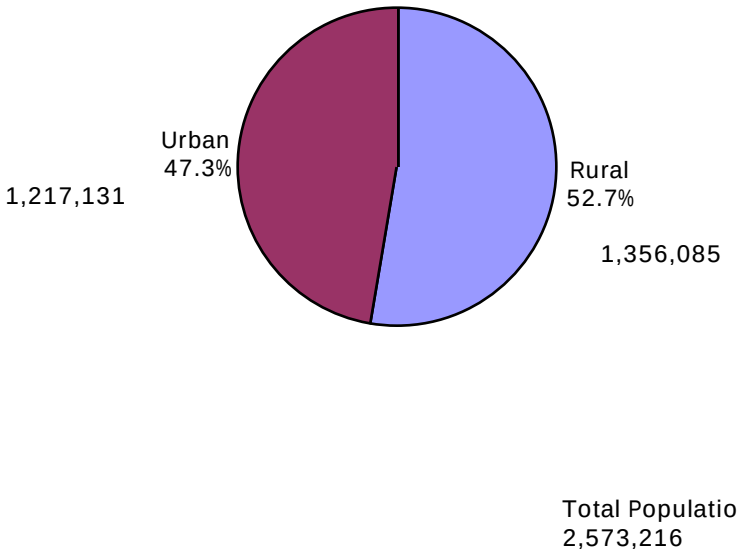
According to the U.S. Census Bureau's 1998 population report on ***Poverty in the United States***, between 1996 and 1998, an average of 18.3% of Mississippi's population lived in poverty. According to the most recent available state rankings data, Mississippi ranks last in per capita personal income, second on the poverty rate (for 1997) and percent of the population receiving Medicaid, and third on the percentage of the population receiving public aid as well as the percentage of households receiving food stamps[.

In terms of education, Mississippi ranks last in the public high school graduation rate.

Based on 1990 census data, 53% of Mississippi's population lives in rural areas with limited access to primary medical care.

1990 census data shows that 53% of the state's 2.6 million residents live in areas classified as rural (living in communities and unincorporated areas of 2,500 or less) by the Census Bureau (see Exhibit 4 below). In 1998, Mississippi ranked second in the percent of population lacking access to primary care (22.1%). Nationwide, 9.6% of the population lacks access to primary care.

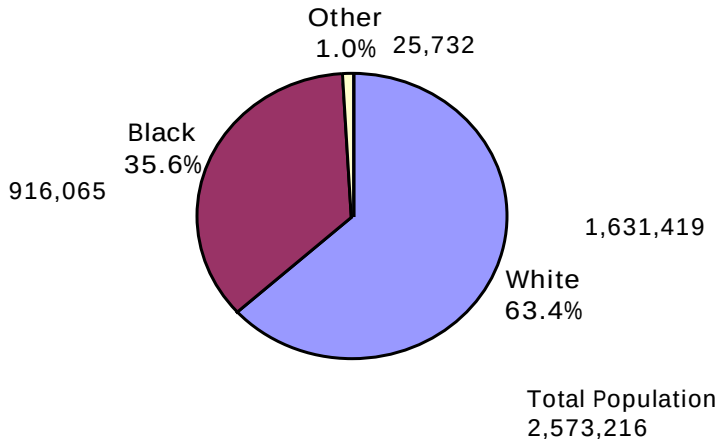
Exhibit 4: Mississippi's 1990 Population, Urban vs. Rural



SOURCE: MSDH 2000 ***State Health Plan***

According to MSDH's ***State Health Plan***, Mississippi's 35.6% black population is disproportionately impoverished. See Exhibit 5, below, for Mississippi's population distribution by race. For example, in 1989, 13.2% of Mississippi black families were below the poverty level compared to 6.9% of white families. Also, the rate of unemployment among the black population in 1989 was 15.9% compared to 5.1% for the white population.

Exhibit 5: Mississippi's 1990 Population by Race



SOURCE: MSDH 2000 ***State Health Plan***

In 1996, Mississippi ranked second in the percentage of adults who reported being overweight (34.3%), seventh in the percentage of adults who reported no exercise (38.9%) and ninth (81.9%) in the percentage of adults who report eating fewer than five servings of fruits and vegetables per day. These behaviors are associated with a higher incidence of many chronic diseases such as hypertension, diabetes, and cancer. Also, studies show that lower income individuals have a higher incidence of cancer. In Mississippi, the greatest cancer burden occurs among blacks.

Public Resources Committed to Public Health in Mississippi

In FY 1999, the State Department of Health expended $175.4 million on public health programs. The majority of revenues (51.2%) consisted of federal funds and the sub-program receiving the greatest total funding ($53.3 million) was the supplemental food program for Women, Infants, and Children (WIC). Between FY 1990 and FY 1999, state funds expended by MSDH nearly doubled, from $20.3 million to $37.5 million.

MSDH FY 1999 Expenditures, by Funding Source

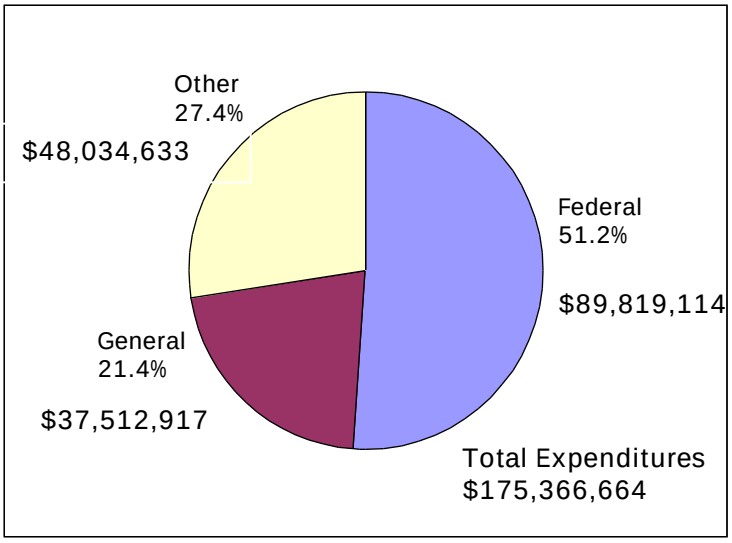
In FY 1999, MSDH expenditures consisted of approximately 52% federal funds, 27% other funds, and 21% general funds.

In FY 1999 MSDH received revenues from three main sources: federal funds, state general funds, and "other" funds (e.g., funds from local governments, fees for services, Medicaid refunds). Also, in FY 2000, MSDH began expending tobacco settlement funds, a new source of "other" funds to the department.

Federal and State Funds

As shown in Appendix D on page 113 and Exhibit 6 on page 13, in FY 1999 federal funds comprised $89.8 million of total MSDH expenditures (51.2%) and state general funds of $37.5 million (21.4%). MSDH generated federal funds primarily through approximately fifty federal grants (refer to listing of grants in Appendix E on page 114). While none of the grants allow the department to expend funds in public health areas other than those specifically designated by the grant, the department has some discretion as to what federal grants it applies for and has some discretion (depending upon the grant terms) as to how it will expend the monies within the designated program area.

Exhibit 6: MSDH FY 1999 Expenditures by Funding Source



SOURCE: MSDH 1999 Annual Report

Other Funds, Including Tobacco Settlement Funds

The Legislature enacted HB 519 that created the Health Care Trust Fund and the Health Care Expendable Fund for money received from the tobacco settlement.

FY 1999 expenditures of the State Department of Health included expenditures from "other" funding sources of $48 million (27.4%).

On July 2, 1997, the State of Mississippi settled its lawsuit with the tobacco companies for an initial lump sum payment of $170 million plus interest and annual payments beginning at $68 million in FY 1999 and increasing annually over five years, at which point annual payments of $135 million will continue in perpetuity. Also, the tobacco companies will pay an additional $500 million during the first five years.

During its 1999 Regular Session, the Legislature passed House Bill 519, creating two funds for the investment and expenditure of tobacco settlement funds:

- the Health Care Trust Fund for the holding and investment of tobacco settlement principal payments to the state; and,

- the Health Care Expendable Fund for the appropriation of funds to be used for improving the health and heath care of Mississippians.

Through FY 1999, Mississippi had received approximately $300 million in settlement payments.

Through FY 1999, the state received nearly $300 million in settlement payments to the Trust Fund, which will be transferred to the Health Care Expendable Fund, as mandated by HB 519, as follows: $50 million for FY 2000, $55 million for FY 2001, $60.5 million for FY 2002, $66.55 million for FY 2003, and a sum equal to the average annual amount of the income from the investment of the funds in the Heath Care Trust Fund since July 1, 1999, for FY 2004 and beyond.

FY 2000 Heath Care Expendable Fund MSDH recipients included the Trauma Care System, MS Qualified Health Center Grant Program, and Maternal and Child Health Programs.

Of the $50 million transferred to the Health Care Expendable Fund in FY 2000, the Legislature allocated $11.4 million to the following MSDH programs, and the remaining $38.6 million to health-related programs in other state agencies: Trauma Care (see Appendix C, page 101): $6 million; the Mississippi Qualified Health Center Grant Program, a program which makes funding available to public or non-profit entities which provide comprehensive primary care services to uninsured and medically indigent patients: $4 million; and Maternal and Child Health Programs, $1.4 million. Other major areas which MSDH identified as potential areas for future funding include the following: cardiovascular disease prevention (including physical activity and hypertension control); breast and cervical cancer screening and treatment; long-term care; mental health; school nurses (if demonstrated to be effective); tobacco use prevention (post-pilot programs); reduction of infant mortality; diabetes management (especially prevention of complications); and injury prevention.

Trends in MSDH Expenditures, by Funding Source, from FY 1990 – FY 1999

From 1990 through 1999, the most rapid increase in MSDH expenditures by funding source was in the category of state general funds, which nearly doubled from $20.3 million to $37.5 million. During the same period, MSDH expenditures of “other” funds increased 24%, from $38.9 million to $48 million. Federal fund expenditures increased 49%, from $60.5 million to $89.8 million.

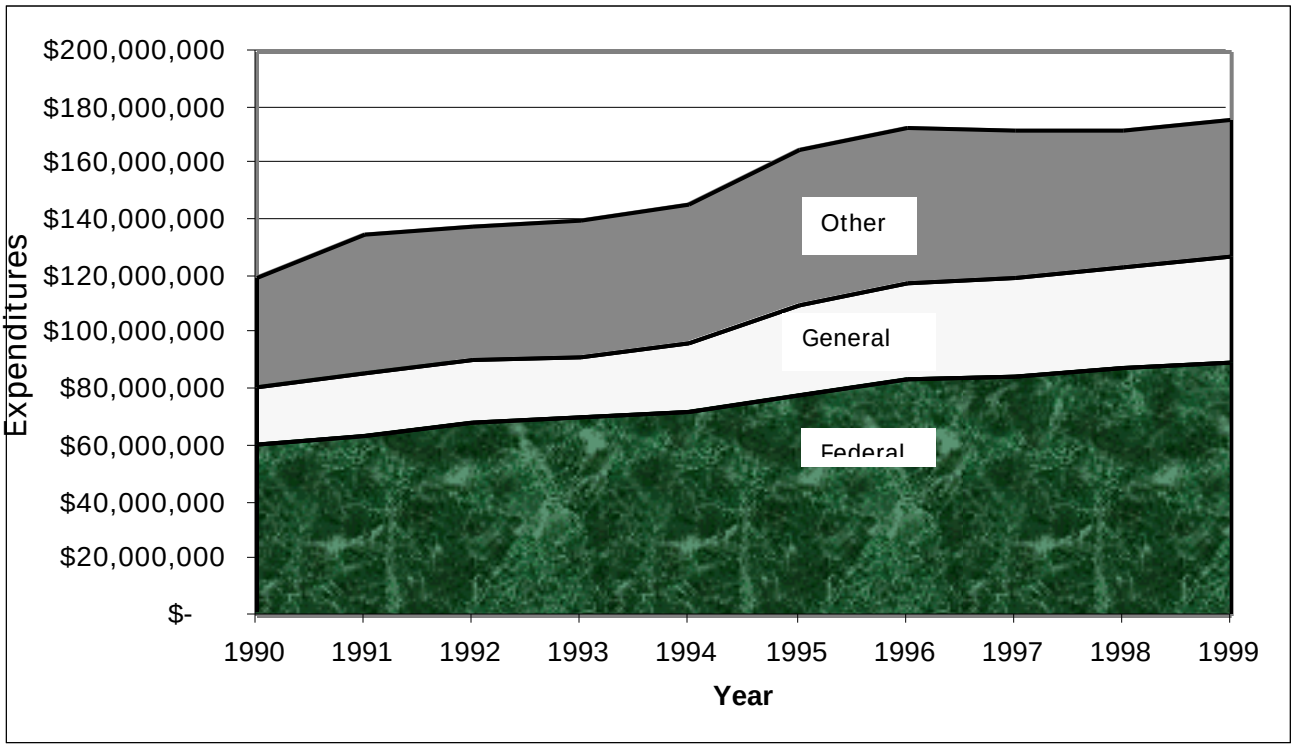
From 1990 to 1999 total MSDH expenditures have increased 47%, from $119.6 million in 1990 to $175.4 million in 1999.

General fund expenditures have increased, as a percent of all expenditures, while percent of federal fund expenditures remained the same and percent of "other" fund expenditures decreased.

As illustrated in Exhibit 7, below, MSDH's total expenditures have increased significantly since FY 1990. From FY 1990 to FY 1999, total MSDH expenditures increased 47%, from $119.6 million to $175.4 million. On a per capita basis over the same period, total MSDH expenditures increased 37%, from $46.88 to $64.04.

For the same period, MSDH's general fund expenditures have risen 84.5%, from $20.3 million to $37.5 million. Not only have total general fund expenditures increased, but general fund expenditures as a percentage of all MSDH expenditures have increased from 17% to 21.4%. Federal expenditures have increased by $29.4 million, while remaining at 51% of all MSDH expenditures. Expenditures from "other" fund sources have increased by 24%, from $38.9 million to $48 million. "Other" expenditures as a percentage of all expenditures have decreased from 32.5% to 27.4%.

Exhibit 7: MSDH Expenditures by Source, FY 1990 through FY 1999

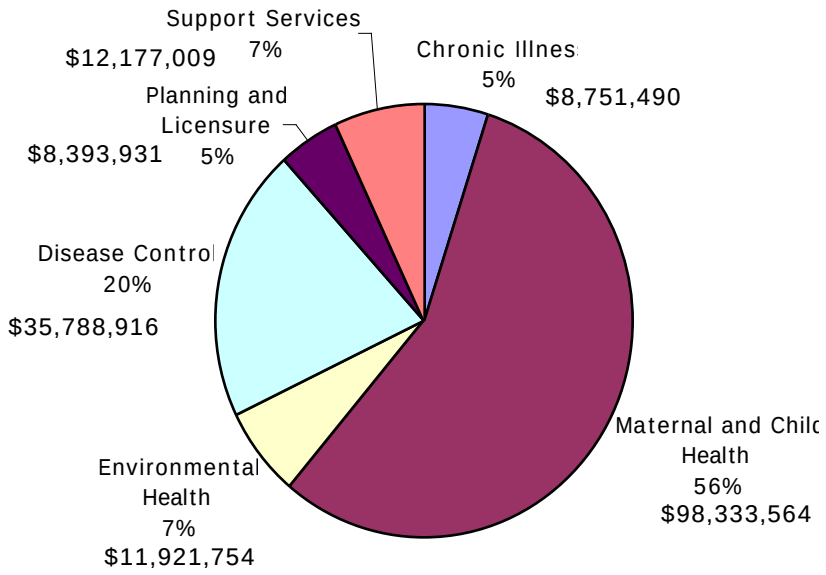


SOURCE: MSDH Annual Reports FY 1991 through FY 1999.

The majority of FY 1999 MSDH expenditures were for maternal and child health (56%), followed by disease prevention (20%).

As shown in Exhibit 2 on page 7, MSDH is organized into six major health program areas, each with its own major sub-programs: Chronic Illness; Maternal and Child Health; Environmental Health; Disease Prevention and Health Promotion; Health Care Planning, Systems Development and Licensure; and Support Services. As shown in Exhibit 8, below, based on FY 1999 actual total MSDH

Exhibit 8: MSDH FY 1999 Expenditures by Program



SOURCE: MSDH FY 1999 Annual Report

expenditures of $175 million, the majority of MSDH program expenditures were for maternal and child health (56%), followed by disease prevention (20%). During FY 1999, MSDH expended $12 million (7% of the total budget) on support services (i.e., functions such as accounting and personnel, which support all program areas).

MSDH FY 1999 Expenditures, By Program

The greatest total FY 1999 expenditures for subprograms include WIC (30%), family planning (11%), and maternity (5%).

Family planning received the greatest percent of FY 1999 general funds (12.4%), followed by WIC (8.9%) and General Environmental Services (8.3%).

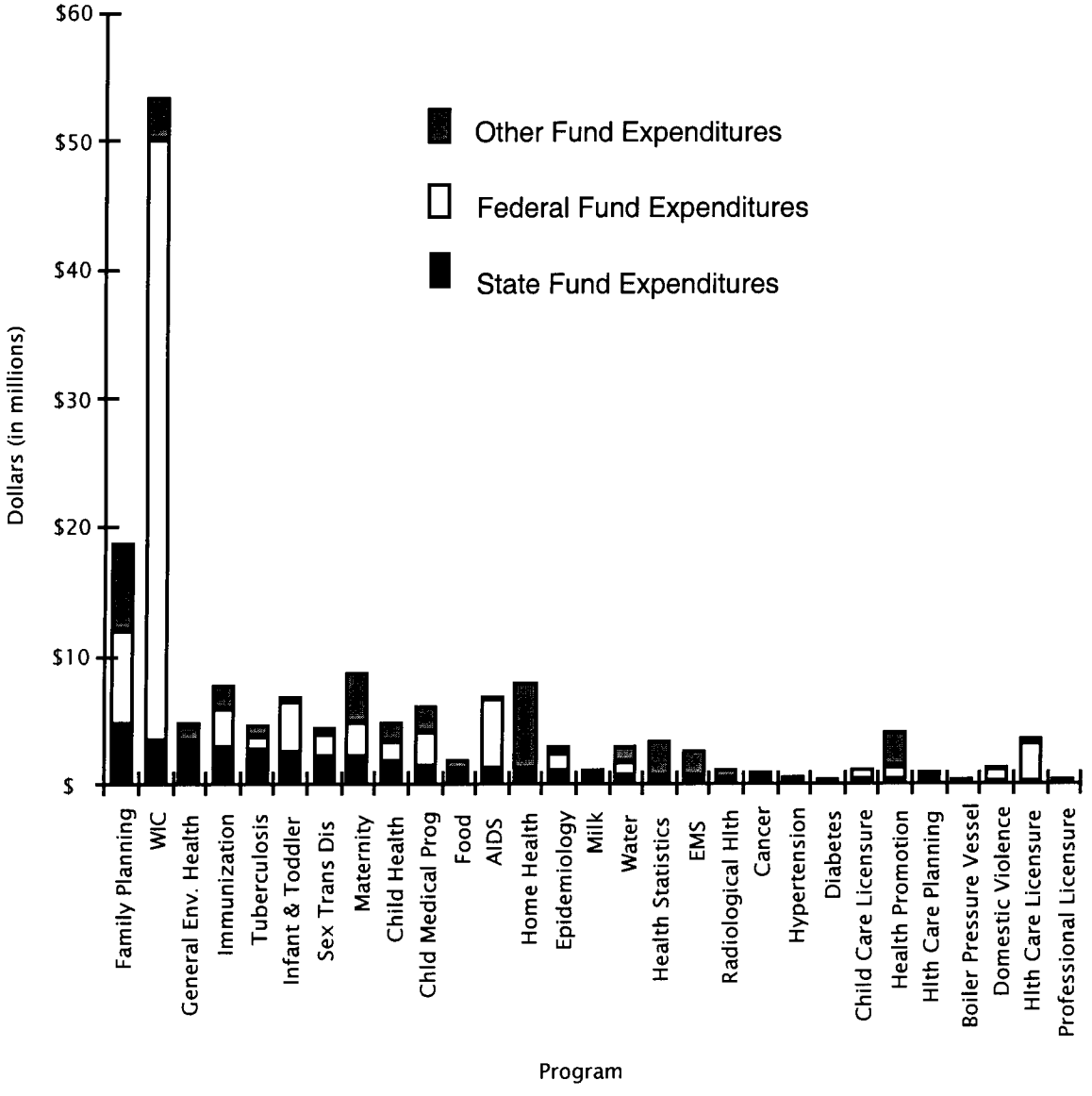
At the sub-program level the greatest total expenditures were for the following three maternal and child health sub-programs: WIC ($53.3 million; 30% of FY 1999 MSDH expenditures), a supplemental food program designed to provide essential nutritional counseling and supplemental foods to pregnant and breast-feeding women and to infants and children; the family planning program ($18.8 million, 11% of FY 1999 expenditures), a program providing family planning services to low-income women and at-risk teenagers; and the maternity program ($8.7 million, 5% of FY 1999 expenditures), which provides maternity services to low-income women. Despite the significant amount of funds expended on the WIC program, the rate of births of low birthweight remained fairly constant from 1990 through 1998 (refer to Exhibit 18, on page 41).

Within each of the remaining four MSDH programs, greatest subprogram expenditures were:

- Home Health in Chronic Illness program ($7.9 million);
- General Sanitation (i.e., on-site wastewater disposal systems) in Environmental Health program ($4.7 million);
- Immunization ($7.8 million) and AIDS ($6.7 million) in Disease Prevention program; and,
- Health Care Licensure in Health Care Planning program ($3.5 million).

Exhibit 9 on page 18, illustrates FY 1999 expenditures by funding source and sub-program, in order of decreasing general fund expenditures. Family planning received the greatest percent of FY 1999 general funds (12.4%), followed by WIC (8.9%) and General Environmental Services (8.3%). Appendix D, page 113, presents a breakdown of FY 1999 program and sub-program expenditures by funding source.

Exhibit 9: MSDH FY 1999 Sub-Program Expenditures



SOURCE: MSDH Internal Financial Analysis

Trends in MSDH Expenditures, by Program, from FY 1991 – FY 1999

From FY 1991 through FY 1999, MSDH's Chronic Illness program was the only program to experience a decline in expenditures (from $19.8 million to $8.8 million, a 56% decline). (PEER did not include FY 1990 data in this analysis because during FY 1990, MSDH included expenditures for support services within each program and did not isolate the data.) The remaining five programs all experienced increases in expenditures. Disease Prevention and Health Promotion increased the most--207%, from $11.7 million to $35.8 million. In terms of total expenditures, Maternal and Child Health had the second greatest increase--22%, from $80.8 million to $98.3 million, followed by support services ($5.6 million), Environmental Health ($4 million), and Health Care Planning and Licensure ($.2 million). Expenditures for Chronic Illness decreased 56%, from $19.8 million to $8.7 million. Exhibit 10, page 20, tracks expenditures as a percent of total expenditure per program from FY 1991 through FY 1999. Exhibit 11 on page 21 displays the trend in total program expenditures.

The decrease in Chronic Illness expenditures is primarily attributable to changes in the medical care market affecting the Home Health Program. MSDH estimates that the department lost approximately thirty percent of caseloads in the state as a result of changes in federal regulations.

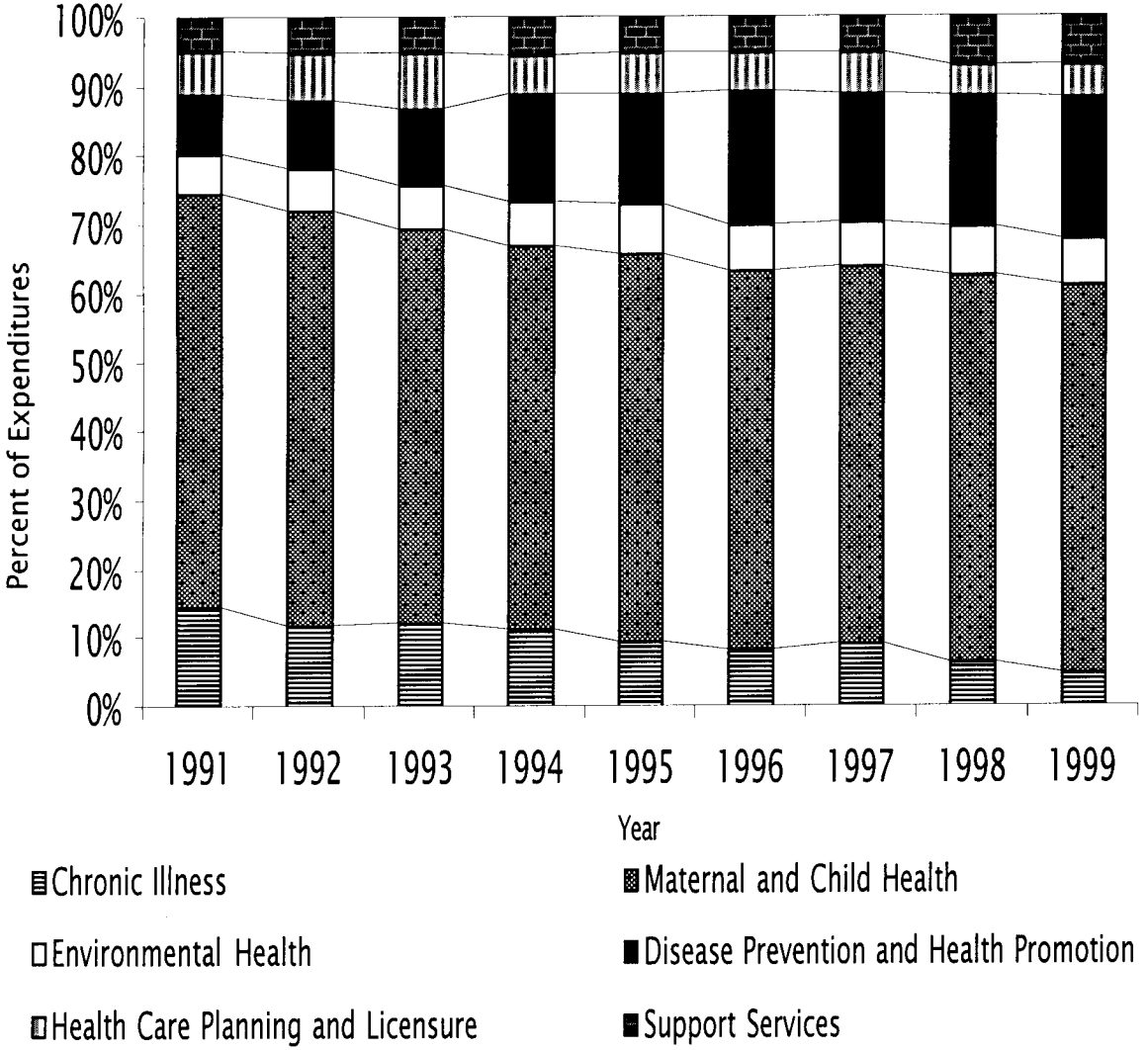
MSDH FY 1999 Staffing Levels, by Sub-program

In FY 1999 the Maternal and Child health program employed the highest percentage of staff (50.3%).

Based on State Personnel Board records, in FY 1999 (as of June 30), MSDH employed 2,420 workers at a total annual cost of approximately $85 million, representing 48% of the department's total budgeted expenditures. According to a MSDH FY 1999 staffing analysis, throughout the fiscal year the Maternal and Child Health program had the greatest number of MSDH full-time equivalent (FTE) employees (1198.6 [50.3%]), followed by Disease Control (469.1 [19.7%]), Environmental Health (250.8 [10.5%]), Chronic Illness (189.7 [8%]), Support Services (149.7 [6.3%]) and Health Care Planning and Licensure (125.1 [5.2%]).

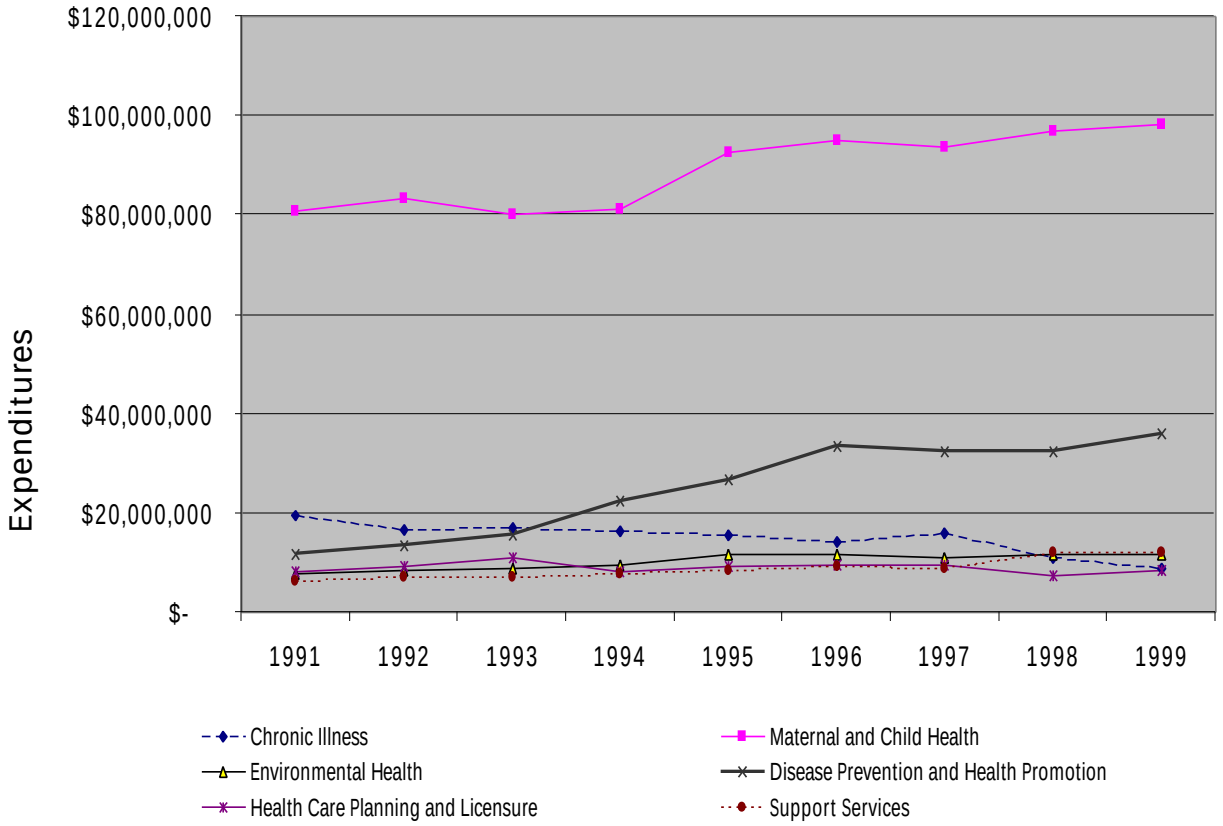
Exhibit 12, page 22, presents FY 1999 MSDH staffing, by sub-program. As was the case with funding, the WIC program is the largest, with 21% of total staffing (489.5 staff), followed by Family Planning (278, or 12%) and

Exhibit 10: MSDH Program Expenditures as a Percent of All Expenditures, FY 1991 through FY 1999



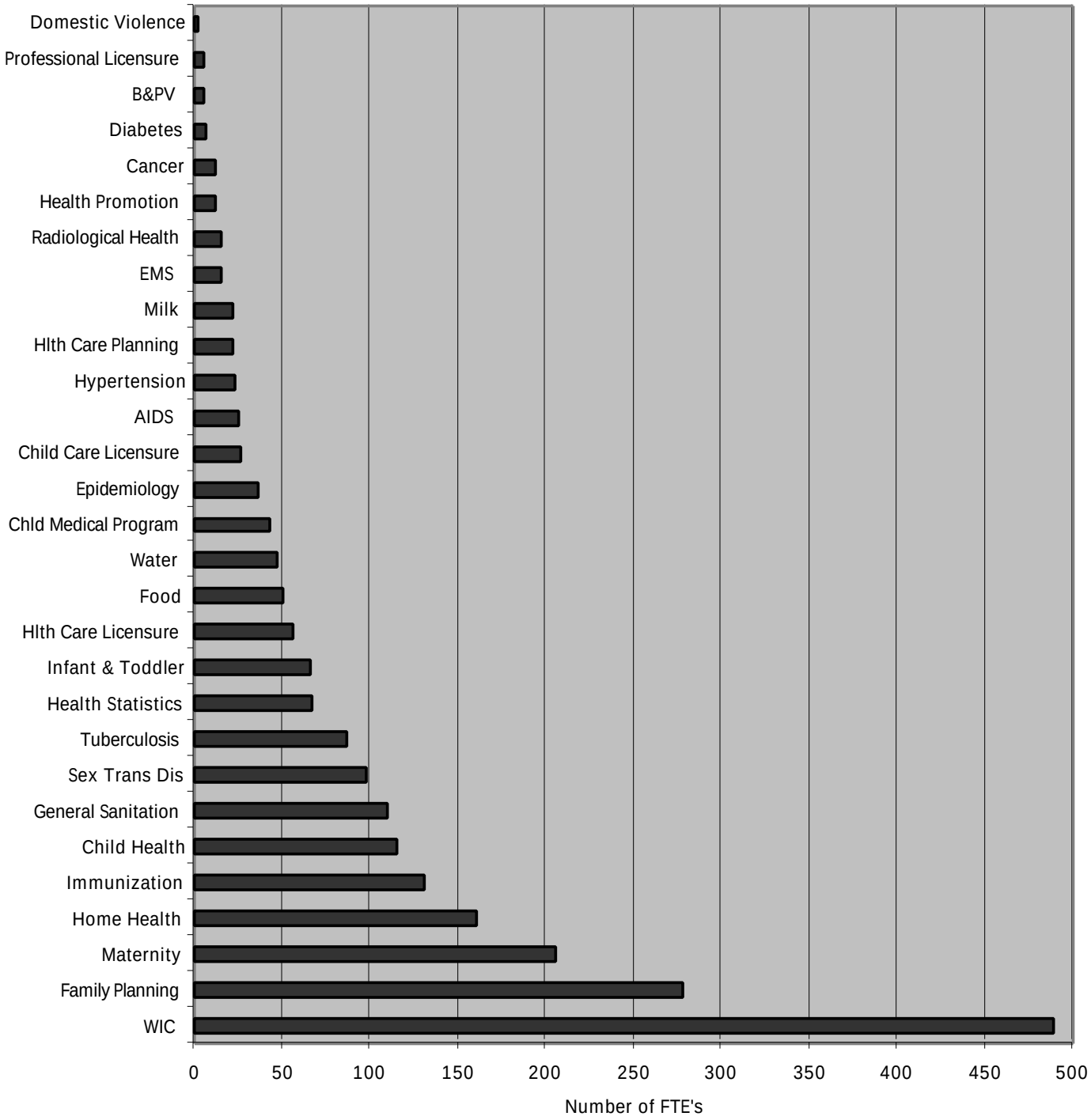
SOURCE: MSDH.

Exhibit 11: MSDH Program Expenditures, FY 1991 through FY 1999



SOURCE: MSDH Internal Financial Analysis.

Exhibit 12: FY 1999 MSDH Staffing, by Sub-Program



SOURCE: MSDH.

Maternity (205.9, or 9%). These three sub-programs, as well as others, are all within MSDH's Maternal and Child Health program.

Trends in MSDH Staffing Levels for FY 1990 – FY 2000

Through the annual appropriation process, the Legislature specifies the number of positions (PINS) which an agency may fill and the corresponding salaries, wages, and fringe benefits for those positions. From FY 1990 through FY 2000 the number of PINS appropriated to MSDH (including full- and part-time permanent and temporary) increased slightly, from 2,869 PINS appropriated in FY 1990 to 3,141 in FY 1996, then decreasing to 3,030 in FY 2000. Corresponding expenditures for salaries, wages, and fringes have increased from $57,569,114 in FY 1990 to $96,109,539 authorized for FY 2000.

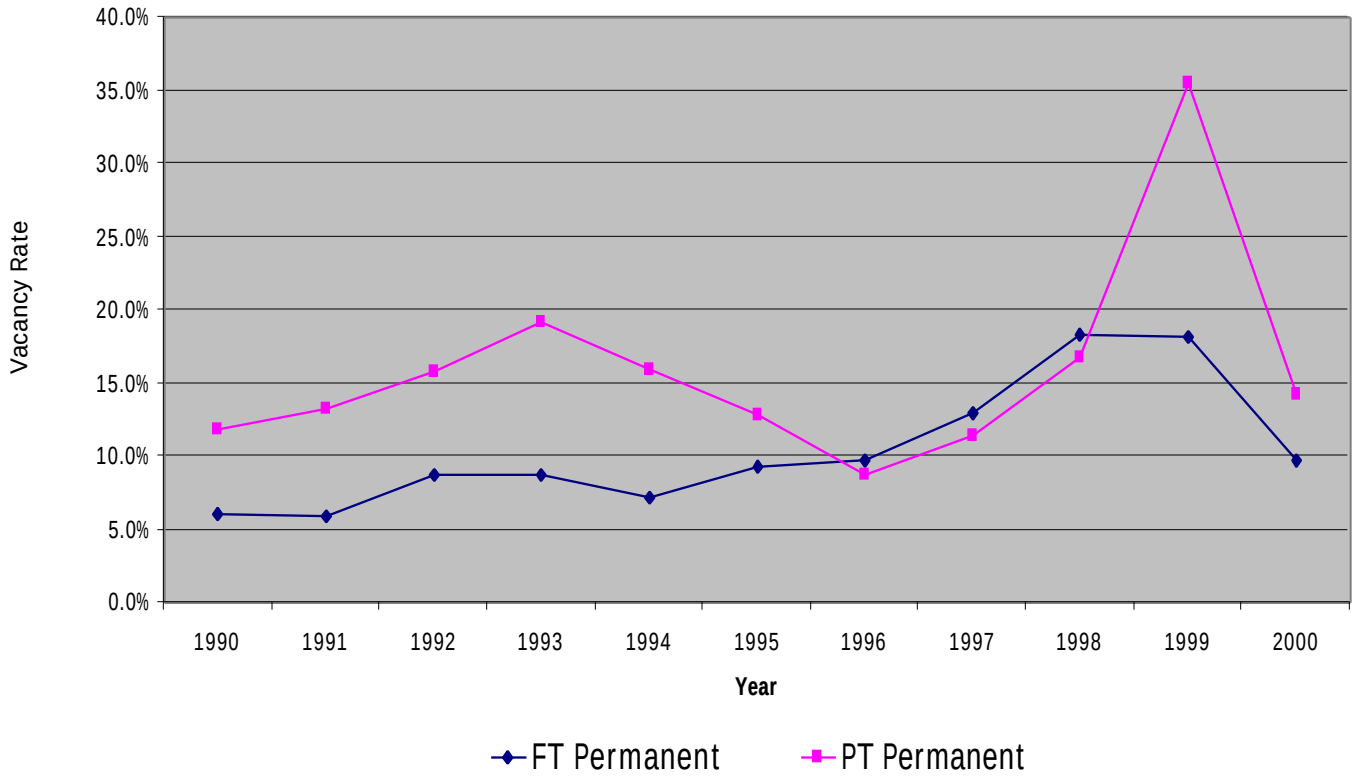
Trends in MSDH Vacancy Rates for FY 1990 – FY 1999

In FY 1999, vacancy rates had reached 18.2% for full-time permanent positions and 35.5% for part-time permanent positions.

As illustrated in Exhibit 13, page 24, for the period FY 1990 through FY 1999 the MSDH vacancy rate for full-time permanent positions increased from 6% to 18.2%. The rate for part-time permanent positions also increased from 11.8% to 35.5%. The increase in vacancy rates can be partially attributed to MSDH not deleting authorized PINS as the need and intention to fill the vacant PINS diminished.

According to MSDH, there was a significant shift in responsibility for the delivery of health care during the 1990s as a result of the implementation of Medicaid managed care.

Exhibit 13: MSDH Average Annual Vacancy Rates FY 1990 through FY 2000 (estimated) for FT and PT Permanent Positions



SOURCE: MSDH Budget Request FY1992 through FY2001.

In FY 2000, MSDH deleted 299 vacant PINS, lowering the full-time permanent vacancy rate from 18% in FY 1999 to estimated 9.7%.

As a result of the decrease in caseload, the agency experienced a decrease in the number of positions that needed to be filled in these areas. But, while the number of PINS to be filled decreased, the number of appropriated PINS did not, resulting in an increased vacancy rate.

In December 1999, MSDH deleted 299 vacant PINS. According to SPB staff, the deleted PINS were associated primarily with home health care. This PIN deletion lowered the agency vacancy rate to an estimated 9.7% for full-time permanent and 14.2% for part-time.

Review of the Adequacy of MSDH's Collection and Analysis of Public Health Data

PEER reviewed the department's collection and analysis of three primary categories of public health data (vital statistics, communicable diseases, and chronic diseases) and found problems with timeliness and comprehensiveness of data collection. These problems compromise MSDH's ability to make fully informed public health policy decisions.

Public health data must be comprehensive, timely, accurate, and properly analyzed in order to be of maximum value in determining and addressing public health needs. According to the Institute of Medicine, "An understanding of the determinants of health and of the nature and extent of community need is a fundamental prerequisite to sound decisionmaking about health." Proper analysis of public health data includes the identification of immediate health threats, research into fundamental determinants of health (behavioral, environmental, biological, and socioeconomic), as well as the determination of the adequacy and availability of health-related services to the state's citizens.

PEER identified three primary categories of public health data: vital statistics, communicable disease, and chronic disease. State law also mandates the additional collection of four special categories of public health data: rural health, traumatic injury, birth defects registry, immunization registry, cancer registry, and hearing impaired registry. Exhibit 14, page 26, summarizes PEER's conclusions with respect to the adequacy of MSDH's collection and analysis of vital statistics, communicable disease, and chronic disease data.

Exhibit 14: Overview of the Adequacy of MSDH's Collection and Analysis of Vital Statistics, Communicable Disease, and Chronic Disease Data

	Is the data ***Comprehensive***? (are all elements being collected)	Is the data ***Accurate***?	Is the data received on a ***Timely*** basis?	Is there adequate ***Analysis***?
Vital Statistics	**YES**	**YES**	**NO**	**YES**
Communicable Disease	**YES** [a]	**Some data elements missing on reported cases**	**NO**	**YES**
Chronic Disease	**NO** [b]	**---**	**---**	**---**

a) MSDH does not collect data for streptococcus disease and toxic-shock syndrome.

b) Currently, MSDH collects only cancer registry data. Therefore, PEER was unable to determine the accuracy, timeliness, and adequacy of analysis for chronic disease data.

SOURCE: PEER analysis of MSDH records.

Vital Statistics Data

The vital statistics data collected by MSDH is comprehensive in relation to federal standards, accurately reported (with an exception in the area of cause of death), and analyzed in accordance with the Centers for Disease Control's National Public Health Performance Standards. However, MSDH does not receive vital statistics data in a timely manner.

Based on federal standards, the vital statistics data collected by MSDH is comprehensive with respect to births and deaths.

The Centers for Disease Control has established standard certificates for vital statistics, which represent the minimum basic data set necessary for the collection and publication of comparable national, state, and local vital statistics data. These forms contain data related to births, deaths, fetal deaths, marriages, and divorces.

Mississippi's vital statistics forms require all of the federally required birth and death information.

PEER compared the state standard certificate forms to the federal standard forms and found that Mississippi's vital statistics forms require all of the federally required birth and death information. While the forms do not require some information with respect to marriages and divorces, PEER found that these missing elements were not critical to public health.

According to the ***Model State Vital Statistics Act and Regulations*** from the Centers for Disease Control, vital statistics data is derived from certificates and reports of birth, death, fetal death, induced termination of pregnancy, marriage (divorce, dissolution of marriage, or annulment) and related reports.

While MSDH's Vital Statistics Division has multiple checks designed to help ensure the accuracy of data keyed into the vital statistics database, problems exist locally and nationally with the accuracy of causes of death reported on death certificates.

MISS. CODE ANN. § 41-57-1 creates the Bureau of Vital Statistics within MSDH. This bureau is to provide an adequate system for the registration of vital events in Mississippi.

To ensure accuracy, MSDH's Vital Statistics Division verifies each vital statistic record individually, prior to data entry. MSDH receives the data from comprehensive report forms, completed by hospitals, funeral homes, coroners, circuit clerks, and doctors. MSDH employs dual key verification for every record--entering all information twice and utilizing the first entry as a check against the second. As an additional safeguard, MSDH utilizes computer programs that perform error-checking routines to test data integrity before inclusion in the database. All corrections receive individual scrutiny as well.

MISS. CODE ANN. § 41-57-27 makes it a misdemeanor for any person to furnish false information for the purpose of making incorrect records or to establish a false identity to MSDH with respect to vital statistics. This law helps to insure that accurate information is completed on the certificates that are sent to the Vital Statistics Division. Likewise, MISS. CODE ANN. § 41-57-59 imposes the same penalty for the same types of reporting issues with respect to data on marriages.

According to physicians, heart failure may be overstated as a cause of death in Mississippi, perhaps because of the limited amount of space on death certificates to describe a person's death and the limitation of selecting one primary cause.

PEER noted, through interviews and literature review, problems locally and nationwide with regard to accuracy of reporting cause of death on death certificates. Some physicians believe that accuracy could be improved if MSDH allowed a description of the circumstances leading to the death rather than forcing the selection of a primary cause. While there are spaces on the certificate for other causes, there is limited amount of space to describe the death of a person. Because of this problem, heart failure may be overstated as a cause of death, according to physicians.

The Mississippi Department of Health is not receiving birth and death certificates in a timely manner.

MSDH's ***Rules Governing the Registration and Certification of Vital Events*** prescribes the filing of certificates of birth and death within five days of the event. According to analysis completed by MSDH's Division of Vital Statistics, the average number of days between birth and file date is 14.8 days (ranging from 2 days to 64 days). The average number of days between death and file date is 14.27 days (ranging from 3 days to 36 days).

While the time of receipt of certificates to MSDH is dependent on many factors, the department's rules contain no penalties for failure to meet the prescribed deadline.

The Vital Statistics Division is adequately analyzing vital statistics data in accordance with CDC performance standards.

MSDH's annual ***Vital Statistics*** publication includes analysis of elements outlined in the CDC's National Public Health Performance Standards Program, except for the rate of repeat teen pregnancy. Mississippi's yearly ***Vital Statistics*** publication includes many data sets related to births, deaths, fetal deaths, induced terminations, marriages, and divorces. Many of these data sets are broken down by relevant descriptors such as age, gender, and race.

Communicable Disease Data

While the communicable disease data which MSDH collects is comprehensive (with the exception of the omission of streptococcus disease and toxic-shock syndrome data), PEER noted problems with respect to the timeliness of

collection and the completion of all data elements on communicable disease reporting forms.

Based on epidemiological standards, MSDH is collecting comprehensive communicable disease data in Mississippi, with the exception of data on streptococcus disease and toxic-shock syndrome.

MISS. CODE ANN. § 41-23-1 (1972) allows MSDH to determine which communicable diseases should be reported in Mississippi, by directing the department to:

> ***. . .adopt rules and regulations (a) defining and classifying communicable diseases and other diseases that are a danger to health based upon the characteristics of the disease; and, (b) establishing reporting, monitoring and preventive procedures for those diseases.***

A communicable disease is transmissible by direct contact with an affected individual or by indirect means.

As of 1997, the Centers for Disease Control had designated forty-three diseases as notifiable at the national level (refer to Appendix F on page 115 for a list of the Centers for Disease Control's Nationally Notifiable Disease List). While the federal government publishes this list of notifiable diseases, collection and reporting of communicable disease data by the states is voluntary. However, in the interest of protecting public health, the states have an informal agreement among themselves to report communicable diseases.

MSDH monitors thirty-nine of the communicable diseases on CDC's notifiable list. The four notifiable diseases that MSDH does not monitor are coccidioidomycosis, hantavirus pulmonary syndrome, streptococcus disease, and toxic-shock syndrome. The Centers for Disease Control designates two of these diseases (coccidioidomycosis and hantavirus pulmonary syndrome) as regional diseases. MSDH staff stated that these diseases do not occur in Mississippi's climate. However, streptococcus disease and toxic-shock syndrome are not regional diseases. In addition to comparing MSDH's list of reportable communicable diseases to the Centers for Disease Control's Nationally Notifiable Disease List, PEER compared MSDH's list to the list of communicable diseases published by the Council of State and Territorial Epidemiologists. The council's list includes ***any*** disease under surveillance in any state. MSDH requires reporting of forty (89%) of the total forty-five diseases on the council's list. The five diseases from the council's list that are not on MSDH's list are coccidioidomycosis, hantavirus pulmonary syndrome, silicosis, streptococcus disease, and toxic-shock syndrome.

MSDH's communicable disease reporting forms are missing data elements.

Two primary types of reporting errors potentially affect the accuracy of MSDH's communicable disease database: failure of sources (e.g., physicians, hospitals, laboratories) to report reportable communicable diseases and failure of sources to report all information required on MSDH's communicable disease reporting form. Without accurate data, MSDH cannot identify trends in and the nature of the occurrences of communicable diseases in Mississippi.

MSDH's communicable disease database lacks some data elements due to failure of sources to report communicable diseases and failure of sources to provide all information required by the department's reporting form.

With respect to the first type of accuracy error (failure to report), MSDH's communicable disease data system relies on sources (physicians, hospitals, laboratories) reporting all cases of reportable communicable diseases to the department either through completion of Form 135 or by calling MSDH's epidemiology telephone hotline. A twenty-four-hour telephone number is published in the Mississippi Morbidity Report. Also, MSDH maintains a sentinel physician system, a group of twenty-seven sentinel physicians from all over the state who provide state-regional sampling.

MSDH does not require multiple levels of verification for communicable disease data (with the exception of HIV/AIDS), as it does for vital statistics data. However, MSDH does have a system in which multiple entities (laboratories, physicians, hospitals) report communicable disease data in order to help "fill in the gaps" if one entity does not report or does not report with complete information. Also, with the exception of HIV/AIDS and STD data (see discussion below), MSDH does not randomly review physician, hospital, and laboratory records to ensure that all reportable communicable diseases are being reported.

With respect to the second type of accuracy error (failure to report all information on a case required by MSDH), PEER analyzed the 1,750 cases of communicable diseases reported during 1998 and found that 59% of the records were missing at least one item of information about the case (e.g., race, attending physician, individual filing the report, name of hospital or clinic). The missing data may impede MSDH's ability to implement quickly the appropriate public health response (e.g., identifying and treating individuals with whom the infected person was in contact).

The department keeps AIDS/HIV and STD statistics in a separate database from other communicable diseases within the Sexually Transmitted Disease Division of MSDH. MSDH handled 10,673 reported cases of AIDS/HIV and

STDs in 1997. MSDH staff stated that they perform the following to ensure the accuracy of its AIDS/HIV and STD data:

- two Quality Assurance staffers review each record for errors;
- a special computer program checks part of the data for error in the twenty most important fields, information that affects the statistical analysis if incorrect;
- on an annual basis, AIDS/HIV and STD personnel visit reporting sites and match records to cases reported to MSDH.

MSDH does not ensure collection of communicable disease data within the timeframe established by MSDH regulations.

State law does not contain penalties for physicians who report occurrences of Class 1 diseases past the twenty-four-hour deadline.

MSDH's reportable disease regulations, ***Rules and Regulations Governing Reportable Diseases and Conditions,*** divide the state's fifty reportable communicable diseases into classes, based upon potential to threaten public health. The regulations require health care providers and laboratories to report occurrences by a specified time, depending upon the disease's classification category. Class 1 diseases (e.g., Hepatitis A, Encephalitis) represent those diseases that require an immediate public health response due to the immediacy/severity of their threat to the public. MSDH regulations require that Class 1 diseases be reported within twenty-four hours of first knowledge or suspicion. Failure to report Class 1 diseases subjects the offending physician, hospital or laboratory director to possible suspension of his or her professional license. Under MISS. CODE ANN. § 41-23-1 (6), MSDH is required to report the non-compliant physician to the Board of Medical Licensure only for a complete failure to report a Class 1 disease. There is no statutory penalty for reporting disease occurrences late.

The risk to the state posed by late reporting is that the person with a highly communicable disease has more time to spread the disease to others before MSDH has a chance to initiate disease control measures.

PEER analyzed MSDH's database of reported communicable diseases for 1998 to determine compliance with timely reporting requirements. Twenty-four percent of all Class 1 disease records that required a laboratory diagnosis show they were reported more than five days after the date on which the laboratory specimen was obtained. The risk to the state posed by late reporting is that the person with the highly communicable disease has more time to spread the disease to others before MSDH has a chance to initiate disease control measures.

With the exception of HIV/AIDS data, MSDH does not routinely analyze its data for timeliness. With respect to HIV/AIDS data, MSDH tracks reporting lag-time. The department's 1998 lag-time data showed that 4% of all HIV cases and 12% of all AIDS cases were reported three or more days late.

MSDH's failure to track timeliness of reporting all other types of communicable diseases undermines the agency's ability to assure the public that it is effectively identifying potential threats to public health. Timely reporting permits better measurement of communicable disease occurrence in Mississippi. By monitoring timeliness, MSDH can identify the nature of the impediments to timely reporting and develop and then implement a corrective plan.

MSDH provides adequate analysis of communicable disease data within Mississippi.

In accordance with CDC National Public Health Performance Standards Program, MSDH analyzes communicable disease data by providing incidence rate of the following diseases: measles, mumps, rubella, pertussis, tetanus, syphilis, gonorrhea, tuberculosis, AIDS, meningitis, Hepatitis A, and Hepatitis B and mortality rate (tuberculosis and AIDS), as well as the proportion of two-year-old children who have received all appropriate vaccines and the proportion of adults aged 65 and older who have been immunized for pneumococcal pneumonia and influenza (within the past twelve months). MSDH publishes a monthly ***Mississippi Morbidity Report***, which highlights a particular disease. Yearly, MSDH publishes a ***Summary of Selected Reportable Diseases***, which outlines many different communicable diseases including AIDS/HIV, STDs, rabies, pertussis, rubella, spinal cord injuries, and many other diseases and conditions. These reports include historical trend analysis, along with demographic and geographic information for the state.

Chronic Disease Data

MSDH is not collecting chronic disease data for all chronic diseases.

Chronic disease is defined as a disease which has one or more of the following characteristics: they are permanent, leave residual disability, are caused by changes in the body tissue or fluids, require special training of the patient for rehabilitation, or may be expected to require a long period

of supervision, observation, or care. Examples of chronic diseases include arthritis, diabetes, high blood pressure, cancer, emphysema and obstructive pulmonary disease, AIDS, muscular dystrophy, and multiple sclerosis.

Mississippi is one of seven states that do not collect hospital in-patient data.

The primary source of chronic disease data is medical service in-patient data (e.g., hospital discharge data). In addition to providing valuable information on disease incidence and patterns throughout the state, in-patient data provides information on resource consumption and physician practice patterns in the state. While forty-four states have systems for routinely accessing and analyzing in-patient data (including some states with web-based systems which can be accessed statewide by all hospitals, outpatient centers, and facilities round the state), Mississippi is one of the seven states that do not collect hospital data. The estimated cost of collecting, analyzing, and reporting hospital discharge data yearly is $.50 per discharge. In 1997, Mississippi had 400,796 acute care hospital discharges; therefore, the cost of collecting data on these discharges would have been approximately $200,000. This figure does not include initial start-up of the system.

The only type of chronic disease data that MSDH collects is cancer registry data, as authorized by state law. More specifically, MISS. CODE ANN. § 41-91-5 (1972) provides:

> ***(2) The cancer registry shall be a central data bank of accurate, precise and current information that medical authorities agree serves as an invaluable tool in the early recognition, prevention, cure and control of cancer. Registry data can be used to plan and evaluate cancer control measures in the areas of risk assessment, prevention, early detection, patient care, public and professional education and clinical research.***

As required by state law, MSDH collects incidence on patients who are diagnosed with or treated for cancer.

MSDH began collecting cancer registry data in 1996. The registry collects incidence data on all patients residing in the state who are diagnosed and/or treated for cancer. The data collected includes the patient's demographics, description of cancer, the first course of treatment, and the survival status for purposes of calculating survival rates.

Mississippi's Performance on Indicators of Public Health

While Mississippi continues to rank poorly on several major public health indicators in comparison to the rest of the country (e.g., years lost by premature death, infant mortality rate, death rates by motor vehicle accidents, incidence of sexually transmitted diseases, teenage birth rate), the state has made progress on a few indicators during the decade of the 1990s (e.g., reduction in syphilis and infant mortality rates) and ranks well on other important public health measures, such as the percentage of children who are immunized.

PEER assessed the performance of MSDH through examination of data measuring the health of the state's population.

Much of the staffing and funding for MSDH are allocated for the purpose of promoting or improving public health. One way to assess broadly the performance of MSDH is through an examination of data measuring the health of the state's population by means of comparison with other states, as well as statewide trends over time.

***Health Care State Rankings* ranked Mississippi 49th in terms of healthy population and access to health care providers.**

Health Care State Rankings for 1999 examined data in twenty-one select areas to determine the state with the healthiest population and the best access to health care providers. States were ranked based upon weighted scores calculating their proximity to the national average. Mississippi ranked 49th out of the 50 states for 1999, dropping from 45th in 1998 (there existed a change in methodology between 1998 and 1999), in terms of the healthiest state award. The authors selected the twenty-one factors that they felt best reflected basic health care and access to health care. Exhibit 15 on page 35 presents Mississippi's rankings on these indicators.

PEER also looked at health indicators where Mississippi ranked in the top ten or bottom ten states, as well as other selected major indicators of public health. The health indicators are presented in Exhibit 16, on page 36, along with ranking and national average. As shown, for all but eleven of thirty-nine reported indicators, the rate of illness, disease, or deaths in Mississippi was higher than the national average. PEER then selected indicators that reflected some major components of the state's public health program and tracked the statewide trends from 1990 through 1998 to determine the state's success at addressing incidence levels.

Selected Health Indicators on Which Mississippi Ranks Poorly in Comparison with the National Average

Mississippi ranked within the top ten and above the national average on: infant mortality, neonatal death rate, births to teenage mothers, births of low birthweight, births to unmarried women, death rate by tuberculosis, death rate by homicide, death rate by motor vehicle accident, and incidences of gonorrhea, syphilis, and chlamydia.

Selected indicators on which Mississippi ranked in the top ten in the 1999 publication of state health rankings and above the national average include infant mortality, neonatal death rate, births to teenage mothers, births of low birthweight, births to unmarried women, death rate by tuberculosis, homicide and motor vehicle accident, and gonorrhea, syphilis and chlamydia. Exhibit 17, on page 38, presents a point-in-time comparison of Mississippi with the highest and lowest state incidence levels on indicators in which Mississippi ranked above the national average.

Exhibit 15: Mississippi's Ranking on Selected Health Indicators

MS and National Rates for Health Care State Rankings (1999)
Healthiest State Indicators

Indicator	National Rate	MS Rate
As a Percent of Specified Population		
Births of Low Birthweight as a Percent of All Births- 1997	7.5%	10.1%
Births to Teenage Mothers as a Percent of Live Births- 1996	12.6%	20.6%
Percent of Mothers Receiving Late or No Prenatal Care- 1996	4.0%	4.2%
Health Care Expenditures as a Percent of Gross State Product- 1993	12.1%	13.4%
Percent of Population Not Covered by Health Insurance- 1997	16.1%	20.1%
Percent of Population Lacking Access to Primary Care- 1998	9.6%	22.1%
Percent of Adults Who are Binge Drinkers- 1997	14.5%	9.5%
Percent of Adults who Smoke- 1997	23.2%	23.1%
Percent of Adults Overweight (based on Body Mass Index)- 1997	31.1%	35.1%
Percent of Children Ages 19-35 Months Fully Immunized- 1997	76.0%	81.0%
Safety Belt Usage Rate- 1998	65.0%	48.0%
Per 100,000 Specified Population (unless otherwise noted)		
Age-Adjusted Death Rate- 1997	478.1	609.7
Infant Mortality Rate per 1,000 Live Births- 1998	7.0	10.1
Age-Adjusted Death Rate by Neoplasms per 100,000-1996	203.5	212.4
Death Rate by Suicide per 100,000- 1996	11.7	11.4
Infant Mortality Rate per 1,000 Live Births- 1998	452.0	472.4
AIDS Rate (new cases reported per 100,000)- 1998	19.5	13.1
Sexually Transmitted Disease Rate per 100,000- 1997	332.8	611.8
Beds in Community Hospital per 100,000 Population	319.0	472.0
Other		
Number of Days in Past Month When Physical Health was "Not Good" -1997	3.1 days	3.1 days

SOURCE: ***Health Care State Rankings*** 1999

Exhibit 16: Health Indicators: MS Rank and Comparison with National Average

Areas Where Mississippi Performs Poorly (per 100,000 select population)

Indicator	MS Rank	MS Rate	National Average
Deaths			
Death Rate by Tuberculosis	1	0.92	0.45
Death Rate by Motor Vehicle Accident	1	32.00	16.50
Death Rate by Injury	2	82.20	57.60
Death Rate by Homicide	2	13.90	7.90
Death Rate by Diseases of the Heart	3	352.00	276.50
Death Rate	7	1007.20	864.90
Incidence of Disease			
Sexually Transmitted Disease Rate	2	611.80	332.80
Gonorrhea Rate	2	306.60	122.50
Syphilis Rate	2	14.40	3.20
Chlamydia Rate	4	290.80	207.00
Meningococcal Infection Rate	9	1.40	1.00
Tuberculosis Rate	9	6.80	5.50

Areas Where Mississippi Performs Poorly (per 1,000 select population)

Infant Mortality Rate per 1,000 Live Births	1	10.20	7.00
Neonatal Death Rate per 1,000 Live Births	1	7.20	4.80
White Infant Mortality Rate per 1,000 White Live Births	4	8.00	6.10
White Neonatal Death Rate per 1,000 White Live Births	5	4.90	4.00

Areas Where Mississippi Performs Poorly (as a percent of select population)

Births			
Percent of Legal Abortions Obtained by Black Women as a Percent of All Reported Legal Abortions	1	62.8%	33.9%
Percent of Births by Cesarean Delivery	1	26.6%	20.7%
Births of Low Birthweight as a Percent of all Births	1	10.1%	7.5%
Births to Teenge Mothers as a Percent of Live Births	1	20.6%	12.6%
Births to Unmarried Women as a Percent of all Births	1	45.5%	32.4%
Legal Abortions Obtained by Unmarried Women as a Percent of all Legal Reported Abortions	4	83.3%	78.7%
Births to Black Teenage Mothers as a Percentage of Black Births	2	28.0%	22.0%
Births to White Teenage Mothers as a Percent of White Births	7	14.3%	11.1%
Births to Unmarried Black Women as a Percent of all Births	8	75.8%	69.1%
Percent of Mothers Beginning Prenatal Care in 1st Trimester	42	80.0%	82.5%
Physical Fitness			
Percent Adults Overweight based on Body Mass Index	3	35.1%	31.1%

Exhibit 16 cont.: Health Indicators: MS Rank and Comparison with the National Average

	MS Rank	MS Rate	National Rate
Areas Where Mississippi Performs Well (per 100,000 select population)			
Births			
Reported Legal Abortions per 100,000 Births	48	8,600.0	31,100.0
Deaths			
Death Rate by Alzheimer's Disease	44	6.0	8.1
Death Rate by Atheroscleosis	44	3.9	6.3
Death Rate by Diabetes Mellitus	41	19.9	23.3
Death Rate by Complications of Pregnancy and Childbirth per 100,000 Female Population	41	0.1	0.2
Incidence of Disease			
Whooping Cough Cases Reported	49	0.1	2.3
E-Coli Rate	48	0.2	1.1
Hepatitis (Viral) Cases Reported	47	1.6	11.4
Areas Where Mississippi Performs Well (as a percent of select population)			
Births			
Births to Unmarried White Women as a Percent of all Births to White Women	45	19.7%	25.8%
Incidence of Disease			
Percent of Children Aged 19 to 35 Months Fully Immunized	10	81.0%	76.0%
Other Health Indicators of Interest (per 100,000 select poulation)			
Incidence of Disease			
AIDS Rate	18	13.1	19.5

Notes: Unless otherwise noted, the rates in this table are calculated based upon specified Population for 1997. The exceptions are as follows; reported abortions obtained by black Women are calculated based on 1995 data; death rates by tuberculosis, homicide, Alzheimer's, atherosclerosis, diabetes mellitus, diseases of the heart, injury, complications of pregnancy and childbirth, drug induced injury and motor injury and motor vehicle, births by cesarean section and Teenage birth rate3s, white infant mortality and neonatal death rates, are calculated based upon 1996 data; infant mortality, teenage birth, E-Coli, hepatitis (viral), AIDS, meoingococcal infection, and whooping cough are calculated based on 1998 data.
SOURCE: ***Health Care State Rankings*** 1999***, MS Vital Statistics*** 1990-1998 and ***Healthy People 2000***

Exhibit 17: Comparison of MS Incidence Rate with the Highest and Lowest Incidence Rates for Selected Indicators on which MS Ranks Poorly

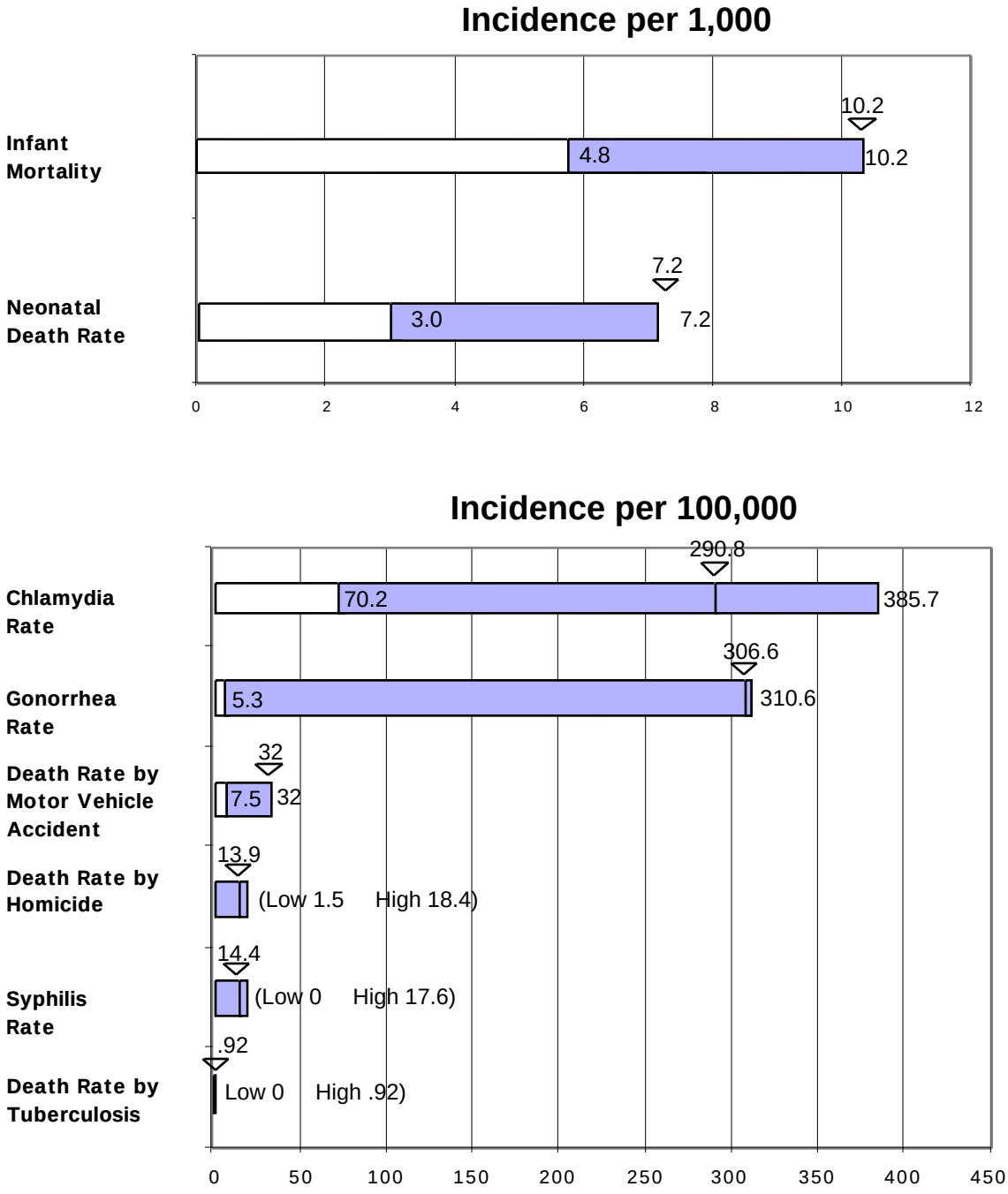
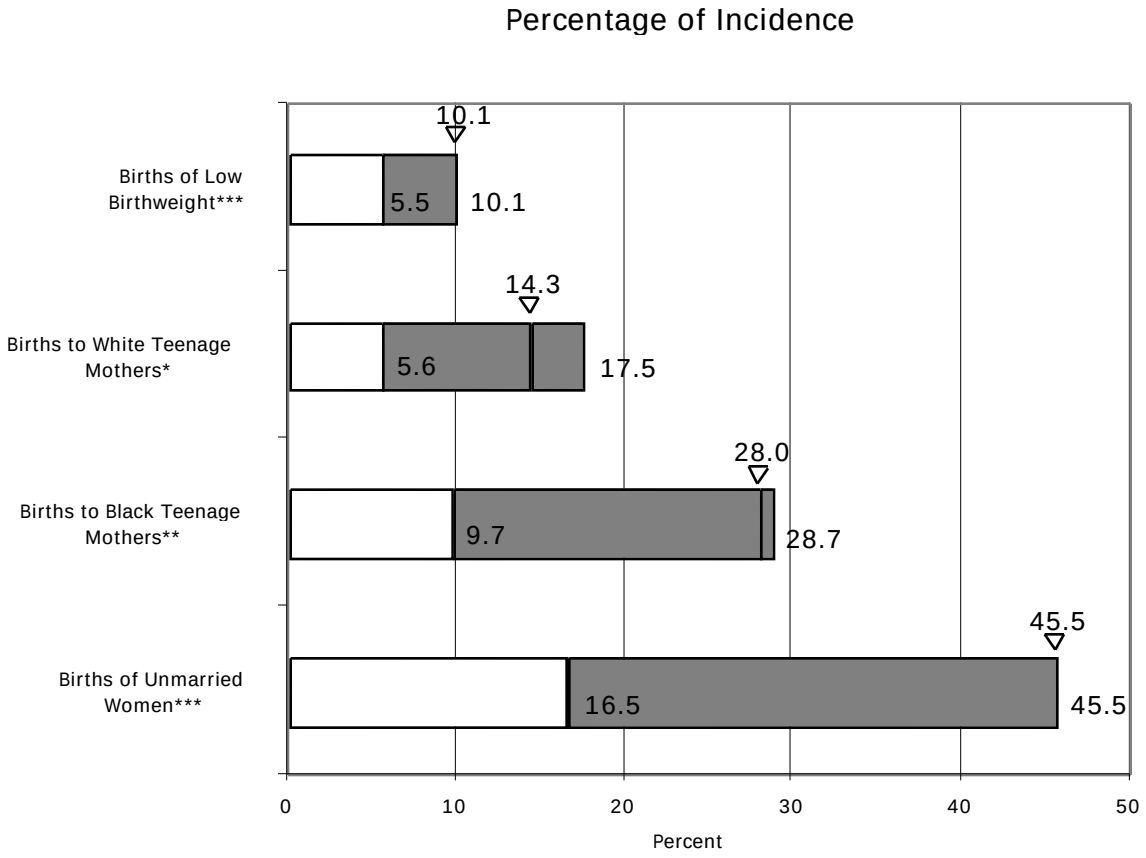


Exhibit 17 continued: Comparison of MS Incidence Rate with the Highest and Lowest Incidence Rates for Selected Indicators on which MS Ranks Poorly



* As a Percent of White Births
** As a Percent of Black Births
*** As a Percent of All Births

Note: The left side of the shaded bar represents the lowest state incidence level. The right side of the shaded bar represents the highest state incidence level. The shaded line within the bar represents Mississippi's incidence level. Unless otherwise noted, the rates in this table are for 1997. The exceptions are as follows; tuberculosis, neonatal, motor vehicle accident, homicide rates and births to black and white teenage mothers are based on 1996 data. Infant mortality rates are based on 1998 data.
SOURCE: ***Health Care State Rankings*** 1999 and MS Vital Statistics 1990-1998

Trend Analysis for Selected Health Indicators

While the state incidence level of births to teenage mothers, infant mortality, neonatal death rate, death rate by tuberculosis, and death rate by homicide and syphilis decreased in the 1990s, the state continues to rank

above the national average and national target rate on births to teenage mothers and infant mortality. In addition, the state has experienced increases in low birthweight, non-marital births, death rate by motor vehicle accidents, and reported AIDS cases.

Point-in-time estimates, such as those provided in Exhibit 17, page 38, offer limited insight into the health trends of the population. PEER applied trend analysis to assess changes in selected health indicators over time.

Births

Mississippi has experienced a decrease in births to teenage mothers and an increase in births of low birthweight and births to unmarried women.

Almost 72% of the live births in 1997 involved "at risk" mothers--29,901 of the 41,527 total births, according to MSDH. "At risk" factors include mothers;

- who are under seventeen years of age or over thirty-five years of age;
- who are unmarried;
- who have completed fewer than eight years of school;
- who had fewer than five prenatal visits;
- who have had no prenatal care within six months of delivery or do not know when care began;
- who have had previous termination of pregnancy; or,
- whose last menstrual period was within eleven months of their prior delivery

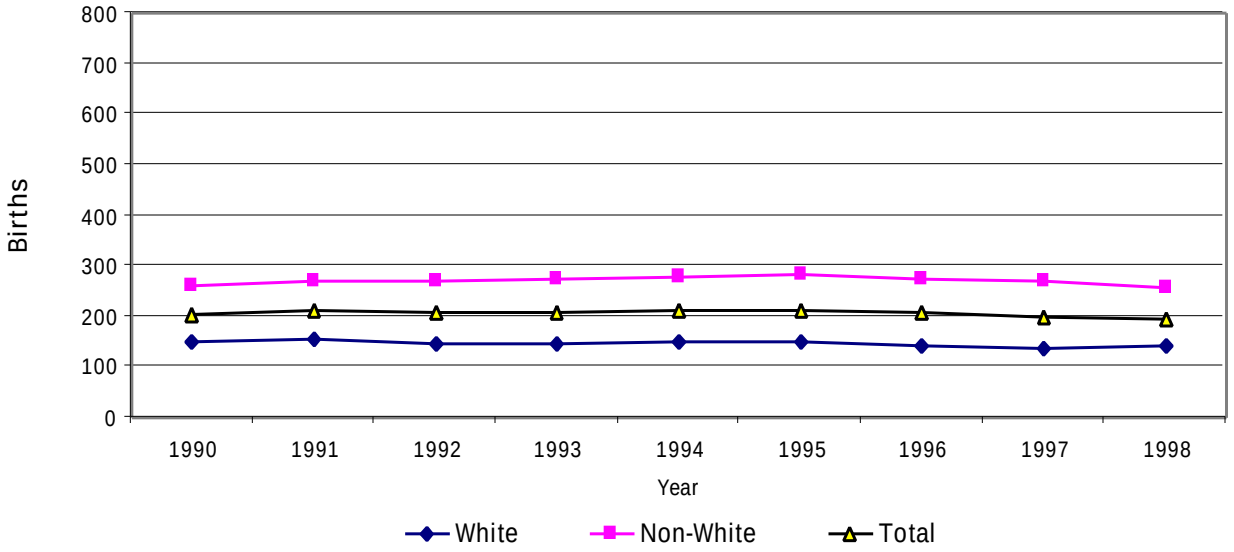
Trends in births to teenage mothers, rates of low birthweight, and non-marital births are a common focus in public health statistics because of the adverse health consequences often associated with these social phenomena. Trend data for these indicators are reported in Exhibits 18 and 19 on pages 41 and 42.

Rates of non-marital births for non-whites are typically two to three times higher than those among whites.

In births to teenage mothers, the rates for non-whites are almost twice as high as the rate for whites, and for births to unmarried women the rates for non-whites are typically two to three times higher than those among whites. Several complex socioeconomic factors are likely driving

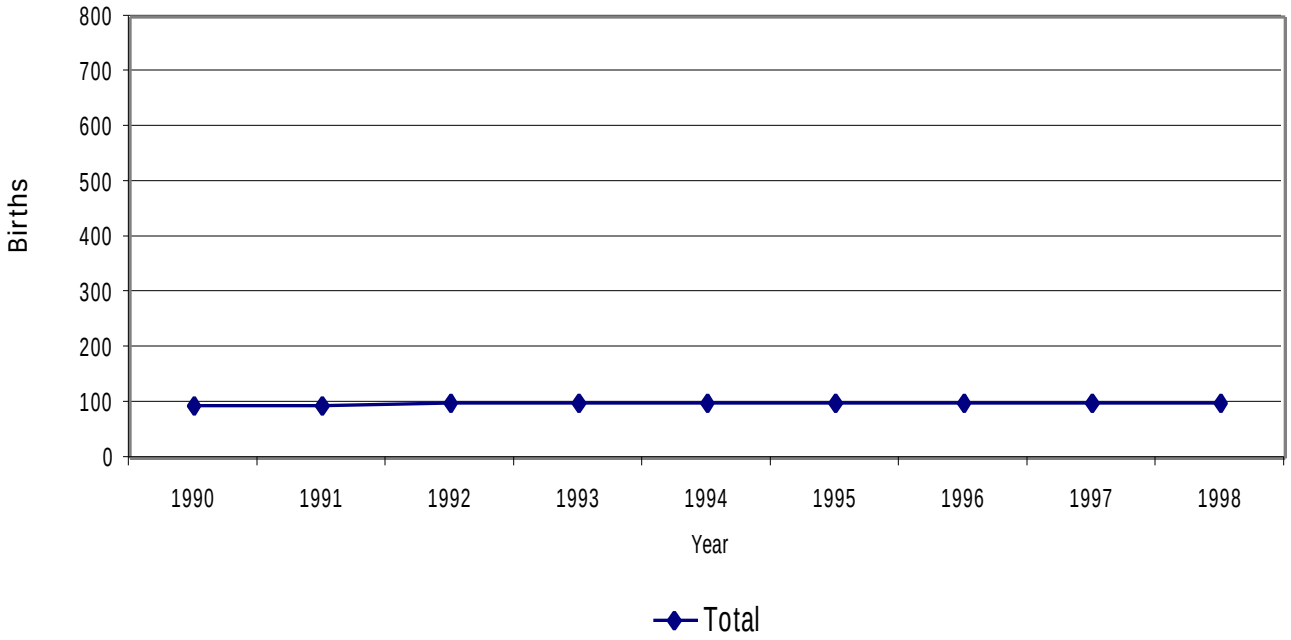
Exhibit 18: Trends in Birth to Teenage Mothers and Low Birthweight

Births to Teenage Mothers (15-19 years old) per 1,000* Live Births
1990 through 1998



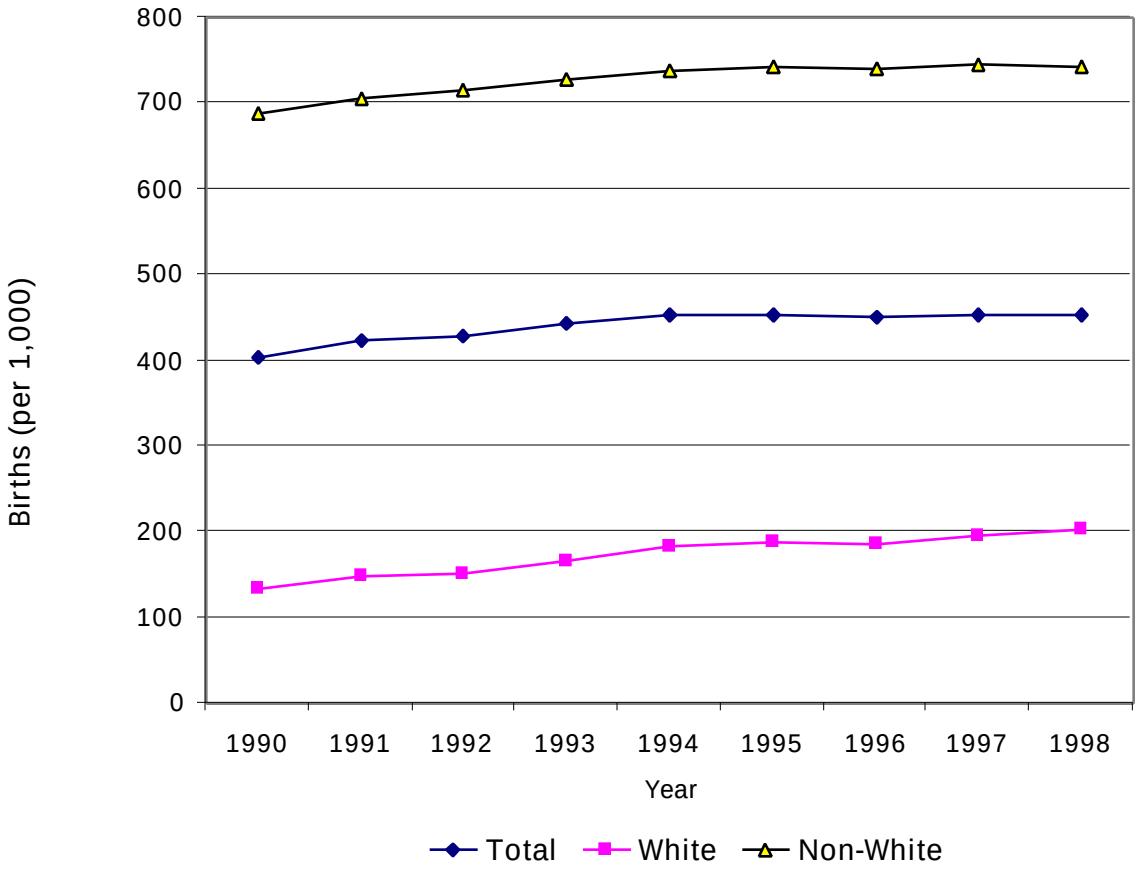
* White is calculated per 1,000 white births, non-white is calculated per 1,000 non-white births and total is calculated per total births.

Births of Low Birthweight (less than 5 1/2 lbs) per 1,000 Live Births
1990 through 1998



SOURCE: ***MS Vital Statistics*** 1990-1998.

Exhibit 19: Trends in Births to Unmarried Women per 1,000 Live Births* 1990-1998



* White is calculated per 1,000 white births, non-white is calculated per 1,000 non-white births and total is calculated per 1,000 total births.

SOURCE: ***MS Vital Statistics*** 1990 through 1998.

these racial disparities (e.g., levels of income). For example, according to MSDH, unplanned pregnancies account for a majority of the births among women with family incomes below the poverty level.

In 1989, 13.2% of Mississippi black families were below the poverty level, compared with 6.9% of white families. The rate of unemployment among the black population in 1989

was 15.9%, compared to 5.1% for the white population. Mississippi's 1990 population included 63.4 percent white, 35.6 black, and one percent other races (e.g., Hispanic, Asian). In correlation, the rate of births to non-white teenage mothers is almost two times higher than those observed among whites.

Births to Teenage Mothers

Mississippi has experienced a slight decrease in births to teenage mothers, from 205 per 1,000 in 1990 to 194 per 1,000 in 1998

In 1996, Mississippi ranked number one in births to teenage mothers as a percent of all births, with 20.6%. (Note: The State Health Care Ranking was based upon the fifteen- to nineteen-year-old age group and PEER's analysis is based upon the same age group). As shown in Exhibit 18, page 41, Mississippi has experienced a slight decrease in births to teenage mothers, from 205 per 1,000 in 1990 to 194 per 1,000 in 1998.

Births of Low Birthweight

Births of low birthweight per 1,000 in Mississippi increased 5.2%, from 96 in 1990 to 101 in 1998.

Low birthweight, less than 5.5 pounds, is considered to be a factor associated with infant mortality. According to MSDH, low birthweight infants are more likely to die during the first year of life and are at increased risk of mental retardation, congenital anomalies, growth and developmental problems, visual and hearing defects, and abuse/neglect. From 1990 through 1998 the number of births of low birth weight per 1,000 in Mississippi increased 5.2%, from 96 in 1990 to 101 in 1998.

Births to Unmarried Women

Mississippi has experienced a steady increase in the number of births to unmarried women.

Mississippi has experienced a steady increase in the number of births per 1,000 to unmarried women. Coinciding with the overall increase, there has been an increase in non-marital births to both whites and non-whites.

The difference between race is apparent when the data on the number of non-marital births are separated by race. While there has been an increase in the number of children born out of wedlock to both races, the rate for non-whites, which has been over 650 per 1,000, is three times higher than the rate for whites.

Deaths

While Mississippi has experienced slight decreases in infant mortality, neonatal death, and death by tuberculosis, and an even greater decrease in homicides, the state death rate by motor vehicle accident has recently increased.

Infant Mortality

Mississippi has experienced a 15.7% decrease in infant deaths per 1,000 (from 12.1 in 1990 to 10.2 in 1998).

While from 1990-1998 Mississippi experienced a decrease in the number of infant deaths (one year old and younger), the state rate remains above both the highest national rate (9.2 per 1,000 live births in 1990) and the U.S. Department of Heath and Human Services' ***Healthy People 2000*** target rate (7 per 1,000 live births). (The ***Healthy People 2000 Review***, compiled by the Centers for Disease Control [CDC] profiles the nation's health objectives and establishes target goals.). As seen in Exhibit 20 on page 45, Mississippi has experienced a 15.7% decrease in infant deaths per 1,000 (from 12.1 in 1990 to 10.2 in 1998).

The Mississippi rate of infant mortality remains higher than both the national rate and the national target.

In addition, the mortality rate for non-white infants in Mississippi in 1998 was more than twice than that of white infants: 14.5 deaths per 1,000 live births to 6.4 per 1,000 for whites. According to the ***State Health Plan***, many researchers believe that inadequate pre-natal care among non-white mothers and a higher incidence of births of low birthweight for non-whites causes higher mortality rates in non-whites.

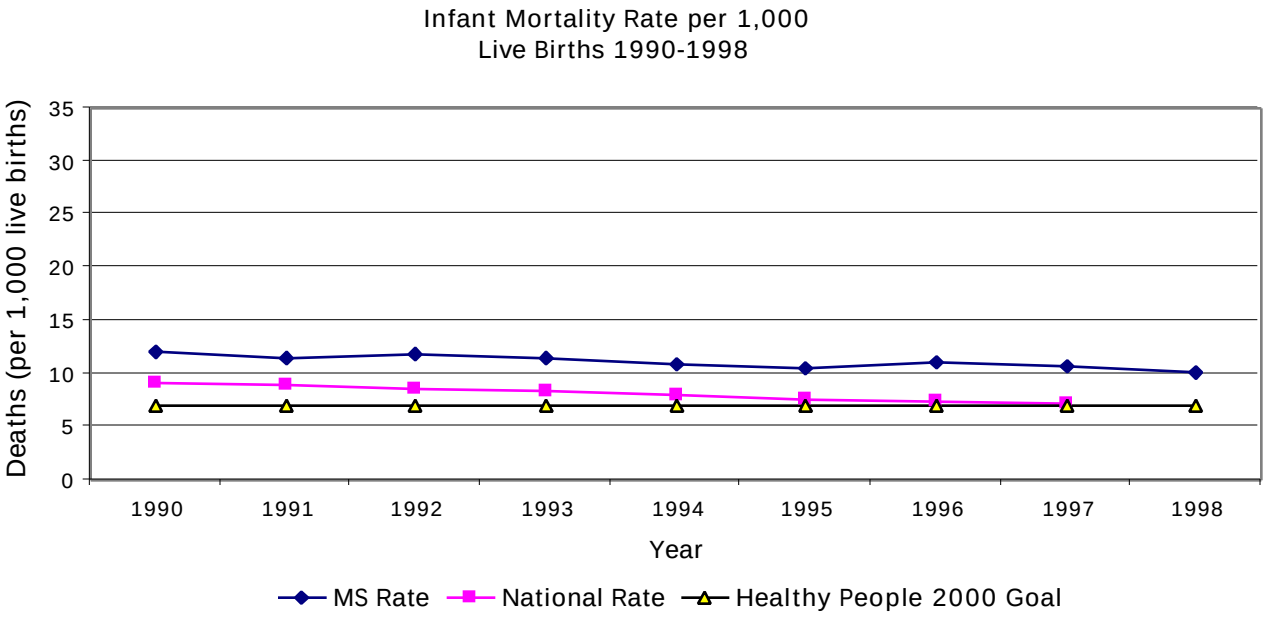
Neonatal Death Rate

The neonatal death rate has decreased slightly, from 7.6 deaths per 1,000 in 1990 to 6.2 per 1,000 in 1998.

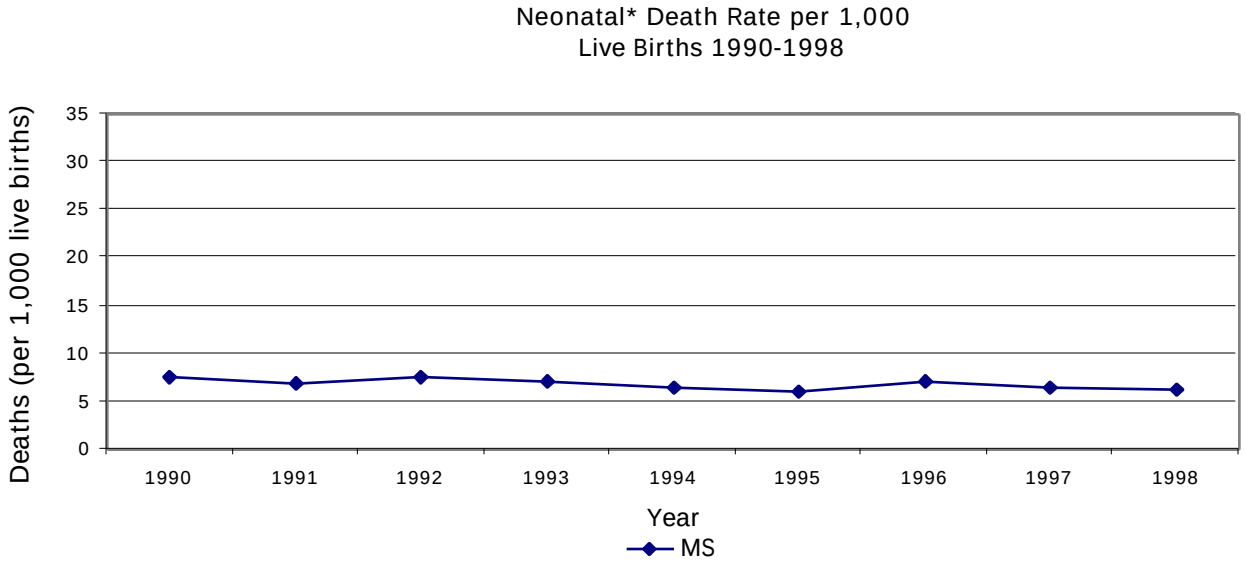
Neonatal deaths encompass deaths of infants twenty-eight days old or younger. According to ***Healthy People 2000***, the leading causes of death in the neonatal period are congenital anomalies, respiratory distress syndrome, disorders relating to short gestation, and effects of maternal complications. Survival during the neonatal period is sensitive to improvement in perinatal services, including the technology of newborn intensive care units, high-quality prenatal care, and use of obstetric technologies. A further reduction in neonatal mortality rates requires concentrated attention to reducing low birthweight and congenital anomalies.

Exhibit 20, on page 45, presents Mississippi's neonatal death rate from 1990 through 1998. While the eight-year period has been marked with slight increases and decreases, overall Mississippi experienced a small

Exhibit 20: Trend Analysis for Infant Mortality and Neonatal Death



* Infants under 1 year of age.
Note: National Rate is projected for 1997.
SOURCE: ***MS Vital Statistics***, ***Healthy People 2000***, and ***Healthy People 2000 Review***.



* Infants under 28 days old
SOURCE: ***MS Vital Statistics*** 1990 through 1998.

decrease from 7.6 neonatal deaths per 1,000 in 1990 to 6.2 per 1,000 in 1998. Similar to infant mortality, the neonatal death rate for non-whites (9.5 per 1,000 live births) was more than twice that of the rate for whites (3.3 per 1,000 live births) in 1998.

Death Rate from Tuberculosis

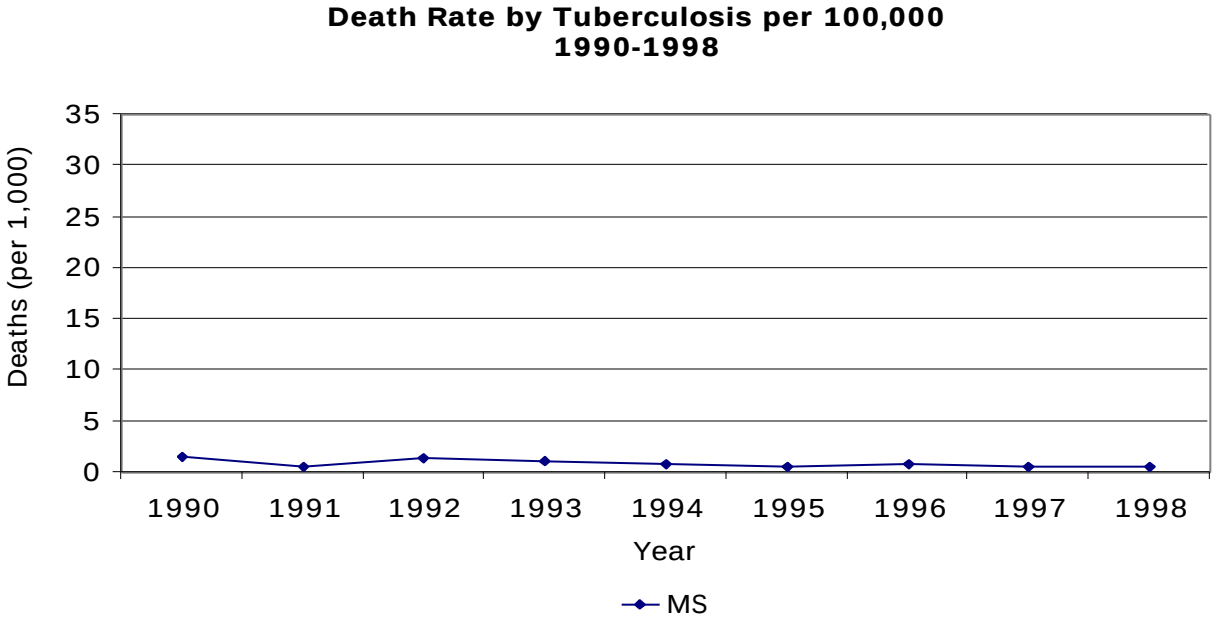
Mississippi has experienced a decrease in the rate of deaths by tuberculosis from 1990 through 1998.

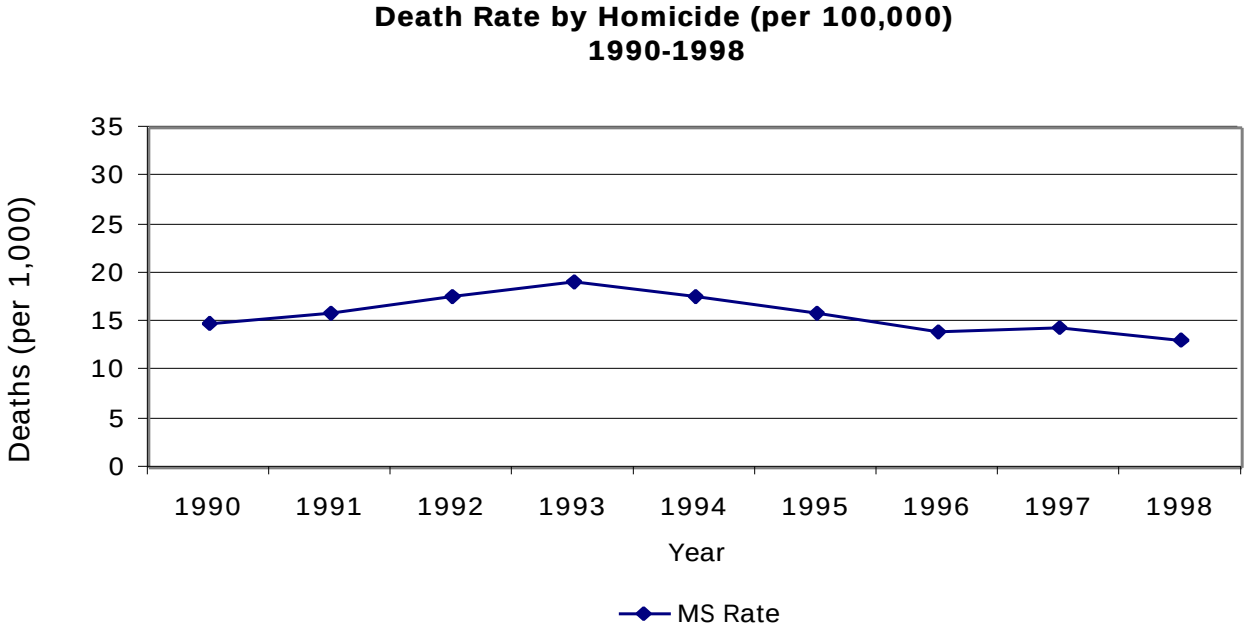
While Mississippi ranked number one in death rate by tuberculosis in 1996, the state has experienced a decrease in the rate of deaths from 1.5 per 100,000 in 1990 to .5 per 100,000 in 1998 (refer to Exhibit 21, page 47). This reduction can in part be attributed to MSDH's tuberculosis program. Because the disease is transmitted through the air indiscriminately, controlling tuberculosis proliferation in Mississippi is a priority of MSDH. According to MSDH, the MSDH tuberculosis program requires that every known case of tuberculosis in the state be provided treatment medication by the department. Directly observed therapy is the method through which the medications are given. In addition, close contacts to the cases are assessed by the local health department to determine their need for preventative therapy.

Death Rate from Homicide

In 1996 Mississippi ranked second in deaths by homicide with a rate of 13.9 per 100,000. As shown in Exhibit 21, page 47, the state experienced annual increases in homicides from 1990 through 1993. In 1993, homicides topped out at a rate of 19.1 per 100,000. The following three years were decreases, resulting in a rate of 14 homicides per 100,000 in 1996. In 1997 the state experienced an increase to 14.4 per 100,000 with a decrease following again in 1998.

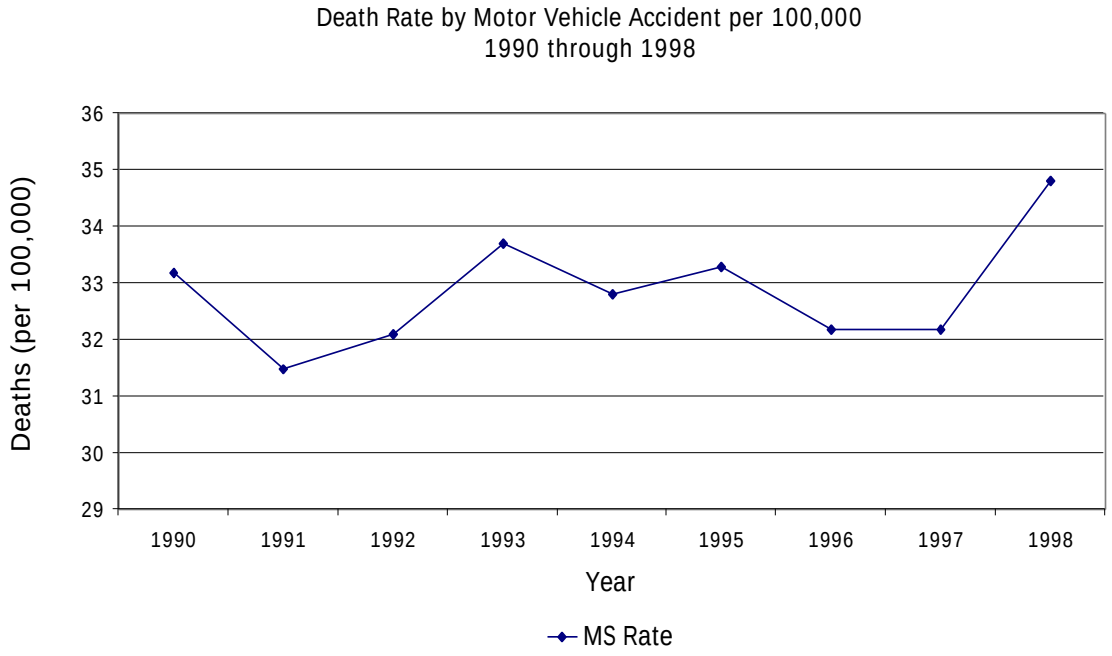
Exhibit 21: Trend Analysis for Death Rate by Tuberculosis and Homicide





* Homicide and Legal Intervention
SOURCE: ***MS Vital Statistics*** 1990-1998

Exhibit 22: Trend Analysis for Death Rate by Motor Vehicle Accidents



SOURCE: ***MS Vital Statistics*** 1990-1998

Death Rate by Motor Vehicle Accident

From1990 through 1998 the state ranked consistently above the national rate and showed little to no improvement.

In 1996 Mississippi ranked first in the fifty states in death by motor vehicle accidents. From 1990 through 1998, the state saw little to no improvement in this rate. As shown Exhibit 22, above, the death rate by motor vehicle accidents increased from 33.2 per 100,000 in 1990 to 34.8 per 100,000 in 1998.

Incidence of Disease

While Mississippi has seen a decline in the rate of gonorrhea, syphilis, and HIV, the state has experienced an increase in reported AIDS cases.

Trends in Sexually Transmitted Diseases

Mississippi ranked fourth in the incidence rate of chlamydia, second in incidence of gonorrhea, and second in incidence of syphilis for 1997. Mississippi ranked eighteenth in the AIDS rate in 1998.

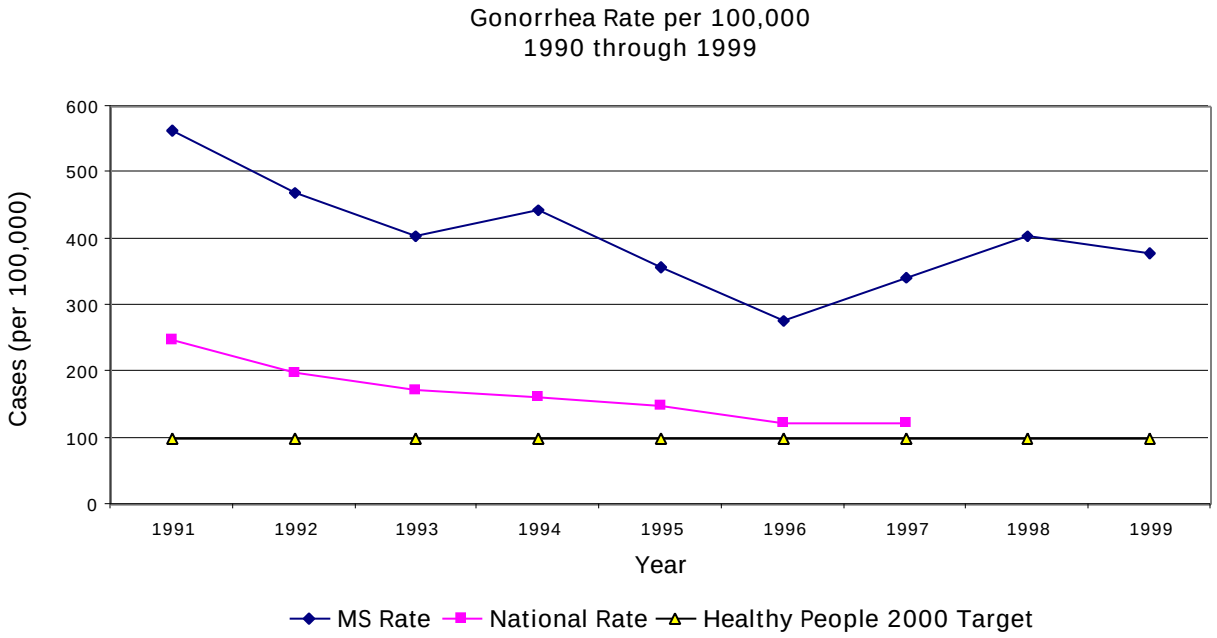
Four of the most prevalent sexually transmitted diseases are gonorrhea, syphilis, HIV, and AIDS. Gonorrhea can cause pelvic inflammation and infertility in women and can also foster the transmission of the AIDS virus. Syphilis bacteria can spread through the body of an infected individual, causing damage to the nervous system and the body's organs and eventually death. HIV works to weaken the immune system and can potentially result in the development of AIDS. According to the ***1999 Health Care State Rankings***, Mississippi ranked second in incidence of gonorrhea and syphilis cases per 100,000 for 1997. Mississippi ranked eighteenth in AIDS cases per 100,000 in 1998.

Gonorrhea

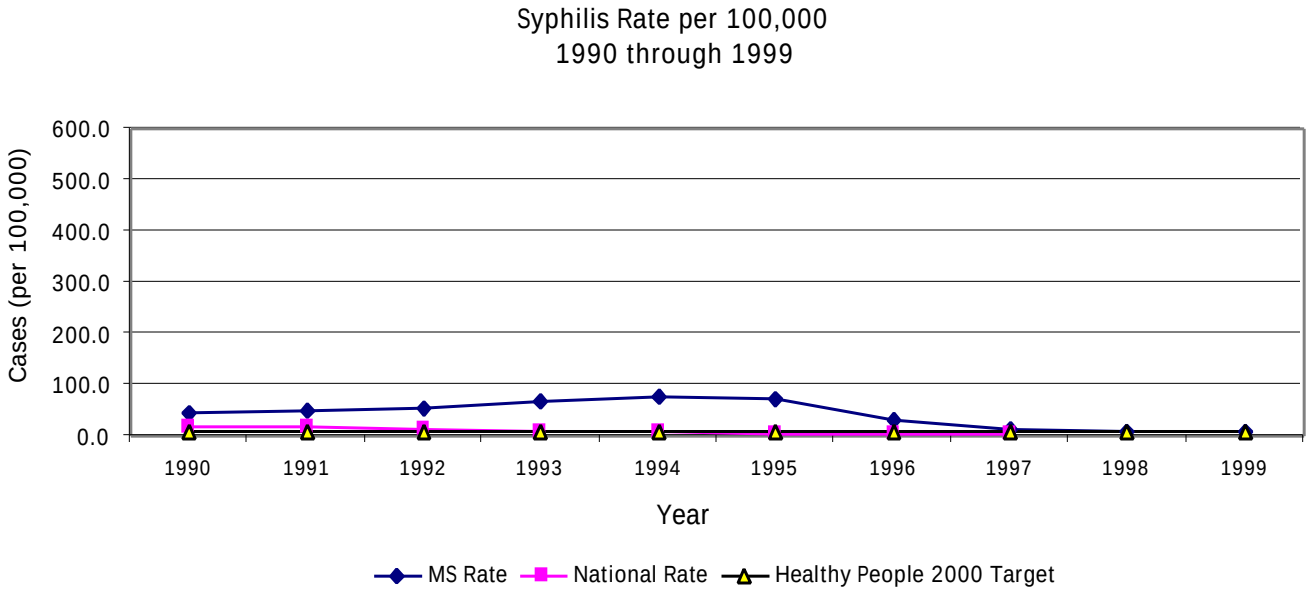
From 1990-1997 Mississippi ranked above the national average and the national target in the incidence of gonorrhea.

As shown in Exhibit 23, page 50, Mississippi has ranked consistently above the national average and the ***Healthy People 2000*** target (225 cases per 100,000) from 1990-1999 for gonorrhea. In addition, the state has seen fluctuation in its success in reducing the prevalence of gonorrhea. From 1990 to 1993, the state experienced a reduction in gonorrhea cases per 100,000, from 556 to 405. In 1994 the number of cases rate rose to 443 per 100,000, only to drop to 276 per 100,000 in 1996. In 1997 and 1998 the incidence rate of gonorrhea again increased, rising to 342 per 100,000 in 1997 and 404 in 1998. In 1999, the rate decreased to 378 cases per 100,000. Nationally, a fifty-state CDC survey found a 9% increase in the rate of gonorrhea, from 121.8 cases per 100,000 people in 1997 to 132.9 per 100,000 in 1998. A CDC epidemiologist speculates that the increase can partially be attributed to a decline in safe sex practices as a result of more effective drugs for the AIDS virus.

Exhibit 23: Trend Analysis for Gonorrhea and Syphilis



SOURCE: ***MS Vital Statistics***, ***MS Morbidity Report*** (June 1999 and June 2000), ***Healthy People 2000***, and ***Healthy People 2000*** 1999 Review.



SOURCE: ***Mississippi Morbidity Report*** (June 1999 and June 2000) and ***Healthy People 2000***.

Syphilis

Mississippi has been successful in reducing the number of reported cases of syphilis.

Mississippi has been successful in reducing the number of reported cases of syphilis to meet the ***Healthy People 2000*** target incidence rate of 10 cases per 100,000. Exhibit 23, on page 50, shows reported cases of primary and secondary syphilis each year. In 1999, a rate of 7 cases per 100,000 was reported, an 84% decrease from 44.7 per 100,000 in 1990. This can partially be attributed to MSDH interviewing all reported early syphilis cases regarding their contacts and offering the contacts prophylactic treatment.

HIV/AIDS

Mississippi saw an increase, followed by a steady decline, in the number of reported HIV cases from 1990-1999.

From 1990 (512 cases) through 1992 (577 cases), Mississippi experienced a 13% increase in the number of HIV cases reported per 100,000. In 1993 the rate dropped significantly to 508 per 100,000, then rose again to 591 in 1994 and 597 in 1995. From 1995 through 1999 the rate of cases per 100,000 decreased steadily from 597 per 100,000 (1995) to 496 per 100,000 (1999). Exhibit 24, on page 52, presents a graphic illustration of the trend.

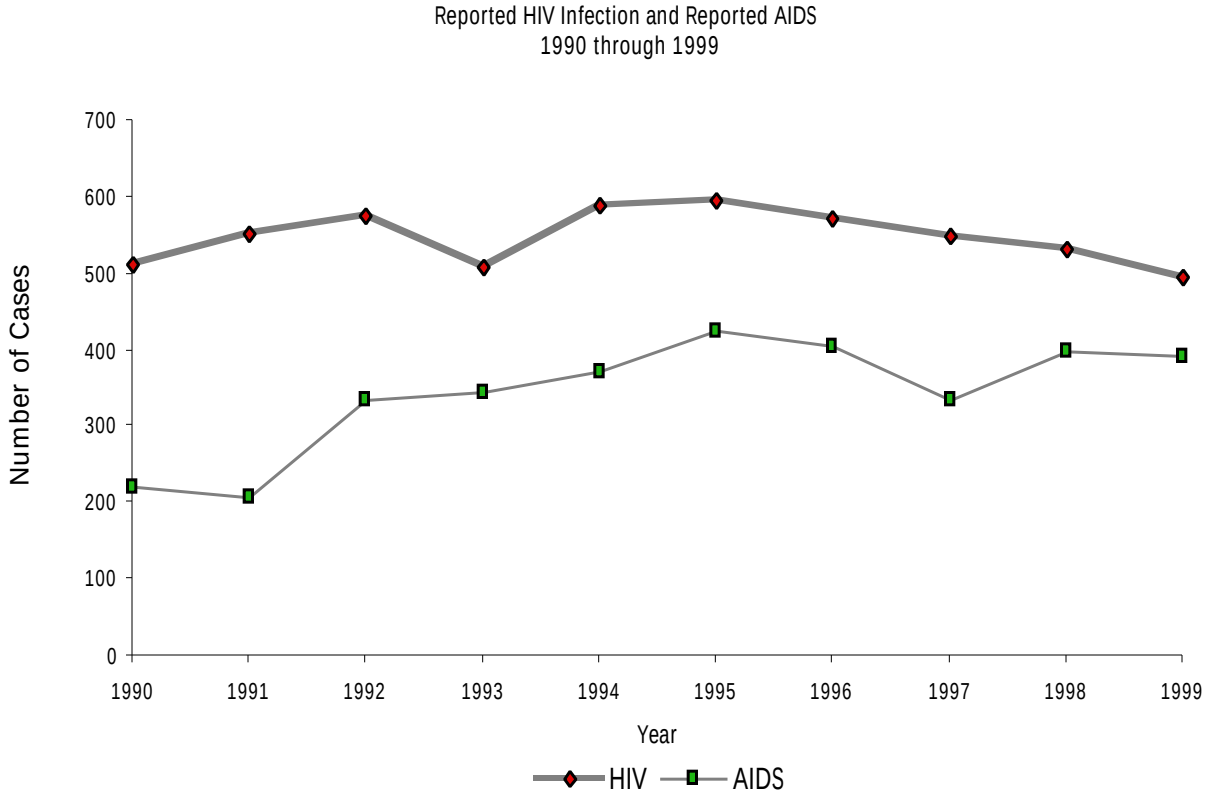
Mississippi has seen an increase in AIDS cases from 222 (1990) to 392 (1999).

From 1990 through 1995, Mississippi experienced an overall increase in the annual number of reported AIDS cases, rising from 222 (1990) to 426 (1995). A sight decrease in 1996 (406) and a more significant decrease in 1997 (334) followed this increase. The decrease was reversed in 1998, with 397 AIDS cases reported. In 1999 the rate decreased by 1% to 392.

Overall, reported HIV infection has increased 13% in the black population from 1990-1999, while decreasing 21% for white women and 55% for white men.

As seen in Exhibit 25, on page 53, the difference in HIV infection rates, when broken down by race and sex, is significant. Overall, reported HIV infection has increased by 13% in the black population from 1990 (324) to 1999 (365), while decreasing 21% (24 cases in 1990 to 19 in 1999) for white women and decreasing 55% (163 cases in 1990 to 74 in 1999) for white men. In 1999, 74% of the reported HIV infections were among blacks, and 155 (42%) of those were women.

Exhibit 24: Trend Analysis on HIV Infection and Reported AIDS

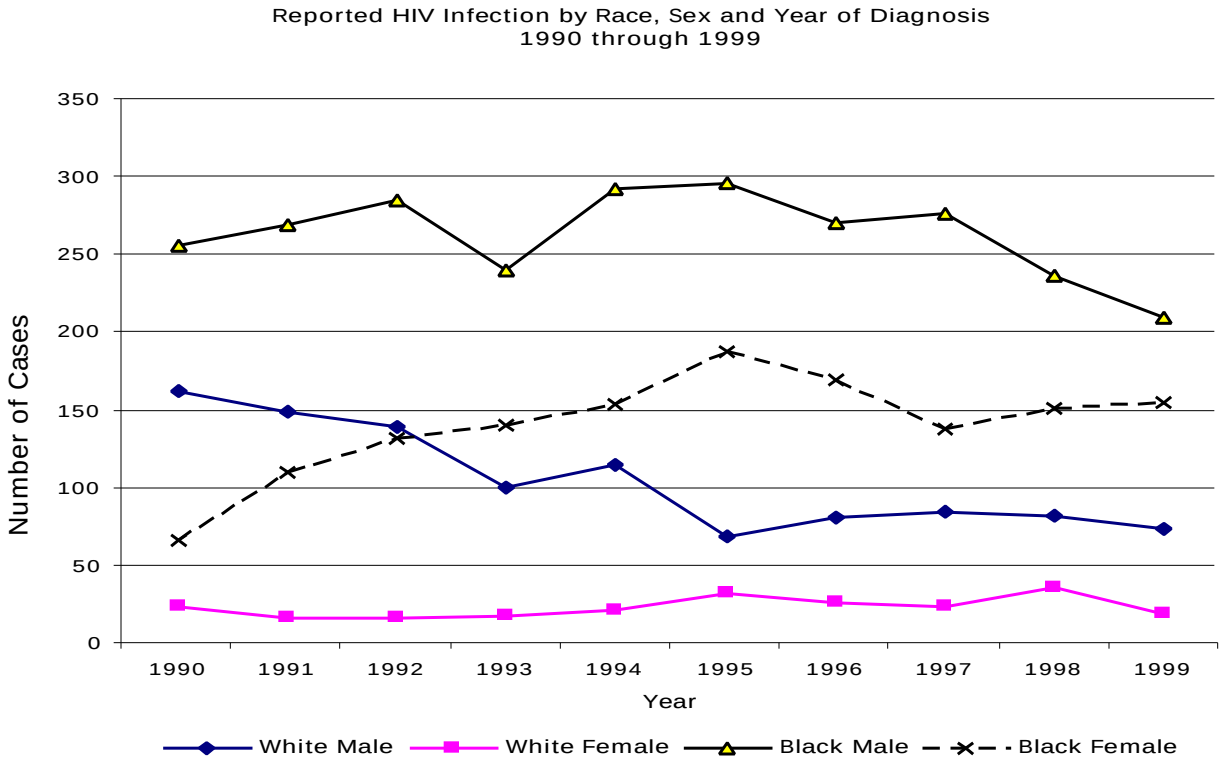


SOURCE: ***MS Morbidity Report*** 1999 Summary (June 2000)

Mississippi's Performance on *Healthy People 2000* Goals

A comparison of Mississippi's status with ***Healthy People 2000*** national objectives shows that as of 1997, the state had only met fifteen of the eighty-seven (17%) objectives on which MSDH collects data. Appendix G, page 116, presents the state's deviation from the ***Healthy People 2000*** target goals. While these goals are established for year 2000, analysis of the 1997 state data shows the state's progress toward its goals is limited.

Exhibit 25: Trends in Reported HIV Infections



SOURCE: ***MS Morbidity Report*** (June 2000)

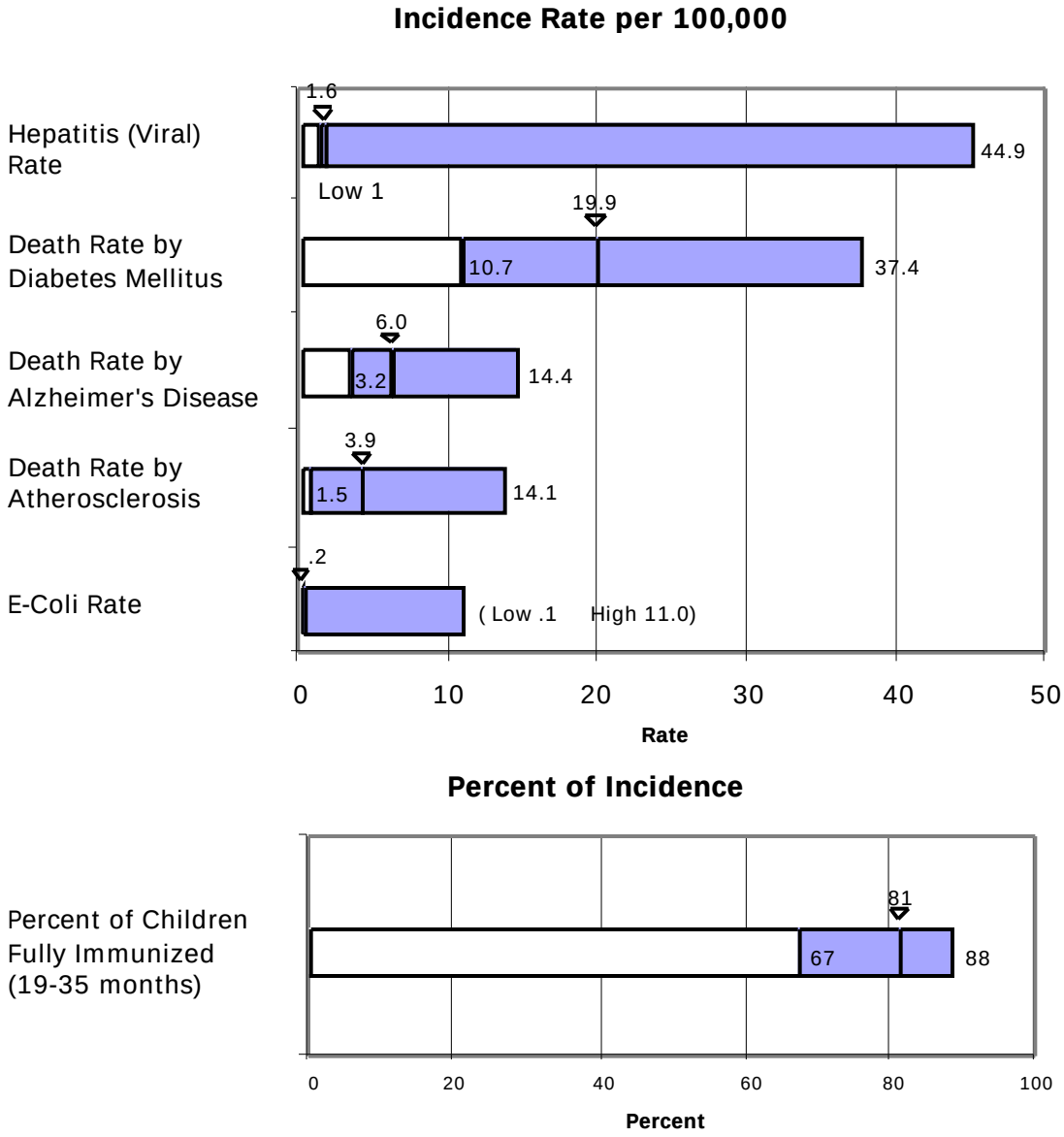
Selected Health Indicators on Which Mississippi Ranks Well in Comparison with the National Average

***Mississippi ranks favorably in relation to the national average on the following selected health indicators: death rate by Alzheimer's disease, death rate by atherosclerosis, death rate by diabetes mellitus, E-Coli rate, hepatitis (viral) and children fully immunized (19-35 months*).**

Selected indicators on which Mississippi ranks favorably in relation to the national average include; death rate by Alzheimer's disease, death rate by atherosclerosis, death rate by diabetes mellitus, E-Coli rate, hepatitis (viral) and children fully immunized (19-35 months). Exhibit 26, on

page 55, presents a point-in-time comparison of Mississippi with the highest and lowest state incidence levels on indicators in which Mississippi ranked above the national average.

Exhibit 26: Comparison of MS Incidence Rate with the Highest and Lowest State Incidence Rates for Selected Indicators on which MS Ranks Well



Note: The left side of the shaded bar represents the lowest state incidence level. The right side of the shaded bar represents the highest state incidence level. The shaded line within the bar represents Mississippi's incidence level. Unless otherwise noted, the rates in this table are for 1996. The exceptions are as follows, child immunizations is based on 1997 data and e-coli and hepatitis are based on 1998 data.

SOURCE: ***Health Care State Rankings*** 1999

Review of Three MSDH Regulatory Programs

PEER's review of three MSDH regulatory programs revealed deficiencies in enforcement of standards, which compromises the ability of these programs to protect the public from associated health risks.

PEER reviewed three MSDH regulatory programs in response to legislative concerns: food protection, milk (and bottled water) sanitation, and child care facility licensure.

Food Protection Program

While MSDH has adopted policies, procedures, and regulations that meet recommended national standards for food protection, MSDH does not consistently adhere to standards in the areas of enforcement and quality assurance.

Background

The primary objective of MSDH's food protection program is to prevent foodborne illnesses resulting from the consumption of food at public eating establishments. The program focuses on food handling and safety from the point at which food is received by the public eating establishment through the service or sale of the food to the customer. In order to serve food legally to the public, an eating establishment must first obtain an operating permit from MSDH following an on-site inspection for compliance with MSDH food safety and handling policies and procedures. In addition to the issuance of permits, MSDH's primary food protection regulatory activities include periodic health and sanitation inspections of permitted eating establishments and investigations of cases of reported foodborne illness.

Staffing

In FY 1999, MSDH's Food Protection Program performed 27,431 inspections of 16,153 permitted food establishments (an average of 1.7 inspections per establishment). As of January 26, 2000, MSDH employed 113 Public Health Environmentalists (excluding district supervisors), whose responsibilities, in some cases, not only include inspections related to the food protection

In FY1999, 113 Public Health Environmentalists performed 27,431 inspections in 16,153 food facilities.

program, but inspections related to recreational vehicle parks, on-site wastewater disposal systems, private water supplies, and tanning beds. As of that same date, there were thirteen vacant Public Health Environmentalist positions. MSDH estimates that during FY 2000, the number of permitted food establishments will increase by 2% to 16,500 and the department's Public Health Environmentalists will conduct 30,000 food establishment inspections.

Statutory Authority for Food Protection

MISS. CODE ANN. § 41-3-15 et seq. authorizes the State Board of Health to issue permits for public eating establishments, make rules and regulations, assess fees, and collect fines for non-compliance.

The State Board of Health regulates eating establishments where food or drink is regularly prepared, handled, and served for pay. It does not regulate food service of churches, church-related and private schools, and other nonprofit or charitable organizations.

MISS. CODE ANN. § 41-3-15 (4)(i) authorizes the State Board of Health to establish standards for, and issue permits and exercise control over, any cafés, restaurants, and all other establishments, other than churches, church-related and private schools, and other nonprofit or charitable organizations, where food or drink is regularly prepared, handled, and served for pay. This section also requires that a permit be obtained from the Department of Health before such persons begin operation.

MISS. CODE ANN. §41-3-17 authorizes the State Board of Health to make rules and regulations necessary to enable it to discharge its duties and powers and carry out the purposes and objectives of its creation. This section further authorizes the department to make sanitary rules and regulations to be enforced in the counties by the county health officer under the supervision and control of the State Board of Health.

MISS. CODE ANN. §41-3-18 states that the State Board of Health shall assess annual permit fees on food establishments as follows:

Assessment Category 1	$15
Assessment Category 2	$30
Assessment Category 3	$70
Assessment Category 4	$100
Assessment Category 5	$150

A food establishment's assessment category is determined by the type of community served and the type of food preparation being utilized.

This section also authorizes the board to develop reasonable standards, rules, and regulations to define clearly each assessment category, based on factors such as the type of community served by the establishment (e.g., schools) and the type of food preparation being utilized (e.g., fast food).

MISS. CODE ANN. § 41-3-59 states that any person who knowingly violates provisions of the chapter is guilty of a misdemeanor and, on conviction, shall be punished by a fine not exceeding five hundred dollars or by imprisonment in the county jail for not more than six months, or by both.

FDA-Recommended National Retail Food Regulatory Program Standards

To assess the adequacy of MSDH's Food Protection Program in protecting the public from foodborne illnesses, PEER determined the extent to which program standards meet uniform national standards promulgated by the U.S. Food and Drug Administration (FDA).

The FDA recently issued a draft of Recommended National Retail Food Regulatory Program Standards, designed to address the control of foodborne illness through the fostering of active oversight of food handling and safety issues by food retail managers. The FDA National Retail Food Regulatory Program Standards were formulated by the FDA based upon ideas and input from federal, state, and local officials and food industry experts to create a national standard for application of the Food Code (see following section for a description of the Food Code). The standards apply to the following areas:

The FDA standards were created as a tool to serve as a guide to regulatory food program managers.

1) Regulatory Foundation

2) Trained Regulatory Staff

3) Inspection Program Based on Hazard Analysis Critical Control Point Principles

4) Uniform Inspection Program

5) Foodborne Illness Response

6) Compliance and Enforcement

7) Industry Recognition

8) Program Resources

9) Program Assessment

Compliance with Standards

While MSDH is in compliance with most FDA recommended national standards, PEER noted weaknesses in the areas of enforcement and internal program assessment that have the potential to affect MSDH's ability to protect and promote public health.

The MSDH Food Protection program meets recommended national standards in the following areas which impact public health: regulatory foundation, training, and inspection based on critical issues.

Regulatory Standards

MSDH adopted the FDA's Food Code in October 1997.

MSDH adopted the 1997 Food Code in October 1997. The Food Code is published by the FDA and serves as a guide to retail outlets such as restaurants on how to prevent foodborne illness. The FDA, Food Safety and Inspection Service (FSIS), and Centers for Disease Control and Prevention (CDC) endorse the Food Code because the code provides public health and regulatory agencies with practical science-based advice and manageable, enforceable provisions for mitigating risk factors known to contribute to foodborne illness. As of September 1998, at least one agency in fourteen states had adopted the Food Code and approximately twenty-five states had at least one agency in the process of adoption. With adoption of the Food Code, MSDH established the regulatory foundation recommended in the draft of FDA standards.

Trained Regulatory Staff

The Food Protection Program's training encompasses those elements recommended by the FDA.

The MSDH Food Protection Program encompasses the elements included in the FDA-recommended training for Public Health Environmentalists. MSDH training includes joint and individual inspections, orientation, communication, inspection and enforcement skills, Fundamentals of Food Science and Foodborne Disease, Food Inspection Criteria/Policies and Procedures/Hazard Analysis Critical Control Point and Food Manager Certification.

Inspection based on Hazard Analysis Critical Control Point (HACCP)

With MSDH's adoption of the Food Code, MSDH adopted HACCP principles in the retail food inspection program.

HACCP systems are designed to prevent the occurrence of potential food safety problems by addressing the primary causes of foodborne illness. This is achieved by assessing the inherent risks attributable to a product or process and then determining the necessary steps that will control the identified risks. HACCP is a core element of the 1997 Food Code. Provisions of the Food Code are compatible with the HACCP concept and terminology in identifying and monitoring the critical points in retail food preparation where the risks of foodborne hazards (i.e., microbial, chemical, and physical) occur.

With MSDH's adoption of the Food Code, MSDH adopted HACCP principles in the retail food inspection program. Adoption of HACCP principles by MSDH will aid the Food Protection Program's ability to protect public health by identifying critical risks prior to evolution into foodborne illness.

Areas of Non-Compliance

Enforcement

In some cases MSDH environmentalists are not adhering to program policy governing the frequency of inspection, timeliness of follow-up inspection, issuance of enforcement notices, or verification and enforcement of the Certified Food Manager program.

In assessing the regulatory function of the Food Protection Program, PEER evaluated food facility inspection files. In reviewing food facility inspection, PEER selected the second largest and smallest counties in each of the nine health districts. PEER then selected ten facility files per environmentalist. In instances in which the facilities were closed, PEER reviewed only the open facility files belonging to that environmentalist. As a result, PEER evaluated 265 food facility files. Of these, 17 (6.4%) files had, at a minimum, one undated inspection form. As a result, PEER could only base timeliness conclusions on 248 files.

Frequency of Inspection

MSDH policy requires food facilities to be inspected from 1 to 4 times per year, based upon the risk category of the establishment.

MSDH Sanitation Regulation and Policies state that all inspections are to be conducted using the principles of HACCP as a basis for recommendations and enforcement actions. According to HACCP, inspections and enforcement focuses upon items of critical risk. The frequency of inspections is variable and determined by public health priority calculated by the Food Establishment Public Health Risk Assessment. This is a tool developed by MSDH according to 1997 Food Code requirements. Based on the priority calculated, MSDH requires facilities to be inspected from one to four times per year. Exhibit 27, on page 62, displays the food facility risk levels and inspection frequencies as assigned by MSDH. Of 262 files reviewed by PEER, as of the most recent documented inspection, 12.2% (32) were risk category 1, 35.1% (92) were risk category 2, 39.3% (103) were risk category 3, 13.4% (35) were risk category 4 and 0 were risk category 5. Fourteen percent (thirty-four) of the 248 facility files evaluated by PEER were not inspected at the frequency dictated by agency policy. Twenty-six percent of the thirty-four facilities not inspected at the required frequency were assigned a risk level of 4 on the last facility inspection. For example, one facility assigned a risk level of 4 was inspected in June 1998 and not again until November 1999. These risk level 4 facilities maintain numerous practices which have the potential to impact public health (e.g., extensive handling of raw ingredients).

Exhibit 27: MSDH Food Facility Risk Levels, Annual Permit Fees, and Inspection Frequency

Food Establishment Risk Assessment

Risk Level Fee	Frequency (# per Year)	Examples Including (but not limited to)
1 $15	1	Bar lounges, sno-ball stands, coffee carts, warehouses handling dry products only. Convenience stores with hot dogs and/or nachos.
2 $30	1 to 2	Bakeries such as Dunkin Donuts, Krispy Kreme, which serve only baked goods. Convenience stores with sausage biscuits, soft-serve prep. Baskin Robbins, Subway, concession stands at theaters, skating rinks. Small child care centers with limited food preparation.
3 $70	2 to 3	McDonald's, Hardee's, Wendy's, Arby's, Taco Bell, Burger King, Dairy Queen, Ward's, Krystal, Pizza Hut, schools, child care facilities, Waffle House, IHOP and KFC.
4 $100	3 to 4	Large delis, major supermarkets such as Jitney, Kroger, Sunflower, Albertson's, Winn-Dixie, Delchamps. Walmart. Buffet chains such as Morrison's, Piccadilly. Nursing homes, community hospitals. Bennigans, Applebees and Quincy's.
5 $150	3 to 4	Large continuous operation buffets- ex. casinos, large food operations open 24 hours, major hospitals.

SOURCE: Sanitation Rules and Regulations 10/15/98.

Timeliness of follow-up Inspections

MSDH conducts a follow-up inspection when a facility fails the initial inspection. If, after a follow-up inspection, a facility continues to be in violation, MSDH issues an enforcement notice.

MSDH policy directs environmentalists to conduct a follow-up inspection of a food establishment when a routine inspection of the establishment reveals a violation of any critical item. A critical item, as defined in the 1997 Food Code, means "a provision of this Code that, if in non-compliance, is more likely than other violations to contribute to food contamination, illness, or environmental health hazard." The owner/operator shall be notified that the establishment is not considered to be in compliance with MSDH rules, and a follow-up to the inspection will be necessary. The severity of the violations and the history of the establishment will determine the method of follow-up. Severe critical items (such as items #3, food temperatures, and #7, cross contamination of ready-to-eat foods) that are not or cannot be corrected during the inspection must be followed up within twenty-four to seventy-two hours. If the violations are not deemed to be of a critical nature, and the history of the establishment has demonstrated that the violations may not be corrected without a follow-up inspection, the facility will be reinspected within a time frame agreed upon in writing by the owner/operator and the environmentalist.

MSDH policy further states that the environmentalist must document on the follow-up inspection report all corrections and continued violations of critical items. Upon finding a continued violation in a follow-up inspection, the environmentalist must issue an enforcement notice stating that if the facility does not correct the violation within a stated time frame, MSDH will suspend its permit to operate.

In some cases, MSDH did not complete follow-up inspections within the scheduled time frame.

As a result of the fact that many of the facility files reviewed by PEER did not specify a follow-up time frame for correction of the violation, PEER was unable to obtain a percentage of those not adhering to the time frame.

However, cases did exist in which the scheduled follow-ups were not conducted according to policy. For example, in the case of Facility A, which failed inspection on March 12, 1999, MSDH scheduled a follow-up inspection for April 16, 1999. The department did not conduct the follow-up inspection until July 2, 1999. In another example, Facility B failed inspection on August 19, 1998, and MSDH scheduled a follow-up inspection for August 26, 1998. The department did not conduct the follow-up inspection until October 2, 1998.

Issuance of Enforcement Notice

78% of the facilities failing follow-up inspections did not have enforcement notices in the facility file.

While nine (4%) of the 248 facilities for which PEER examined files failed follow-up inspections, thereby necessitating issuance of an enforcement notice, seven (78%) of the nine facility files contained no documentation of the required enforcement notice.

In reviewing facility files, PEER also noted disturbing cases in which food establishments repeatedly failed routine inspections, but passed follow-up inspections. This pattern indicates that the establishments are patching rather than solving the documented problems, which threatens public health.

For example, the following is a record of inspections for Facility #116:

Date	Action	Critical Item
03/04/98	failed inspection	1,7,12,20,35,41
03/18/98	passed follow-up	
07/29/98	failed inspection	3,7,12
08/05/98	passed follow-up	
03/24/99	failed inspection	3,4,27
03/31/99	passed follow-up	
10/06/99	failed inspection	7,12,35
10/15/99	passed follow-up	

Critical Items Cited for Facility #116	
1	food
3	food temperature requirements during serving, storage, and transportation
4	adequate equipment to maintain food temperatures
7	prevention of cross-contamination
12	hygienic practices
20	sanitation rinse for food equipment and utensils
27	water source
35	insect and rodent control
41	toxic items

Five (2%) of the facility files reviewed showed this pattern of repeated passing and failures.

Enforcement of Requirement for Certified Food Manager

As of January 1, 1999, all food facilities at risk levels 2-5 must have a Certified Food Manager (CFM).

MSDH policy states that all food facilities which prepare and serve foods in risk categories 2 through 5 must employ a certified food manager or a justification as to why they do not have a certified manager/designee. If justified, a variance will be issued provided the following criteria are met:

1) training will be attended at the next available location.

2) written procedures are in place to assure food safety.

At food facilities recently inspected, at least 12% of those required to have a Certified Food manager did not have one on staff.

Of the most recent inspections for the 265 facility files evaluated, 33 (12%) of the facilities did not have a CFM and 22 (8%) of the CFM boxes were blank.

MSDH staff stated that since the Certified Food Manager program is new, they allowed some flexibility in 1999, but strict enforcement will begin in 2000.

Quality Assurance

The Food Protection Program's internal auditors compromise the effectiveness of their audits by allowing each district to select the files for review.

Through the Bureau of Field Services, MSDH maintains a quality assurance program, the purpose of which is to ensure uniformity among regulatory staff in the interpretation and application of regulatory requirements, policies, and procedures.

Quality assurance staff have allowed the district or county health office to select files for review.

The Bureau of Field Services began Quality Improvement Reviews for Environmental Health in FY 1998. According to Field Services staff, the initial reviews encompassed the district's selecting which counties would be reviewed, except in cases where there existed specific problems associated with a particular county. If specific problems existed, such as complaints regarding inspections of certain facilities, Field Services automatically selected and reviewed that county. Following the selection of those counties, Field Services then allowed the counties to select which files would be reviewed.

Field Services staff state they recognize the problems associated with this method of selection, and in future reviews Field Services plans to select the counties and files.

Also, while the Bureau of Field Services reports the deficiencies, its staff does not have line authority to enforce corrections. Field Services sends a copy of the findings to the District Health Officer, whose responsibility it is to remedy and monitor the deficiencies.

Milk and Bottled Water Program

Although MSDH has adopted sound milk inspection regulatory standards, the department is not enforcing all of the standards, which compromises the program's ability to protect the public.

Regulation

MSDH's Milk and Bottled Water Program is responsible for regulation by inspection and sampling of milk and bottled water plants.

The MSDH Milk and Bottled Water Program is a subprogram of Environmental Health. The Milk Program regulates milk production, the milk industry, and distribution of milk and milk products in Mississippi by inspection and sampling and ensures compliance with state and federal laws, rules and regulations regarding dairies, pasteurization plants, transfer stations, bulk milk haulers, and transportation tanks throughout the state. This program also regulates bottled water.

The overall goal of the Milk Program is to reduce as much as possible the spread of disease through milk and milk products.

The overall goals of the Milk Program are to reduce, as much as possible, the potential for the spread of disease through milk and milk products and to ensure that Mississippi's producer marketing organizations and milk industry have the option to participate in interstate commerce by ensuring that every producer, marketing group, and milk plant maintains a satisfactory rating score on state and federal check ratings. The Milk Program is divided into two branches, the Dairy Farm Inspection Branch and the Milk and Bottled Water Plant Inspection Branch. PEER's regulatory review focused on the Milk and Bottled Water Plant Inspection Branch.

In FY1999 the Milk and Bottled Water Program conducted 30 plant inspections on 5 milk plants and permitted 11 bottled water plants.

The program's administrative personnel are based in the central office, while the two inspectors (environmentalists) with direct responsibility for the day-to-day regulation and monitoring of milk plants and bottled water plants across the state are based in Marion and Pontotoc counties. The environmentalists are also responsible for conducting annual inspections of bottled water plants (prior to the issuance of an operating permit) to determine the level of compliance with state sanitation regulations. In FY 1999, the Milk and Bottled Water Program conducted thirty plant inspections on five milk plants and permitted eleven bottled water plants.

Milk Program

Although MSDH inspected milk plants at the required frequency and took prompt action to suspend permits when the milk contaminant level exceeded requirements, weakness exists in enforcement of regulations and adequacy of the inspection form.

MSDH has authority to establish programs and publish regulations to promote public health in milk sanitation.

MISS. CODE ANN. Section 41-3-15 (5) (a) (ix) gives the Mississippi State Department of Health the authority to establish programs to promote public health in Milk Sanitation. MISS. CODE ANN. Section 41-3-17 gives the Mississippi State Board of Health "power to make and publish rules and regulations."

MSDH has established its own milk regulations. According to MSDH staff, the department adopted by reference the current revisions of the "Grade A Pasteurized Milk Ordinance" (PMO).

Frequency of Milk Plant Inspections

During 1997 and 1998, MSDH inspected milk plants at the required frequency.

PEER reviewed 72 inspection reports and found that the inspections were conducted in a timely manner consistent with department policy.

MSDH rules and regulations require inspectors to inspect each milk plant at least once every three months using a standardized milk form to cite violations. PEER reviewed a total of seventy-two inspection reports conducted from January 1997 through February 1999 and found inspectors conducted inspections within the three-month frequency.

Compliance and Enforcement

While MSDH took prompt action to suspend milk products or place them on warning when the contaminant level exceeded requirements, program managers provided inspectors with inadequate support to enforce regulations.

PEER reviewed 1,004 samples collected and found MSDH issued warnings and suspensions of product permits in 99% of the cases in violation.

Upon review of the results from 1,004 raw, pasteurized, dispenser, and product samples collected during CY 1997 and CY 1998, PEER found that MSDH issues warnings and suspensions of product permits in compliance with state and federal regulations for 99% of the cases. PEER found only one instance in which MSDH did not promptly suspend the milk product as required by state and federal regulations.

Improper Citation of Inspection Findings

In order to avoid suspending milk plant permits, inspectors (with the approval of program managers) did not properly cite violations.

Program managers would not support inspectors in suspending plants for violations that did not constitute a direct contamination of milk.

The PMO states that "if two successive inspections disclose a violation of the same requirement" as indicated by an x on the required inspection form, the milk plant shall be subject to a suspension of permit and "the regulatory agency shall take immediate action to prevent further processing of such milk or milk products until such violations have been corrected."

PEER's analysis of the seventy-two milk plant inspection reports (for FY 1997, FY 1998, and FY 1999) and documentation showed a pattern in which inspectors frequently noted violations of a longstanding nature in an alternate manner on the inspection form instead of officially marking violations as indicated by an x. For example, if the inspector cited violation(s) on the inspection form on one month, inspectors did not cite the same violation(s) on the inspection form the next month to avoid suspending the plant's permit. Inspectors noted that same violation in a memo advising the plant about the violation or unofficially noted it on the inspection form. PEER interviewed program managers who stated that they would not support suspending plants for violations that did not constitute a direct contamination of milk.

Although such violations did not directly pose a threat to public health, MSDH failed to enforce strictly its own regulations that state that a plant's permit should be suspended if "any" violation is cited in two successive inspections. MSDH's failure to enforce regulations compromises public health and safety by seeking to excuse violations rather than penalize plants for not taking corrective actions.

Correction of Plant Violations

Program managers failed to require plants to correct violations that had been cited by inspectors for the past two years.

PEER identified two milk plants that were cited for sanitation deficiencies alternately beginning in CY 1997 through CY 1999. PEER accompanied one of the milk plant inspectors and the program director on a regulatory inspection (conducted on April 12, 1999) and identified sanitation deficiencies of a long-standing nature at one plant, but no action was taken by MSDH to penalize the plant. PEER analysis of the milk plant's file indicates that the violations have persisted as far back as September 1996.

MSDH's failure to enforce regulations aggressively has affected the plant's compliance with public health regulations, since plant personnel have observed management's hesitancy to suspend the plant for longstanding violations. The program managers' failure to support corrective action to penalize plants has also affected the regulatory inspectors' performance in regulating the plants for compliance.

Administrative Weaknesses

PEER found administrative weaknesses in record keeping and adequacy of inspection forms. These weaknesses could potentially compromise the regulation of milk production.

Issuance of Milk Plant Permits

The Milk and Bottled Water Program did not maintain records validating the issuance of permits.

Although the division conducted the required inspections from January 1997 through February 1999, the division did not maintain records validating the issuance of a permit to three milk plants operating in CY 1997 and one that operated in CY 1998. PEER found in its review of inspection reports that inspections were conducted for permitting plants to operate. However, MSDH could not provide PEER with documentation that these milk plants received valid permits during the year. MSDH administrative personnel contend that a change in staff could have possibly resulted in the inability to locate documentation.

Adequacy of Inspection Forms

The milk inspection form does not reflect a current milk regulation, nor do the inspection items correspond with regulations that are used by inspectors for reference purposes.

The PMO requires the regulatory agency to use standardized forms when inspecting the physical conditions of milk plants and equipment. PEER identified discrepancies in MSDH's milk inspection form that could potentially affect inspectors' enforcement procedures. The MSDH regulations (PMO) state that raw milk should be maintained at forty-five degrees. The regulations further state that cooling raw milk at a temperature above forty-five degrees could result in a greater increase of bacteria in milk, thus affecting public health.

Because MSDH has not updated its milk inspection form to correspond with current regulations, the form that MSDH uses shows that the maximum allowable temperature for milk stored in the plant is fifty degrees, five degrees higher than regulations allow. PEER found that the

inspection form was last updated in July 1986. The form also contains an outdated regulation and is not consistent with current standards. Additionally, the numbered items do not correspond to the list of sanitation items inspectors are to use for reference purposes during inspections. For a new inspector, this could lead to confusion during the inspection process and possibly cause one to overlook some items to be inspected.

Bottled Water Program

While federal and state law instill responsibility for ensuring sanitation and safety in the sale of bottled water, prior to 1999 MSDH did not conduct inspections or issue permits pursuant to MSDH rules and regulations.

Regulation

The FDA regulates bottled water as a food product and it is subject to the FDA's extensive safety and labeling requirements.

All food manufacturing establishments are subject to inspection by the Federal Food and Drug Administration (FDA). These inspections focus on the Good Manufacturing Practices (GMPs) outlined in the Code of Federal Regulations. FDA regulates bottled water as a food product and it is subject to FDA's extensive safety and labeling requirements. These regulations pertain to both the quality of the water, with regard to the contaminant levels, and the utilization of good manufacturing practices for the processing and bottling of drinking water. Section 129.1 of the ***Code of Federal Regulations*** stipulates that "the facilities, methods, practices, and controls used in the processing, bottling, holding, and shipping of bottled drinking water must conform with or be operated or administered in conformance with GMPs to assure that bottled drinking water is safe and that it has been processed, bottled, held, and transported under sanitary conditions."

MISS. CODE ANN. § 75-29-801 states that the State Board of Health has authority to make sanitary investigations and prepare necessary rules and regulations governing the sanitation of bottled water.

MISS. CODE ANN. § 75-29-803 authorizes the State Board of Health to "certify each source or supply of bottled drinking water as meeting equivalent health protection standards as prescribed for drinking water under the Mississippi Safe Drinking Water Law (§41-26-1).

MISS. CODE ANN. §75-29-809 authorizes and empowers the State Department of Health "to perform any and all

acts necessary to carry out the purposes and requirements" for bottled drinking water.

MISS CODE ANN. § 41-3-15 (4) (ii) states that the State Board of Health has authority "to require that a permit be obtained from the Department of Health before such persons begin operation."

Timeliness of Inspections and Issuance of Permits

While MSDH regulation states the health authority shall inspect annually each instate bottled water plant prior to issuing a permit, two years lapsed before program managers initiated bottled water plant inspections.

While state law does not require the division to conduct sanitary investigations, MSDH regulation states that "the Health Authority shall inspect annually each instate bottled water plant prior to issuing a permit." Two years lapsed before program managers initiated the responsibility to ensure that bottled water plants were inspected for compliance with good manufacturing practices.

PEER found that in February 1997, MSDH reorganized the Milk Program by transferring the responsibility for the inspection of bottled water plants from the Food Program. County health environmentalists were responsible for regulating the day-to-day operation of bottled water plants.

In CY 1997, 3 of the state's 9 bottled water plants were licensed without being inspected, and in CY 1998, 7 of the state's 10 bottled water plants were licensed without being inspected.

Although new responsibilities were transferred to the Milk and Bottled Water Program, program managers never developed an inspection schedule, yet continued issuing licenses to the state's bottled water plants. In both CY 1997 and CY 1998, the state's bottled water plants were only inspected in those cases in which county inspectors continued to inspect the plants (due to a lack of knowledge concerning the transfer of bottled water responsibility), even though authority to do so had been transferred to the Milk Program. Despite MSDH's requirements that the state's bottled water plants be inspected annually as a condition of licensure, in CY 1997, three of the state's nine bottled water plants were licensed without being inspected, and in CY 1998, seven of the state's ten bottled water plants were licensed without being inspected. Concerned over their program's lack of oversight of the state's bottled water plants, in September 1998, the program's inspectors developed their own bottled water plant inspection schedule (without direction of program managers) for the issuance of CY 1999 permits in an attempt to ensure the inspection of all plants as a precondition to licensure. As of January 1999, eleven of the thirteen bottled water plants had been inspected and two had inspections pending.

Because before 1999 program managers did not initiate action to determine the level of compliance with state regulations for the state's bottled water plants, MSDH had no knowledge of the bottled water sanitary conditions. Therefore, MSDH's failure to inspect bottled water facilities annually prior to issuing permits demonstrates a lack of quality assurance within the program, which could have potentially resulted in the sale of unsafe bottled water and could have affected public health.

Child Care Facility Licensure

With respect to implementation of the state's child care laws and regulations, MSDH is not adequately enforcing these laws and regulations. Also, Mississippi's child care laws and regulations are not comprehensive because they do not apply to all types of child care programs and make the registration of family child care homes with MSDH optional rather than mandatory.

State law authorizes MSDH to regulate two types of child care establishments: ***child care facilities***, which provide care for six or more children under the age of thirteen and, on a voluntary basis, ***family child care homes***, which provide care to five or fewer children under the age of thirteen who are not related to the provider. As of November 1999, there were 1,636 licensed child care facilities in Mississippi caring for an estimated 90,000 children.

Licensing

State law establishes licensure requirements for certain child care facilities.

According to MISS. CODE ANN. Section 43-20-3 (1972), the purpose of Mississippi's Child Care Licensing Law is:

> ***. . .to protect and promote the health and safety of the children of this state by providing for the licensing of child care facilities as defined herein so as to assure that certain minimum standards are maintained in such facilities. This policy is predicated upon the fact that a child is not capable of protecting himself, and when his parents for any reason have relinquished his care to others, there arises the probability of exposure of that child to certain risks to his***

health and safety which require the offsetting statutory protection of licensing.

State law requires MSDH to conduct annual inspections of all licensed child care facilities and to ensure that all owners and employees of said facilities have undergone detailed background checks.

MISS. CODE ANN. Section 43-20-5 defines child care facilities as places providing shelter and personal care for six or more children under the age of thirteen. The state's Child Care Licensing Law designates the State Department of Health as the licensing agency and requires all child care facilities in the state to obtain a license from MSDH in order to operate. State law requires MSDH to inspect child care facilities at least once per year.

While state law authorizes MSDH to promulgate rules and regulations concerning the licensing and regulation of child care facilities (43-20-8), it also specifically directs MSDH to require to be performed "a felony conviction records check, a sex offense criminal records check and a child abuse registry check for any owner/operator of a child care facility and any person living in a residence used for child care." The law further requires the fingerprinting of the applicant and submission of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The law requires child care facilities to perform the same checks on every employee and applicant for employment at the facility.

State law establishes penalties for non-compliance with child care laws, including fines, and license suspension, revocation, or restriction.

State law makes it a misdemeanor to operate a child care facility without a license, punishable by a fine of not more than $100 for the first offense and $200 for each subsequent offense.

State law establishes an appeal process for MSDH licensure decisions.

Also, state law (CODE Section 43-20-14) authorizes MSDH to suspend, revoke, or restrict the license of any child care facility where the licensee has been found guilty of conduct which has endangered or is likely to endanger the health or safety of the children entrusted to or cared by such facility. The law defines such conduct to include conviction of a crime in any state or federal court for acts having a direct and detrimental effect on the children under the licensee's care as well as violation of any of the regulations promulgated by MSDH.

This same section also provides that before MSDH may deny or refuse to renew a license, any applicant affected by such a decision is entitled to a hearing in which the applicant may show cause why the license should not be denied or should be renewed. Further, if the applicant is dissatisfied with MSDH's decision with respect to the suspension, revocation, or restriction of a license, the applicant may appeal to the chancery court of the county in which such facility is located.

State law establishes standards for operation of family child care homes.

While state law establishes detailed standards governing who can work, reside, or volunteer in a family child care home, registration of family child care homes with MSDH is optional.

MISS. CODE ANN. § 43-20-51 separately addresses the regulation of family child care homes, defined as any residential facility which provides care to five or fewer children under the age of thirteen who are not related to the provider. State law does not require these homes to be licensed, instead allowing them to register voluntarily with MSDH.

The list of standards set forth in state law for family child care homes is more detailed than the list for licensed child care facilities. The list includes prohibitions against persons working, residing, or volunteering in such a home who have:

- been convicted of any of a list of crimes spelled out in the law--e.g., conviction for sex offense, child abuse or neglect;
- had parental rights terminated;
- had a child who the court has declared deprived or in need of care based on an allegation of physical, mental, or emotional abuse or neglect or sexual abuse;
- been adjudicated as a juvenile offender; or,
- an infectious or contagious disease.

Also, state law prohibits a disabled person in need of a guardian and/or conservator from maintaining a family child care home.

Comprehensiveness of State Law Regarding Licensure

Mississippi's Child Care Licensing Law is insufficient with respect to the NAEYC principle of licensing all child care programs, because it exempts several categories of child care facilities, including programs operating for limited periods and school-based programs.

The National Association for the Education of Young Children (NAEYC) recommends that all programs providing care and education to children from two or more unrelated families should be regulated, with no exceptions--regardless of sponsorship, length of program day, or age of children served.

NAEYC believes that mandatory registration (as opposed to licensure) is sufficient to regulate family child care homes as long as: (1) standards are developed and applied; (2) permission to operate may be removed from homes that refuse to comply with the rules; (3) parents

are well informed about the standards and the process; and (4) an effective monitoring process, including on-site inspections by the regulatory agency, is in place.

Mississippi's Child Care Licensing Law is insufficient because it does not allow for an equal level of health and safety protection for all children. This is because the Child Care Licensing Law exempts:

- child care facilities which operate for no more than two days per week, and whose primary purpose is to provide respite for the caregiver or temporary care during other scheduled or related activities;

- organized child care programs which operate for three or fewer weeks per year, such as, but not limited to, vacation Bible schools and scout day camps;

- elementary and secondary school systems;

- Headstart programs established as structured school or school readiness programs, operating in conjunction with an elementary school system; and,

- organizations that charge only a nominal annual membership and which must be in compliance with national standards and procedures, such as the Boys and Girls Club of America and the YMCA.

Also, with respect to family child care homes (a residential facility which provides child care services to five or fewer children under the age of thirteen who are not related to the provider), Mississippi does not meet the NAEYC standard because it makes registration of these homes voluntary rather than mandatory.

An example of the insufficiency of exemption of programs can be seen with the Headstart program. Headstart, a federally funded program, offers comprehensive services for three- and four-year-olds and some infants and toddlers, including activities that help children grow mentally, socially, emotionally, and physically. Headstart programs housed in a school, but sponsored and/or operated by a community action agency or other entity, require a license, while Headstart programs sponsored by a school program do not require a license.

By exempting so many types of facilities and by making registration of family child care homes voluntary, MSDH allows large numbers of children go without any degree of protection afforded by government oversight.

Enforcement

MSDH is not vigorously or uniformly enforcing state child care facility laws and regulations.

Child care facility licensure files maintained by MSDH districts are disorganized and do not contain all required documentation of compliance.

PEER attempted to take a representative random sample of licensed child care facility files by pulling 350 files from MSDH's nine district offices. However, based on the disorganized condition of the first eighteen files pulled in the sample (i.e., forms not in the order prescribed by MSDH central office staff, forms missing, forms located in other folders), PEER reduced its sample to 153 total files (i.e., ten randomly selected files per child care facility inspector).

Twenty percent of the required inspection forms were missing from the 153 files reviewed. The types of documents most often missing were current licenses (in some cases, licenses were over a year old), current inspection records, the maximum capacity worksheet, qualifications of the director, and the notarized verification of background checks, first aid, and cardiopulmonary resuscitation.

153 child care licensure files reviewed by PEER were missing 20% of the required inspection forms, which compromises assurance that these licensing requirements are being met.

According to MSDH, as of November 1999, eighty-one centers were "delinquent," meaning that their licenses had expired.

PEER documented through a sample of 153 cases seven significant violations of the MSDH Board of Health's regulations for child care facilities.

Failure to Make Record of a Child Care Hearing

On September 9, 1999, a fatal accident occurred at a child care facility licensed by MSDH. The facility's employees had put a five-month-old child down for a nap on a bed rather than a crib. The child fell between the bed and wall and suffocated. According to the licensure report, accounts by individuals at the facility conflict as to what occurred and who was on site. The licensing official was unable to conduct any further investigation because, at the

time of PEER's review, district licensing officials had not received the coroner's report or any police report.

Although the district held a hearing concerning a fatal accident at a licensed child care facility, departmental officials have no documentation or transcript on file regarding findings of the hearing.

Following the child's death, the District Public Health Officer suspended the facility's license on September 10, 1999, in accordance with MSDH Regulation 25-1, and held a hearing on September 20, 1999, that included area residents. Based on pressure from these residents, the district reopened the facility on September 27 under a probationary license that prohibits the facility from serving children under the age of one year.

According to MSDH Regulation 25-4, the purpose of the September 20 meeting should have been to gain the facts of the case and to determine whether the facility should be reopened. A center should not be reopened based on the need for a facility, but rather on the safety that facility can provide to the children in its care.

At the time of PEER's review, January 2000, the licensing official had no documentation regarding the findings of this hearing. There are no transcripts available for Child Care Licensing officials or independent parties.

Prior to the accident, the district had made a routine inspection and noted violations. The district fined the center for the violations but did not close it, which could have been done under departmental regulations.

Also, on August 27, 1999, at the same child care facility, MSDH district licensing officials had made a routine inspection and noted violations. One significant violation was that the center exceeded its maximum capacity by nine children. The district fined the center for this violation, but according to the regulations**,** the center could have been closed and perhaps the accident might not have occurred.

Failure to Enforce Regulations Governing Physical Facility

One district supervisor has approved facilities with portable sinks. According to child care licensing officials, this is so that there will be more licensed day care facilities in a district that has a limited number of licensed child care facilities. While regulations do not specifically address portable sinks, there are regulations that outline handwashing lavatories. Reg. 11-5(d), and 16-1 state that the handwashing lavatories must have hot and cold running water. Portable sinks could not have running hot and cold water, thus causing unsanitary conditions in the facilities.

One district licensed a facility that did not have hot and cold running water at all of its sinks, which creates the potential for unsanitary conditions. Another district filed licensing paperwork for a facility that had obviously not been physically inspected.

Also, there is evidence some licensing officials are not visually inspecting centers with regarding to the physical layout of the facility. For example, the district worksheet on a particular facility was sent to the Central Office so that the license could be printed. (All licenses are printed at the Central Office in order to have a check against the information that the official receives on an inspection. A worksheet is completed and sent to Central Office in order to maintain the central database of child care facilities.) This particular worksheet listed fifteen toilets and lavatories for a facility with eight children. Since this is not a logical setup for such a facility, Central Office sent the worksheet back to the district for corrections. The worksheet was sent for a second time showing the same number of bathroom facilities. Central Office personnel then had to call and verify with the center that only two toilets and lavatories existed. The integrity of the licensing program is compromised when MSDH officials and the public cannot rely on the accuracy of licensure documents.

Failure to Conduct Program Reviews Prior to Relicensure, as Required by Regulation

According to MSDH's Policies and Procedures Manual for Licensure of Child Care Facilities, the licensing official must complete a child care program review of each licensed facility three to six months prior to annual license expiration and a child care facility inspection and relicensure report prior to license renewal. MSDH policy specifies that the program review of a child care facility must include:

- checking the facility's child/staff ratio by noting the number of children and staff present in each room;
- reviewing 10% of all children's records or ten records, whichever is greater, and 50% of all staff records. If the inspector finds an incomplete record, the licensing official may stop checking the records at that point and take appropriate action--writing up the violations, imposing a fine, and scheduling a time to recheck the information;
- reviewing 100% of immunization records on children and staff;
- completing the food service inspection or checklist;
- verifying that a properly approved and current two-week menu cycle is posted and followed, to include observation of at least one meal or snack service, with

dated documentation of appropriate substitutions; and,

- checking the playground and completing an assessment, if applicable.

Only two of MSDH's nine districts have been conducting program reviews as required by departmental policies and procedures.

Child care licensing officials told PEER staff that due to a heavy workload, many times the inspectors reissue licenses without first conducting the required program review. PEER staff found that only two of MSDH's nine districts were conducting the program reviews as required by policies and procedures. Most of the districts either conduct the program review at the same time that the license is issued (rather than three to six months prior) or after license renewal. The program reviews allow for the official to conduct two inspections per year as outlined in the Policies and Procedures Manual. This will allow the official to determine if there are problems within a child care facility that must be corrected before the annual license renewal inspection.

Failure to Relicense Child Care Facilities on a Timely Basis

As of November 1999, there were eighty-one "delinquent" centers. This means their licenses have expired. According to the Child Care Licensure database, there were two delinquent centers from 1996, two delinquent centers from 1997, and 13 centers in 1998 which do not have valid licenses.

This allows the possibility of unlicensed centers to operate without the basic regulatory standards being met, which could provide an unsafe environment for children.

Failure to Impose Fines Mandated by Regulations for Class 1 Violations

PEER determined that on at least one occasion, one District Public Health Officer told the licensing official and her supervisor not to impose fines for Class 1 violations. This was brought to PEER's attention through a file review. This particular case deals with a facility being over maximum capacity. The facility should have been fined in accordance with regulations in order to deter the center from exceeding capacity at other times. Exceeding maximum capacity can have the potential to endanger children because of limited staff.

No specific regulations outline when a facility must be closed due to violations.

In one district, when an unlicensed child care facility is discovered, the district immediately closes the facility with the assistance of the local fire department. This is not the case in the other eight public health districts. According to MSDH, no specific regulations outline when a facility must be closed; therefore, each district can use its discretion to shut down facilities. Each district can use its own discretion because the regulations state that the district can close the facility that day if it finds violations. A facility can be closed if "there is reasonable cause to believe the operation of the child care facility constitutes a substantial hazard to the health or safety of the children cared for by the facility."

The lack of uniform enforcement among districts regarding unlicensed facilities could place children in potentially dangerous situations.

This lack of uniformity regarding compliance with regulations can lead to unlicensed facilities that have not met any regulations being open for business, which can put children in dangerous situations. Since each district is different, facility owners know that certain districts are getting away with lax compliance of regulations while other districts have a stricter stance on regulations. This can lead to significant variance of compliance with regulations within the state.

Many of these problems could be remedied with viable quality assurance.

MSDH has not instituted an internal audit (quality assurance) function within the Child Care Division. Currently, the division is in the process of putting together a system to insure that all licensing officials uniformly apply regulations to facilities around the state.

The division plans to have quality assurance inspectors go to each public health district and to randomly selected centers to determine whether the licensing official in that district has been carrying out inspections in a timely and orderly fashion. The quality assurance inspectors will conduct a full inspection of the center and then go to the district and check the licensing official's file on that center. This should show whether the official has actually inspected the center and if the documentation and findings match that of the quality assurance team. If they do not, the district will be cited for deficiencies. Currently there are no enforcement guidelines for the districts to correct deficiencies located by quality assurance.

MSDH has not allocated sufficient staff to ensure that the required number of child care facilities are inspected thoroughly and in a timely manner.

MSDH child care facility inspector caseloads range from 84 to 139 per inspector, the latter being nearly double the NAEYC recommended standard of 75 cases per inspector.

NAEYC recommends that, on average, a child care facility regulator should have a caseload of no more than seventy-five facilities, with fifty being a more desirable number. NAEYC believes that this is the maximum caseload which allows for timely processing of licenses, periodic on-site inspections, and prompt follow-ups to complaints.

MSDH is not meeting the recommended NAEYC caseload standard because its inspectors average 109 facilities each, with one of the inspectors responsible for inspecting 139 facilities (refer to Exhibit 28 below). Currently, Mississippi has fifteen child care facility inspectors in nine public health districts who are responsible for 1,636 licensed facilities, with 201 pending applications (as of November 17, 1999). To meet the NAEYC standard of a maximum of seventy-five facilities per inspector, MSDH would need to reallocate or reassign staff to perform inspections.

Exhibit 28: Current Staffing Levels of MSDH Child Care Licensing Officials

District	Number of facilities	Number of Officials	Average number of facilities per official
1	139	1	139
2	192	2	96
3	202	2	101
4	168	2	84
5	358	3	119
6	108	1	108
7	104	1	104
8	124	1	124
9	241	2	121

SOURCE: PEER analysis of MSDH information and interviews.

Recommendations

Collection and Analysis of Public Health Data

1. To improve accuracy and timeliness in the reporting of communicable disease data, MSDH should:

   -- facilitate reporting by printing the phone number, fax number, and MSDH's mailing address on Form 135, the form used to report communicable diseases;

   -- investigate the possibility of online reporting of data;

   -- add to Form 135 the date that the laboratory results were available, as this is a more accurate date to assess timeliness;

   -- track, document, and send educational material to every physician who reports more than seven days after the stated deadline for all classes of communicable diseases to encourage more timely reporting; and,

   -- identify physicians who rarely report communicable diseases and pro-actively contact a specified number per month to inform them of the reportable diseases and proper reporting procedures.

2. The Legislature should consider amending MISS. CODE ANN. § 41-23-1 to provide for several levels of penalties for late reporting and failure to report communicable diseases (e.g., suspension of license, revocation of license, $100 for the first violation, $500 for the second violation).

3. MSDH should add streptococcus disease and toxic-shock syndrome to its list of reportable diseases, since these diseases are on the Centers for Disease Control's nationally notifiable list and are not regional diseases.

4. To address the problem of MSDH not having comprehensive chronic disease data, the Legislature should consider mandating hospitals to report discharge data to MSDH.

5. MSDH should explore ways of improving the accuracy of reporting causes of death. For example, the department might consider changing the death report form to allow for more than one cause of death and should train doctors, funeral home directors, hospitals, and coroners in the importance of accurate reporting.

6. In order to improve the timeliness of vital statistics reporting, the Legislature should consider imposing penalties parallel to those established for the reporting of communicable diseases (see recommendation 2).

Food Protection

7. MSDH should establish a maximum number of inspections a food establishment can fail within a given time frame, regardless of whether it passes follow-up inspections, before suspending its permit for a specified period.

8. MSDH should inspect food establishments with the frequency required by regulation and more strictly enforce policies governing the Certified Food Manager Program.

9. When conducting internal audits of the food protection sub-program, MSDH internal auditors, not the district, should select the counties to be evaluated and the files within the county offices to be reviewed.

10. MSDH internal auditors should ensure correction of deficiencies cited in internal audit reports by continuing to follow up until the deficiencies are corrected.

Milk Sanitation

11. MSDH should update its Milk Plant inspection form to correspond with the Grade A Pasteurized Milk Ordinance.

Child Care Facility Licensure

12. MSDH should reallocate staffing resources in order to meet the National Association for the Education of Young Children staffing standard for child care facility inspectors of a maximum of 75 facilities per inspector.

13. MSDH should formalize its hearing process for violations of child care facility licensure regulations and make a record in all child care cases, including all findings and conclusions.

14. MSDH should implement its planned quality assurance function in order to ensure that child care facility inspectors uniformly enforce regulations.

Appendix A

Description of Entities with Major Health-related Responsibilities in Mississippi and Their Relationship with MSDH

Entity with Major Health-related Responsibility	*Role of Entity with Major Responsibility*	*# of Entities*	*Relationship of Entity with MSDH*
Health Personnel			
		**	
• Medical Doctors	provide direct medical care to patients.	5,093	MISS. CODE ANN. § 41-23-1 (1972) requires physicians to submit information to MSDH on reportable diseases MSDH determines areas of the state where there is a shortage of physicians and administers the federally funded rural physician program to attract physicians to underserved rural areas. Licensed by the Board of Medical Licensure
• Osteopaths	provide direct medical care to patients.	187	Licensed by the Board of Medical Licensure
• Dentists	provide direct medical care to patients.	1,245	Licensed by Board of Dental Examiners
• Dental Hygienists	primary allied dental personnel, assist dentists	687	Licensed by Board of Dental Examiners
• Registered Nurses	provide nursing services in hospitals, nursing homes, schools of nursing, community health clinics, public health clinics, home health agencies, medical offices, or schools	28,052	Licensed by Board of Nursing
• Nurse Practitioners	RN's certified with an expanded role in adult care, midwives, nurse anesthetists, family nurse, family planning, gerontological nursing, neonatal nursing, OB-GYN nursing, pediatric nurse, women's health, and acute care	1,045	Licensed by Board of Nursing
• Licensed Practical Nurses	Nurses licensed to administer care, usually under the direction of a licensed physician or a registered nurse. They provide services in hospitals, nursing homes, medical offices, private duty, community health, public health, and home health agencies.	11,221	Licensed by Board of Nursing
• Nursing Assistants /Aides	Individuals who assist nurses by performing the patient-care procedures that do not require special technical training, such as feeding and bathing patients, and by taking temperature, pulse and respiration.	5,178	Licensed by MS Department of Health Licensure and Certification contracted with Board of Nursing
• Podiatrists	provide direct medical foot care services to patients.	61	Licensed by the Board of Medical Licensure
• Chiropractors		229	Licensed by Board of Chiropractic Examiners
• Psychiatrists	Physicians who specialize in study, treatment, and prevention of mental illness.	198	Licensed by Board of Medical Examiners
• Psychologists		372	Licensed by Board of Psychology

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• Licensed Professional Counselors	Marriage and family therapy; vocational, educational, rehabilitation counseling; psychotherapy; consultation; and assessments	560	Licensed by Board of Examiners for Licensed Professional Counselors
• Ophthalmologists	Branch of medical science dealing with the structure, function, and diseases of the eye	160	Licensed by Board of Medical Examiners
• Optometrists	Primary health providers who diagnose, manage, and treat conditions and diseases of the human eye and visual system	271	Licensed by Board of Optometry
• Pharmacists	Individuals who are licensed to prepare and dispense drugs.	2,491	Licensed by Board of Pharmacy
• Physical Therapists	Provide preventative, diagnostic, and rehabilitative services to restore function or prevent disability from disease, trauma, injury, loss of limb, or lack of use of a body part.	1,318 25 independent	Licensed by MSDH Professional Licensure Independent PTs must be registered and certified by MSDH Licensure and Certification
• Physical Therapy Assistants	Assistants to physical therapists	444	Licensed by MSDH Professional Licensure
• Occupational Therapists	Health and rehabilitation profession that serves people who are physically, psychologically, or developmentally disabled.	581	Licensed by MSDH Professional Licensure
• Occupational Therapy Assistants	Assistants to occupational therapists	168	Licensed by MSDH Professional Licensure
• Respiratory Care Practitioners	Graduates of technician or therapist programs and work under the direction of qualified physicians. This is a specialty within the rehabilitation of patients with lung programs.	1,756	Licensed by MSDH Professional Licensure
• Speech-Language Pathologists	specialized assistance to persons with communication problems, primarily speech, language, and voice disorders	696	Licensed by MSDH Professional Licensure
• Audiologists	specialized assistance to persons with communication problems, primarily hearing problems	109	Licensed by MSDH Professional Licensure
• Registered Dietitians/Licensed Nutritionists	Provide medical nutritional therapy for the treatment of disease, as well as providing education of the prevention of disease and disability	543 (regular) 49 (provisional)	Licensed by MSDH Professional Licensure
• Hearing Aid Dealers	Deal hearing aids within Mississippi	109	Licensed by MSDH Professional Licensure
• Social Workers	Practice and serve as an integral part of a complex and multidisciplinary health care system.	3,331	Licensed by Board of Examiners for Social Workers and Marriage and Family Therapists
• Athletic Trainers	Individuals who assist in the physical and mental conditioning programs of others.	149	Licensed by MSDH Professional Licensure
• Certified Medical Technologists	Work in conjunction with pathologists, physicians and scientists in all general areas of the clinical laboratory	900	Licensed by the American Society of Clinical Pathologists
• Certified Radiologic Technologists	Includes specializations in radiography, nuclear medicine, ultrasound, and radon therapy.	1,615	Registered with MSDH

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Ambulatory Care			
• MSDH County Health Department Clinics	provide ambulatory care to all Mississippians. MSDH provides a broad scope of preventative and primary care services. These include maternity, family planning, child health, dental health, supplemental food program for women, infants, and children (WIC), immunization, sexually transmitted disease control, tuberculosis control, cardiovascular, hypertension, diabetes control, and home health. These clinics can serve as an individuals' primary care clinic. MSDH employs a multi-disciplinary staff composed of physicians, nurses, social workers, nutritionists, clerical personnel, disease investigators, and other support.	107	Part of MSDH, the clinics submit information on reportable diseases to MSDH's central office in Jackson
• Community Health Centers	federally-subsidized, non-profit corporations which deliver primary and preventative health care and social services. CHCs provide access to medical care for residents who are plagued by a shortage of medical services, financial restrictions, and other social or economic barriers. They offer a range of services including medical, dental, radiology, pharmacy, nutrition, health education and transportation.	20 primary clinics 36 satel-lites	MSDH administers the state grant programs which help to fund these centers and conducts yearly meetings with center directors regarding services provided and areas to target. MSDH administers the federal grant program that provides technical assistance to these centers.
• Rural Health Clinics	provide general outpatient health services for underserved populations in rural area of the country. US Congress authorized RHCs to receive cost-based Medicare and Medicaid reimbursement for services by mid-level practitioners such as nurse practitioners and physician assistants. RHCs must be located in an area defined as rural by the US Census Bureau and designated as Medically Underserved Area or a Health Professional Shortage Area by the US Dept. of Health and Human Services. These clinics may be owned by physicians, provider-based clinics, hospitals, nursing homes, or home health agencies.	164	MSDH certifies and licenses rural health clinics.
• Ambulatory Surgical Facilities	provide elective surgical treatment to "out-patients" whose recovery, under normal circumstances, will not require "in-patient" care.	10 (free-standing) 73 (hospital-based)	MSDH licenses and certifies ambulatory surgical facilities. Under the state's Certificate of Need program, MSDH reviews the need for ambulatory surgical facilities and equipment for these facilities. (SHP)

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Hospitals			
• Medical-Surgical	Provide treatment to patients with general medical and surgical needs requiring care over a continuous period exceeding 24 hours.	99 acute care hospitals (81 in rural areas) 11,734 licensed beds	MSDH certifies and licenses hospitals in the state. Hospitals are required to submit to MSDH information on reportable diseases, as well as cancer registry and trauma Under the state's Certificate of Need program, MSDH reviews the need for hospitals and equipment for hospitals. MSDH provides consultation services to the state's hospitals regarding hepatitis C.
• Whitfield Medical-Surgical Hospital	Acute care hospital for psychiatric patients at the Mississippi State Hospital at Whitfield. This is a state supported and state run facility.	43 beds	MSDH certifies and licenses hospitals.
• Medical-Dental Facility at Parchman	This is a state run and state supported hospital that provides acute and psychiatric care to inmates at the Mississippi State Penitentiary.	56 beds	MSDH certifies and licenses hospitals.
• Long term Acute Care Hospitals	These hospitals provide care to patients who need less than 3 hours of rehabilitation per day but who have an average length of stay greater than 25 days.	3 hospitals, 7 CONs approved 107 beds	MSDH certifies and licenses hospitals
• Veterans' Administration Hospitals	Federal government operates hospitals which provide services to all veterans.	2	MSDH certifies and licenses hospitals.
• US Air Force Facilities	Facilities that serve active duty military personnel at Columbus and Keesler Air Force bases.	2	
• Indian Health Service Hospital	In Philadelphia, MS, and serves Choctaw Indians.	1 35 beds	
• University of Mississippi Medical Center (UMC)	State supported Medical Center. University teaching hospital associated with Schools of Medicine, Dentistry, Nursing, and Health Related Professions, which include dental hygiene, health information management, medical technology, physical therapy, occupational therapy, cytotechnology, and emergency medical technician training	1 623 beds	UMC provides laboratory assistance to MSDH (e.g., pap smears), conducts disease research, 2 UMC consultants work with MSDH to write the Morbidity Report. MSDH's State Epidemiologist teaches infectious disease classes at UMC. Other MSDH staff are adjunct faculty. Other UMC physicians provide specialty care for MSDH.
Long-term Care			
• Skilled Nursing Homes	Extended care facilities for persons who need medical attention of the type and complexity not requiring hospitalization	181 facilities 16,090 beds	Licensed and certified by the MSDH. Under the Certificate of Need program, MSDH reviews the need for long-term care facilities. MSDH requires long-term care facilities to report client deaths.
• MS Band of Choctaws Nursing Home	Nursing home that serves the MS Band of Choctaw Indians.	1 120 beds	Licensed and certified by MSDH. Not subject to Certificate of Need programs.

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• MS Dept. of Mental Health Nursing Homes	Provide nursing home services to residents of mental health facilities.	2 facilities 680 beds	Licensed and certified by the MSDH. Not subject to Certificate of Need programs
• MS State Veteran's Affairs Board Nursing Homes	Provide nursing home service to veterans.	4 facilities 575 beds	Licensed and certified by MSDH. Not subject to Certificate of Need programs
• Intermediate Care facility for the Mentally Retarded (ICF/MR)	MS Dept. of Mental Health operates five of these facilities. They provide residential services which include psychology, social services, medical and nursing services, recreation, special education, speech therapy, occupational therapy, physical therapy, audiology, and vocational or work training.	10 facilities 2,445 beds	Licensed and Certified by MSDH. Under the Certificate of Need program, MSDH reviews the need for long-term care facilities. MSDH requires long-term care facilities to report client deaths.
• Distinct Part/ Skilled Nursing Facilities	MS hospitals that provide limited nursing home care. These units are located in physically identifiable distinct part of the hospital and are certified for participation in the Medicare program as skilled nursing facilities, but cannot participate in the Medicaid program.	41 hospitals 677 approved beds 463 beds in operation	Licensed and Certified by MSDH. Under the Certificate of Need program, MSDH reviews the need for long-term care facilities. MSDH requires long-term care facilities to report client deaths.
• Swing Beds	Hospitals which provide beds approved to alternate as needed between acute care and long-term care hospitals of fewer than 100 beds.	53 facilities ~ 180 beds in 1999	Licensed and Certified by MSDH. Under the Certificate of Need program, MSDH reviews the need for long-term care facilities. MSDH requires long-term care facilities to report client deaths.
• Personal Care Homes	Facilities provide their residents with sheltered environment and assistance with the activities of daily living, but they do not provide medical care.	165 facilities 3,495 beds	Licensed and Certified by MSDH.
• Retirement Communities, Senior Housing Facilities	Provide apartments for independent living, with services such as transportation, weekly or bi-weekly housekeeping, and one to three meals daily in a common dining room. Many of these facilities include a licensed personal care home where the resident may move when he or she is no longer physically or mentally able to remain in their own apartment.	50	Personal care homes are licensed and certified by MSDH.
• Continuing Care Retirement Community	Includes three stages: independent living in a private care facility, a personal care facility, and a skilled nursing home.	1	Personal care homes and nursing facilities are licensed and certified by the MSDH.

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Other Regulated Health Facilities			
• Home Health Agency	Publicly or privately owned agency or organization which provides individuals at the written direction of a licensed physician, in the individual's place of residence, skilled nursing services by or under the supervision of a registered nurse licensed in MS one or more of the following services: physical, occupational or speech therapy; medical social services; home health aide services; medical supplies, other than drugs and biologicals, and the use of medical appliances; medical services provided by a resident.	15 regional home health agencies of MSDH serving 59 counties 30 hospital based 25 private agencies 2 in Memphis 82,142 services on 1997	MSDH licenses and certifies home health agencies. MSDH administers its own regional home health facilities in certain regions Under the state's Certificate of Need program, MSDH reviews the need for home health agency facilities and equipment.
• End Stage Renal Disease Facility	provides dialysis to patients with irreversible and permanent kidney impairment.	60 facilities 13 CONs approved	MSDH licenses and certifies end-stage renal disease facilities. Under the state's Certificate of Need program, MSDH reviews the need for end-stage renal disease facilities and equipment.
• Hospice	program which provides palliative care to terminally ill patients and counseling to the patient's family. Palliative care controls pain and the symptoms of the dying process and is not intended to be curative in nature.	40 Medicare-certified programs	MSDH licenses and certifies hospices.
• Abortion Facility	performs abortions on an outpatient basis.	2	MSDH licenses and certifies abortion facilities.
• Health Maintenance Organizations	provide health care services to enrolled participants.	15	MSDH licenses and certifies health maintenance organizations.
• Emergency Medical Services	Emergency Medical Services are health care services delivered under emergency conditions that occur as a result of a patient's condition, natural disasters, or other situations.	136 licensed ambulance providers 3 helicopter air services 3 out-of-state air ambulance services	MSDH licenses and certifies emergency medical services, emergency medical technicians, and other emergency medical services personnel.
Perinatal Care			
• Task Force on Infant Mortality	Advocates and informs the public on maternal and infant health issues, conducts studies, develops policies to improve maternal and infant health.		MSDH administers the task force and supervises support staff.
• Maternity Services	Maternity services through county health departments and clinics, targeting women with incomes at or below 185% of the federal poverty level. Provides ambulatory care throughout pregnancy and the postpartum period.		MSDH administers clinics.

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• Toll-Free Maternal and Child Health and Children with Special Health Care Needs Hotline	Provides assistance to clients seeking services, family planning services, Medicaid, and WIC.		MSDH maintains the hotline.
• Supplemental Food Program for Women, Infants and Children (WIC)	Provides essential nutritional counseling and supplemental foods to pregnant and breastfeeding women, as well as infants and children.		MSDH administers the federal WIC program.
• Perinatal Regionalization	This system of care was to allow every mother and newborn timely access to an appropriate level of health care according to their risk status without administrative obstacles.		MSDH to develop a regionalized system of care. MSDH Licensure and Certification subsequently designated levels of hospital care and included levels in licensure standards.
• Take Care	Public awareness project that develops public service announcement spots for television and radio directed toward early prenatal care and teen pregnancy prevention.		WIC, with MSDH, provides continuation funds for the project.
• Perinatal High Risk Management/Infant Services System (PHRMM/ISS)	Risk education program for high risk pregnant and postpartum women and infants. Program is designed to reduce low birthweight and infant mortality by providing a comprehensive array of supplemental services such as nutrition and psychosocial assessments, counseling, home visiting, transportation assistance, and health education.		MSDH administers this program.
• Born Free	Program for pregnant women and infants affected by perinatal substance abuse.		MSDH and PHRMM/ISS refer individuals to this program operated by Catholic Charities.
• Fetal and Infant Mortality Review Project	Grant for the Maternal and Child Bureau to conduct a study that provides more definitive information about causes of infant death; identifies the general community, social, economic, cultural, and health systems; determines service delivery systems or resource problems that require change; and develops recommendations, assists in implementation of change and monitors the ongoing progress of changes made.		MSDH administers this grant and study.
Rehabilitation			
• Mississippi Department of Rehabilitation Services	Provides a variety of services to disabled persons and their families that include medical assistance, physical and occupational therapy, counseling, educational assistance, job training, and placement		The State Health Officer serves on the Board.
• Mississippi School for the Deaf & Blind	Provides residential and day programs with elementary and secondary education curricula for hearing and visually impaired children and youth through age twenty-one. Operated by MS Dept. of Education.		
• Children's Rehabilitation Center	A unit of UMC that provides inpatient and outpatient habilitation and rehabilitation services for physically and developmentally disabled children and youth through age twenty.	1 unit 25 inpatient pediatric beds	MSDH licenses and certifies the Children's Rehabilitation Center.
• Delta Regional Medical Center	Specialized burn unit.	1 16 bed	MSDH licenses and certifies all hospitals.
• Comprehensive Inpatient Medical Rehabilitation Services	provides comprehensive medical rehabilitation services to patients six years and older with chronic illness and disability.	4 hospital-based units 113 beds	MSDH licenses and certifies all hospitals.

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• Mississippi Methodist Hospital and Rehabilitation Center	provides comprehensive medical rehabilitation services to patients six years and older with chronic illness and disability.	1 124 beds	MSDH licenses and certifies the Mississippi Methodist Hospital and Rehabilitation Center.
• Comprehensive Outpatient Rehabilitation Facilities	provide diagnostic, therapeutic, and restorative services to outpatients and meet specified federal Medicare conditions of participation.	20 Medicare certified facilities	MSDH certifies CORFs.
• Children's Medical Program	provides medical care and rehabilitative services to children with physical disabilities whose families cannot afford the cost of properly caring for their children		MSDH administers and provides staff support for the Children's Medical Program
• First Steps	A joint effort of the Mississippi departments of health, education, mental health, rehabilitative services, human services, and the Division of Medicaid, which provides early intervention services for infants and toddlers with developmental disabilities		MSDH is the lead agency in this program as well as the payer of last resort to reimburse providers for needed services.
• Private Rehabilitation Agencies	Private agencies provide integrated multi-disciplinary programs designed to upgrade the physical function of disabled individuals. This includes physical therapy, speech therapy and social services.	40	MSDH licenses and certifies rehabilitation agencies.
Third Party Reimbursement			
• Medicare	Federally administered program that provides payments for hospital, physician, and other medical services for patients 65 years of age and older and disabled persons entitled to Social Security cash benefits for 24 months. There are two parts: (Part A) compulsory hospitalization insurance and (part B) voluntary supplemental medical insurance, which covers physician services and some medical services and supplies not covered by Part A.		MSDH bills Medicare for services provided, such as home health and selected clinic services.
• MS Division of Medicaid	provides funding for health care services for eligible persons; mandatory services include inpatient hospital; outpatient hospital; laboratory and x-ray; nursing facility services; physician services; early and periodic screening, diagnosis , and treatment (EPSDT) for patients aged 20 and under; home health; family planning; rural health clinic services; transportation/emergency ambulance services; and nurse-midwifery services. Optional services include outpatient prescription drugs, dental services, intermediate care facility services for the mentally retarded, eyeglasses after surgery, home and community based services, durable medical equipment, mental health services (comprehensive regional mental health/retardation centers), and inpatient psychiatric services for persons under 21.		MSDH bills Medicaid for services provided. MSDH certifies Medicaid eligible facilities. Interagency Agreements: Regular Medicaid PHRM CHIP II/Immunizations
• Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	US Dept. of Defense provides health insurance for covered medical care provided in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel (unless eligible for Part A of Medicare)		??
• State Children's Health Insurance Program (CHIP)	Targeted children not eligible for Medicaid, whose family income is below 200% of the federal poverty level.		MSDH serves as an outreach point and as a provider of clinic services.

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Environmental Protection			
• MS Department of Environmental Quality	administers comprehensive programs for prevention, control, and abatement of air and water pollution; hazardous waste oversight		
• MSDH's Office of Environmental Health	protects health and safety of the state's citizens through programs in food sanitation, milk protection, general sanitation, etc.		Division of MSDH
• US Dept. of Agriculture	inspection and grading of meat and poultry		Interagency agreement regarding the grading of meat and poultry
• Mississippi Emergency Management Agency	toxic chemical identification		
Other State Agencies with Health-related Responsibility			
• Mississippi Department of Human Services	Administers the following health-related programs: food stamps, child welfare and protection, eligibility determination for Medicaid, and coordination and funding of programs for the elderly; and programs to address sexual abuse treatment, education, and prevention		Reports cases of abuse to MSDH.
• Mississippi Department of Education	School lunch program, pupil transportation, health related services and physical education		MSDH collaborates with the state Department of Education on programs such as First Steps, physical activity, and the School Nurse Program. Both MSDH and the State Department of Education have school nurse programs.
• Mississippi Department of Economic and Community Development	Community education and planning		MSDH's role is interagency cooperation
• Mississippi Department of Mental Health	Coordinates and administers the delivery of mental health services, alcohol/drug abuse, and mental retardation services throughout the state. Their responsibilities include (a) state-level planning and expansion of all types of mental health services, (b)standard-setting and support for community mental health/mental retardation and alcohol/drug abuse programs, (c) state liaison with mental health training and educational institutions, (d) operation of the state's psychiatric facilities, and (e) operation of the state's facilities for individuals with mental retardation.		MSDH collaborates with the Department of Mental Health on First Steps. Also the Department of Mental Health is a referral source for MSDH programs.
Health Related Associations			
• American Heart Association-Mississippi Affiliate	screens 15,000 to 20,000 people per year for hypertension.		MSDH offers screening and follow up through county health departments.
• American Diabetes Association • Diabetic Foundation of Mississippi	Provides information and support to individuals with diabetes, and offers programs of service and education throughout the state. Supports state specific research, professional education, patient education, and public awareness campaigns.		MSDH Diabetes Program provides services, including screening and referral for definitive diagnosis, joint medical management, and professional education for physicians, nurses, nutritionists, and other health professionals.

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• American Lung Association of Mississippi	Dedicated to lung disease prevention and control, provides several programs geared toward public awareness. This includes public information, patient services, emergency financial assistance, public and professional education, and medical research.		MSDH provides screening for tuberculosis as well as preventative and curative therapy.
Health Advisory Committees			
• WIC Formula Committee	A group of physicians, nurses and nutritionists to discuss the use of non-standard formula in the WIC Program and to discuss issues related to providing infant formula in the WIC program.		Representatives from WIC local staff and Central Office staff are on the committee.
• Income Integrity Work Group USDA/FNS Southeast Region	This work group will work to set policy and procedures for the regional states to implement the new rules and regulations.		MSDH representatives are in the work group.
• MS Breastfeeding Coalition	Provide opportunities for area health professionals and breastfeeding advocates to share new information, ideas, and strategies for increasing initiation and duration rates in MS to the Healthy People 2000 goals.		MSDH WIC and Personal Health Services representatives are in the coalition.
• National Association of WIC Directors (NAWD) Breastfeeding Promotion Committee	To work with the USDA Food and Nutrition Service and others as appropriate to develop recommendations and standards for the promotion of breastfeeding among mothers participating in the WIC program.		MSDH representative on the committee.
• National Association of WIC Directors	To develop association policy and guidance and related positions with respect to marketing the WIC program.		MSDH representative in the association.
• Preventative Health and Health Services Block Grant Advisory Committee	The committee conducts public hearings on the state plan, makes recommendations regarding the development and implementation of the state plan and makes recommendations regarding the collection of reporting of data as it relates to the program activities funded by the grant.		MSDH staff contact person.
• MS Chronic Illness Coalition	Serves as an advisory group to the Division of Health Promotion/Education/Chronic Disease in the development of programs to increase awareness of chronic illness and related risk factors.		MSDH representative on coalition.
• Early Hearing Detection & Intervention in MS Advisory Committee	This group advises the Dept. of Health and the state Interagency Coordinating Council regarding matters of the Infant and Toddler Hearing Impaired Registry and implementation of early intervention programs for infants and toddlers with hearing impairments.		MSDH contact staff person.
• MS SIDS Coalition	This group is to advise the MSDH SIDS Coordinator regarding ways of increasing public and health care professionals' awareness, education and knowledge of risk reduction factors of Sudden Infant Death Syndrome (SIDS) through written materials, oral, audiovisual and mass media avenues.		MSDH contact staff person.
• State Interagency Coordinating Council	This council serves in an advise and assist role to the MSDH in its role as the lead agency for the implementation of the Individuals with Disabilities Education Act (IDEA) Part C.		MSDH contact staff person.
• Lead Screening Advisory Committee	The main function of this committee is to work on a new State Lead Plan that incorporates the new Centers for Disease Control Lead Screening guidelines. The committee also works to enhance education on lead poisoning prevention and screening, promoting (advocating) legislation involving lead issues, and serving as authorities in their many areas of expertise relating to lead.		Special Agency Initiative, MSDH staff contact person.

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• MS Birth Defects/Genetics Advisory Committee	Was created to advise the State Health Officer and the Board of Health on the promulgation of rules, regulations, and procedures of the birth defects registry and the Genetics Program.		MSDH staff contact person.
• Ad Hoc Committee on SSI Child Beneficiaries	To monitor changes in SSI eligibility regulations, SSI between agencies and consumers, address policy and individual case issues.		MSDH staff contact person
• Children's Medical Program Advisory	Was established to assist the program in identifying the health needs of handicapped children, evaluating service delivery and recommending services to meet identified needs.		MSDH contact staff person.
• Transition Advisory Committee	To design, provide, and facilitate the implementation of strategies, skills, and initiatives for improving transition of children with special health care needs toward adult independence.		MSDH staff contact person.
• MS Alliance for School Health (MASH) Coalition	Advisory group of individuals, agencies, and organizations who strive to strengthen all components of a coordinated school health program.		MSDH School Health Coordinator.
• MS State Immunization Coalition (MSIC)	The function is to promote immunization activity in MS through improved service delivery, assessment, and education and information.		MSDH staff person.
• MSIC Steering Committee	To examine and review the charter of the MSIC including goals and objectives, establish a strategic plan for the coalition in order to accomplish one major goal annually, schedule times and dates and develop meeting agendas for all coalition members, and recruit new members for the coalition and become a self-sufficient organization.		MSDH staff contact person.
• MS Breast and Cervical Cancer Control Coalition	Purpose of the coalition is to develop, recommend, and advocate sound policies, priorities, and strategies for the prevention, early detection, treatment and surveillance of breast and cervical cancer in MS.		MSDH staff contact person.
• Family Planning Advisory Council	Organization of consumers and interested members of the community which is organized to provide information and recommendations to the family planning program on the program's strategies and activities.		MSDH staff contact person.
• Information and Education Committee	Advisory committee of 5-9 members who are broadly representative of the community; must review and approve all informational and educational materials developed or made available under the project prior to distribution to assure that the materials are suitable for the population and community.		MSDH staff contact person.
• Injury Prevention Advisory Committee	Advisory Committee to the MSDH Injury Prevention Program on issues associated with the reduction of injuries in MS. The main task has been to advise an the Injury Prevention Program in the development and dissemination of an Injury Prevention State Plan		MSDH Injury Prevention Activities Coordinator
• MS Community Planning Group for HIV Prevention	Established to assist MSDH in its HIV Prevention community planning program. The process includes developing a statewide comprehensive HIV Prevention plan for the HIV/STD Division.		MSDH staff contact person.
• MS Faith Initiative Planning Committee for the Prevention of STD/HIV	Develop faith-based prevention interventions for faith organizations in Mississippi. The committee will identify potential strategies and interventions, develop a program manual and training guide, and evaluate the planning process and program for a faith-based prevention intervention.		MSDH staff contact person.

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• HIV Prevention Evaluation Committee	An advisory group in the development of a Comprehensive HIV Prevention Evaluation Plan for STD/HIV. The responsibilities of the Committee include evaluating the impact of HIV/AIDS prevention intervention in specific populations throughout the state, assessing the state's resources for the delivery prevention services, and advising the division on specific evaluation design issues.		MSDH staff contact person
• HIV/AIDS CARE and Services Planning Council	serves as an advisory group to the Care and Services Branch of the Division of STD/HIV in the development of a Comprehensive HIV Service Plan for MS. The responsibilities of the Council include evaluating the impact of HIV/AIDS in specific populations throughout the state, assessing the state's resources for the delivery of HIV services, defining and strengthening partnerships between providers of HIV services within the state, and advising the MSDH on specifics as they arise.		MSDH staff contact person.
• Central Cancer Registry Advisory Committee	The committee has three objectives: (1)implementation of "Statewide Cancer Registry"; (2) advocate the Central Cancer Registry role within the medical community; (3) assist in the development of Central Cancer Registry policies		MSDH staff contact person.
• Health Promotion Clearinghouse Advisory Committee	To assist in the further development of clearinghouse services to benefit the state's population as a whole. To include working to determine the scope of the clearinghouse (what subject areas in which to collect information), creating a marketing strategy, and promoting agency/organizational support of the clearinghouse.		MSDH clearinghouse coordinator.

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Appendix B

Agreements/Memoranda of Understanding Between the Department of Health and Other Agencies As of August 1999

Agency in Agreement	Description
Dept. of Human Services, Division of Aging and Adult Services	assure that the State Survey Agency (MSDH) avoids giving notice of a survey through the scheduling procedures and to comply with the long term survey protocol. This agreement allows cooperation in scheduling and concerns with licensed health care facilities between MSDH and MSDHS.
G.V. "Sonny" Montgomery VA Medical Center	maintain communication regarding the quality of care of patients in VAMC contract nursing homes. This agreement maintains communication between the MSDH and the VAMC Community Care Evaluation Team.
Department of Environmental Quality	provide personnel from DEQ for Lead program within the state.
Division of Medicaid	coordinate with Perinatal High Risk Management Services- the purchase of case management and extended services for Medicaid recipients, also includes Early Periodic Screening Diagnosis and Treatment (EPSDT)
JSU - Public Policy and Administration	scheduling of interns for Office of Primary Care Liaison
MSU- School of Human Services	Dietetic Internship Program in District IV
Office of the Attorney General - Medicaid Fraud Control Unit	cooperation with Division of Licensure and Certification for copies of investigative reports, records and information regarding allegations of neglect, abuse and misappropriation
Division of Medicaid	identify certain programs which are of mutual interest to the cooperating agencies regarding Maternal-Child Health populations. These services include Children with Special Health Care Needs, comprehensive prenatal care, WIC, family planning services, EPSDT, and the pharmacy.
Division of Medicaid	presented as it relates to the confidentiality, publication, and security of Medicaid recipients and paid claims and Dept. of Health's vital records data.
MS Dept. of Human Services	purpose is to provide the exchange of accurate, timely information regarding the voluntary acknowledgment of paternity and non supporting parents. Services to be used solely for the purpose of establishing support orders and in investigating or enforcing the support liability of the absent parent.
Social Security Administration	allow SSA to obtain birth, death, and marriage records via verification/certification by electronic mail

Social Security Administration	allows SSA to provide data to MSDH for administration of certain income-maintenance or health-maintenance programs
New Orleans District of the Food and Drug Administration	partnership program of training and inspection designed to enhance the effectiveness of inspections of firms engaged in the manufacture and distribution of prepared sandwiches in MS and to reduce duplication of regulatory efforts.
New Orleans District of the Food and Drug Administration	partnership for the regulation of the fish and fishery products processing industry in MS.
MS Commission on Marine Resources	share investigative findings and materials with respect to the control and operation of molluscan shellfish processing plants and distribution facilities handling molluscan shellfish in MS.
Dept. of Environmental Quality	establish broad areas of responsibility in the administration of the environmental monitoring and oversight activities associated with the US Dept. of Energy. The Division of Radiological Health is to provide DEQ with input for periodic reports in a timely manner.
Each school of nursing in the state	Scheduling of nursing students for clinical rotations in health departments
New Orleans District and the Southeast Regional Lab of the FDA, MS Dept. of Marine Resources, MS Dept. of Agriculture and Commerce	agreement to work together in a coordinated way to address any consumer product public health emergency

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

HEALTH RESPONSIBILITY	MSDH RESPONSIBILITY (DIVISION)	OTHER STATE AGENCY RESPONSIBILITY	MISS. CODE ANN. REFERENCE	MANDATED OR AUTHORIZED	PRIMARY ACTIVITIES
Chronic Illness					
Diabetes Treatment					
Establish a program of public education and awareness of the symptoms and care and treatment of persons suffering from diabetes; assist in the development and expansion of educational programs; enter into agreements with non-profit organizations for the dissemination of information; employ all necessary administrative personnel	Chronic Illness Program		41-28-3, 41-28-5	Authorized	· Provide supportive services, including screening and referral for definitive diagnosis; · Provide joint medical management; · Provide professional education to physicians, nurses, nutritionists, and other health professionals · Provide insulin and syringes to patients with no other pay source.
Hypertension					· Provide hypertension screening, diagnosis, treatment, and follow-up services through local county health departments.
Home Health					· Provide comprehensive services, including skilled nursing and aide visits, physical therapy, speech therapy, dietary consultation, and psychosocial evaluation to discharged mothers and babies and homebound impaired, elderly, or disabled patients · May provide medical supplies, oxygen, and durable medical equipment
Maternal and Child Health					
Family Planning					
Establish a family planning program; receive and disburse funds for family planning programs to organizations which provide contraceptive supplies; adopt and promulgate rules and regulations regarding the "Family Planning Law of 1972"	Family Planning		41-42-1 to 41-42-7	Authorized	· Provide family planning services including counseling, medical examinations, education, contraceptives, and infertility counseling to at-risk teenagers and women 20-44 years of age with income at or below 150% of the federal poverty level. · Provide every mother and newborn timely access to an appropriate level of health care according to their risk status. · Develop public service announcements for television and radio directed toward early prenatal care and teen pregnancy prevention. · Provide a comprehensive array of supplemental services such as nutrition and psychosocial assessments, counseling, home visiting, transportation assistance, and health education to high risk pregnant and postpartum women and infants. · Program for pregnant women and infants affected by perinatal substance abuse.
Maternity/Perinatal Services					
Coordinate the development and implementation of a regionalized system of perinatal health care services; enter into contracts with and provide grants to health care providers in order to implement the program.	Bureau of Women's Health, county health departments		41-81-1 to 41-81-3, 41-3-15 (5)(a)(i)	Authorized	
Offer rubella screening tests to all females of childbearing age; offer vaccinations	Perinatal Services, Family Planning		41-23-101, 41-23-105	Authorized	
Counsel all females found after testing to be non-immune to rubella	Perinatal Services, Family Planning		41-23-103	Mandated	

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Child Health					
Establish a Maternal/Child health program	Bureau of Child Health		41-3-15 (5)(a)(i)	Authorized	· Provide childhood immunizations, well child assessments, limited sick child care, and tracking of infants and other high-risk children, targeted to children with family incomes at or below 185% of the federal poverty level. The program provides early identification of disabling conditions and linkages with providers for effective treatment and management.
WIC					
Establish, maintain and promote an osteoporosis prevention and treatment education program; employ staff, provide training, improve services, and work with government and community; accept grants, services, and property from the federal government; seek federal waiver(s)	Women's Health		41-93-1 to 41-93-9	Authorized	· Provide essential nutritional counseling and supplemental foods to pregnant and breastfeeding women, as well as infants and children.
Genetics					
Create birth defects registry; adopt rules, regulations, and procedures to govern the registry	Genetics		41-21-205	Mandated	
Establish, maintain, and carry out a newborn screening program designed to detect hypothyroidism, phenylketonuria (PKU), hemoglobinopathy, and galactosemia; adopt rules and regulations necessary to program	Genetics		41-21-201	Authorized	· Provide statewide newborn screening, diagnosis, counseling, and follow-up for a range of genetic disorders, to identify these problems early and allow for immediate intervention to prevent irreversible physical and mental retardation or death.
Follow up on all positive newborn screening tests (mentioned above)	Genetics		41-21-203	Mandated	
Establish testing program for sickle cell anemia; distribute educational materials	Children's Medical Program, Genetics Division		41-24-1 to 41-24-5	Authorized	
Require any school employee to submit to a thorough physical examination to determine whether he or she has any infectious or communicable disease	Children's Medical Program, Genetics Division, State Epidemiologist or State Health Officer		37-11-17	Authorized	
Develop program to accomplish the identification of public school students with abnormal spinal curvature.		State Board of Education	37-11-17	Authorized	
Early Intervention for Infants and Toddlers					
Administer and supervise Early Intervention for Infants and Toddlers programs; develop policies and standards	Early Intervention Program		41-87-11	Mandated	· Provide family-centered linkage and coordination of interagency early intervention services for all eligible children statewide.
Maintain the Infant and Toddler Hearing Impaired Registry; appoint advisory committee to registry	Early Intervention Program		41-90-5, 41-90-7	Mandated	
Adopt rules and regulations concerning hearing impairments in infants and toddlers	Early Intervention Program		41-90-5	Authorized	
Children's Medical Program					
Establish program to provide services to crippled or disabled children	Children's Medical Program		41-3-15(a)(iv)	Authorized	
Provide crutches, braces, and any other mechanical devices to persons with crippling conditions	Children's Medical Program		41-11-111	Mandated	· Provide medical and surgical assistance to middle and low income families of children with special health care needs.
Establish a program for the care and treatment of persons suffering from hemophilia	Children's Medical Program		41-22-3	Authorized	
Environmental Health					
General					
Investigate complaints as to anhydrous ammonia storage facilities, when complaints are in the nature of a nuisance, health or property hazard; immediately condemn storage facility if complaints are well founded.	General Environmental Services		75-57-31	Mandated	

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Regulate sanitation of barber shops and barber schools	General Environmental Services	Board of Barber Examiners	73-5-7	Mandated	
Regulate hotels and innkeepers	General Environmental Services, State Board of Health		41-49-1 to 41-49-9	Mandated	
Approve in writing all rules and regulations relating to sanitation proposed by the State Board of Cosmetology	General Environmental Services	Board of Cosmetology	73-7-7	Mandated	
Make regulations and investigations with respect to the disinfection and sanitation of public buildings trailers, and camps	General Environmental Services		41-25-1 to 41-25-3, 41-25-13, 41-3-15 (4)(k)	Authorized	
Visit all establishments employing child labor and report to the sheriff any unsanitary conditions	General Environmental Services, County health officer		71-1-25	Mandated	
Make sanitary investigations of facilities for safety and health	General Environmental Services, State Board of Health		41-3-15 (4b and 4k)	Authorized	
Establish health and safety regulations for rock festivals	General Environmental Services		45-21-11	Mandated	
Approve and certify proposed plans by any entity desiring to hold a rock festival in the state	General Environmental Services		45-21-11	Authorized	
Order that entrance ramps for the disabled be on all public buildings	General Environmental Services, State Dept. of Health		43-6-101	Mandated	
Inspect institutional housing and service facilities at the State Penitentiary; compile written report of findings to governor	General Environmental Services, State Board of Health	Bureau of Building, Grounds and Real Property Management of Dept. of Finance and Administration	47-5-94	Mandated	
Onsite Wastewater					
Regulate wastewater disposal systems	General Environmental Services, Board of Health		41-67-1 to 41-67-31	Mandated	· Inspect RV parks, on-site wastewater disposal systems, and individual water supplies. · Perform soil and site evaluations and recommend the wastewater system be adapted to the site; · Respond to public complaints regarding unsanitary conditions and related matters.
Regulate sewage disposal systems		DEQ	17-17-1 et seq.	Authorized	
Food Protection					
Provide regulatory framework for the interstate and intrastate sale of food and food products; prevent the sale of adulterated or mislabeled food; inspectors may take samples or specimens for analysis	General Environmental Services		75-29-1 75-29-19	Authorized	
Have free access at all reasonable hours to any place where foods are sold	General Environmental Services		75-29-23	Mandated	
Change or add to specifications for ingredients and amounts thereof required to conform to any changes in federal ruling concerning the addition of vitamins to oleomargarine; enforce Oleomargarine Enrichment Law"	General Environmental Services, Board of Health		75-29-501 to 75-29-511	Mandated	
Establish programs for the sanitation in foodhandling establishments open to the public	General Environmental Services: Food Protection		41-3-15 (5)(a)(xiii)	Authorized	· Attempt to eliminate potential hazards and provide quality assistance and training to the food industry to ensure that facilities comply with state and federal laws, rules, and regulations. Food facilities must receive an annual permit from MSDH to operate.
Establish standards for restaurants	General Environmental Services: Food Protection		41-3-15 (4)(i)	Mandated	

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Milk Program					
Regulate milk and milk products	General Environmental Services		41-3-15(4)(j), 41-3-15(5)(a)(ix), and 75-31-1 to 75-31-427	Authorized	· Inspect and ensure compliance with state and federal laws, rules and regulations regarding dairy farms, bulk milk haulers, transfer stations, receiving stations, pasteurization plants, and bottled water plants · Conduct Milk Sanitation Compliance and Enforcement Ratings of milk supplies within the state. The program ensures that current and minimum public health requirements are applicable to new products and manufacturing processes within the industry.
Public Water Supply					
Perform sanitary investigations and prepare such rules and regulations governing the sanitation and labeling of bottled drinking water.	General Environmental Services		75-29-801	Authorized	· Assure safe drinking water by enforcing the Safe Drinking Water Acts. These acts cover the following major areas: 1) bacteriological, chemical, and radiological monitoring of drinking water quality; 2) negotiation with consulting engineers for the final design of engineering plans and specifications for all new or substantially modified public water supplies in Mississippi; 3) annual surveys of each community public water supply to eliminate operational and maintenance problems that may potentially affect drinking water quality; 4) enforcement to ensure that federal and state standards are followed; 5) licensure and training of water supply officials and training of consulting engineers and MSDH field staff in the proper methods of designing, constructing, and operating public water systems.
Establish a program for the protection of drinking water	State Board of Health, Water Supply Division		41-3-15 (5)(a)(xii)	Authorized	
Regulate drinking water and public water systems	General Environmental Services, Board of Health, Water Supply Division		41-3-18, 41-26-1 to 41-26-21	Mandated	
Radiation Control					
Adopt rules and regulations regarding medical radiation technology	Radiation Control, Dept. of Health		41-58-1 to 41-58-5	Authorized	· Identify sources of radiation exposure; · Understand the biological effects of radiation; · Investigate and evaluate methods of radiation detection; · Formulate and apply procedures for the control of radiation exposure; · Maintain and enforce regulatory standards to ensure low exposure to biologically harmful radiation; · Evaluate each facility licensed to possess and use radioactive materials and each facility registered to operate x-ray devices to determine compliance with the regulations and specific license or registration.
Certify to the commissioner of Agriculture and Commerce that a particular disposal plant or rendering plant is a menace to the public health	General Environmental Services	Agriculture Commission	41-51-25	Authorized	
Establish a Radiologic Health Division	State Board of Health		41-3-15(5)(a)(vii)	Authorized	
Establish guidelines regarding disposal and storage of radioactive wastes; develop policies and programs concerning radiologic hazards; cooperate with other public agencies; encourage and participate in research relating to radiologic health; collect and disseminate information relating to radiologic health; respond to radiologic emergencies	Radiologic Health Division, Board of Health		17-17-49, 45-14-11		

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Boiler and Pressure Vessel Safety					
Boiler and pressure vessel safety regulation; employ a chief inspector	Boiler and Pressure Vessel Safety		45-23-9, 45-23-17	Mandated	
Enforce boiler and pressure vessel safety laws, provide copies of rules and regulations to requesters, issue or revoke inspection certificates, maintain list of qualified inspectors	Boiler and Pressure Vessel Safety (inspector)		45-23-19	Authorized	· Certify the use of all boilers and pressure vessels covered by law. Some are inspected biannually and larger, more dangerous ones are inspected annually.
Disease Prevention and Health Promotion					
General					
Establish programs for the control of communicable and noncommunicable disease	State Dept. of Health		41-3-15 (5)(a)(v)	Authorized	
Designate diseases which are transmissible through blood contact	State Board of Health		41-39-13	Neither; the State Dept. of Health carries out this responsibility	
Prescribe regulations regarding the manner and detail in which the transmission of an infectious disease from patient to provider must be reported.	State Board of Health		41-23-41	Neither; the State Dept. of Health carries out this responsibility	
Establish program in the area of food, vector control, and general sanitation	State Dept. of Health		41-3-15(5)(a)(xi)	Authorized	
Epidemiology					
Adopt rules and regulations defining and classifying communicable diseases and other diseases that are a danger to health based upon the characteristics of the disease; establish reporting, monitoring and preventive procedures for those diseases	Epidemiology		41-23-1	Mandated	· Monitor the occurrence of and trends in reportable diseases statewide; · Investigate outbreaks/clusters of disease/illness; · Provide direct disease intervention for specific illnesses; · Respond to individual requests concerning communicable disease control and prevention, environmental epidemiology, indoor air quality, and international travel requirements.
Establish rules by which exceptions may be made regarding the confidentiality of an individual's infection with Class 1 or 2 disease, when exposure is indicated or there exists a public health threat	Epidemiology		41-23-1	Authorized	
Investigate and control the causes of epidemics	Epidemiology		41-23-5	Authorized	
Report inflammation of the eyes of newborn (by physician, parent, relative, etc.) to local health officer within six hours of first discovery	Epidemiology		41-35-3	Mandated	
Investigate and report (by local health officer) inflammation of the eyes to the State Board of Health	Epidemiology		41-35-5	Mandated	
Enforce provisions of MISS. CODE ANN. Ch. 41-35 (inflammation of the eyes); promulgate necessary rules and regulations; provide a scientific prophylactic for condition; provide, if necessary, daily inspection and treatment; publish information regarding dangers of condition; furnish copies of Ch. 41-35 to all physicians, etc.; keep proper record of cases; report violations of chapter.	Epidemiology		41-35-7	Mandated	
Relax restrictions regarding the use of lures or sound devices during hunting when people or livestock are endangered.	Epidemiology	Wildlife, Fisheries, and Parks	41-7-33	Authorized	
Declare a nuisance the existence of any matter or thing calculated to produce, aggravate, or cause the spread of a communicable disease, or to injuriously affect the public health of the community.	Epidemiology, District Health Officers		41-23-13	Authorized	

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Vaccinate all dogs or cats over the age of 3 months for rabies (duty of owner) -- to be vaccinated by licensed veterinarian or other competent person granted a permit by SBH to perform vaccinations; Destroy any un-owned dog over 3 months who does not have a tag and collar (duty of sheriff, etc.)	Epidemiology, General Environmental Services	Board of Animal Health	41-53-1 41-53-5 41-53-11	Mandated	
Eradicate rabies among foxes in any county when SBH or Game and Fish Commission determine the disease is prevalent in county or district.	Epidemiology, General Environmental Services	Board of Animal Health	49-5-37	Authorized	
Deal with all contagious and infectious diseases of animals -- including authority to enter premises to inspect and disinfect (with proper permission)	Epidemiology, General Environmental Services	Board of Animal Health	69-15-9	Authorized	
Immunization					
Charge and collect reasonable fees for immunizations; inspect children's records	Immunization Division		41-3-15 (4)(f) 41-23-37	Authorized	· Administer vaccines; · Monitor immunization levels and enforcement of immunization laws; · Conduct disease surveillance and outbreak control; · Inform and educate the public.
Assure that children in the state are appropriately immunized against vaccine-preventable diseases; establish a statewide childhood immunization registry (make information regarding the immunization status of these children available to parents and physicians); issue certificate of vaccination; promulgate rules and regulations	Immunization Division		41-88-3 41-23-37	Mandated	
Sexually Transmitted Diseases					
Provide physical examination and inspection of any person suspected of being afflicted with infectious sexually transmitted disease; provide testing for and treatment of sexually transmitted disease	Office of Community Health Services		41-23-29, 41-23-30	Mandated	· Conduct comprehensive epidemiology; · Interview, counsel, and screen high-risk populations for asymptomatic sexually transmitted disease and infections; · Insure that all individuals with a positive laboratory test are followed for treatment and partner elicitation/notification; · Implement education programs directed toward the general public and population at risk, creating an awareness of sexually transmitted disease as well as preventative measures available; · Ensure that proper uniform standards of health care are available to all persons in need in the public and private medical community.
Isolate, quarantine or otherwise confine, intern, and treat person afflicted with infectious sexually transmitted disease	STD/HIV Division		41-23-27	Authorized	· Provide, through 100% federal funding, prevention services, field services, surveillance, and care services; · Coordinate services provided by coalitions, state and federal agencies, and voluntary organizations with HIV/AIDS-related missions; · Assist district and local health department staffs to develop, implement, and evaluate HIV/AIDS goals and objectives
Perform syphilis test as a prerequisite to obtaining a marriage license	STD/HIV Division		93-1-5(e)	Mandated	
Treat persons infected with sexually transmitted diseases; pass rules and regulations regarding treatment; examine and inspect persons suspected of being afflicted with sexually transmitted disease; treat minors without parental consent	Family Planning, Perinatal Services, STD/HIV Division		41-23-27, 41-23-29, 41-41-13, 41-3-15 (5)(a)(v)	Authorized	· Provide prevention services through MSDH clinics, at no cost to the public, such as counseling, testing, partner notification, referral to available care and services, and health education/risk reduction training. Mississippi is one of eight states selected to participate in a program to evaluate the effect of HIV/AIDS referral to care and services on AIDS patient outcomes.

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Tuberculosis					
Require anyone believed by the county health officer to have active tuberculosis to submit to a medical examination	Tuberculosis Control Division		41-33-15	Mandated	· Provide early and rapid detection of persons with or at risk of developing TB; · Provide appropriate treatment and follow-up of diagnosed cases of TB; · Provide preventative therapy to persons at risk of developing the disease; · Provide technical assistance to public and private agencies and institutions, particularly in high-risk health care settings or institutional settings such as hospitals, nursing homes, mental institutions, and penal institutions; · Work with the public and private medical sectors to assist in promoting the latest models and methodologies of TB treatment and follow-up.
Commit any person who has been diagnosed with active TB and who fails to carry out minimum precautions to hospital until the person will carry out suitable precautions	Tuberculosis Control Division		41-33-3	Authorized	
Cancer Prevention					
Establish and maintain central cancer registry for the state; execute contracts, record and analyze data, compile and publish statistical studies, obtain federal funds, receive and use gifts.	Cancer Program/ Epidemiology		41-91-5 41-91-7	Authorized	· Designed to collect 100% of the expected cases of invasive cancer occurring in Mississippi residents in a diagnosis year. State statutes mandate the reporting of cancer data from clinical laboratories, hospitals, physician offices, cancer treatment centers, and other health care providers. · Screen and treat cervical cancer in women of reproductive age. Twelve county health departments hold dysplasia clinics and perform colposcopies, directed biopsies, and cryosurgery. The program also reimburses patients with dysplasia or cancerous conditions for diagnostic services and has a limited amount of free medication available for the treatment of breast cancer. · Provide public education, as requested
Maintain accurate, precise, and current information for cancer registry; keep identity of patients confidential	Cancer Program/ Epidemiology		41-91-5 41-91-11	Mandated	
Domestic Violence/Rape Prevention and Crisis Intervention	Domestic Violence/ Rape Crisis				· Contract with 12 domestic violence shelters which provide direct services to victims of domestic violence, including their children, and provide a public education campaign with regard to domestic violence and the impact that can be made on the cycle of violence. · Contract with 8 rape prevention and crisis intervention programs which provide direct services to victims of rape and sexual assault and provide a public awareness campaign aimed at reducing the incidence of sexual assault and rape through a variety of media. Special target populations include: colleges, senior citizen groups, and professionals having contact with victims of assault, adult survivors, and children.

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Public Health Statistics					
Establish a Bureau of Vital Statistics	Vital Statistics		41-57-1 41-3-15 (5)(a)(xiv)	Mandated Authorized	· Provides a system of vital and health statistics for use at the local, district, state, and federal levels; · Provides vital records services to the general public; · Administers and analyzes MSDH's time study which is used in cost allocations and agency management; · Provides quality control for all MSDH statistical materials other than epidemiologic studies, and serves as a consultant on surveys and studies initiated by the agency; · Provides copies of birth and infant death records, a listing of births at risk for postneonatal deaths, and all SIDS deaths to the MCH program for distribution to the district and county nurses for follow-up or appropriate action; · Generates special statistical reports on a routine schedule for various MSDH programs.
Enter into agreements with municipalities regarding regulations concerning the collection of vital statistics	Vital Statistics		41-3-57	Authorized	
Exempt access to vital statistics records to those parties without a legitimate and tangible interest in such records; exempt certain licensure application and examination records from public access requirements.	Vital Statistics		41-57-2, 73-52-1	Mandated	
Health Promotion/ Education					
Grant permission for any state agency to establish a wellness/exercise program for employees	Division of Health Promotion		41-97-3	Neither; the State Board of Health performs this responsibility	
Establish a school nurse intervention program within the State Dept. of Health	Division of Health Promotion		41-79-1 to 41-79-5	Neither; this program has been established within the Dept. of Health	
Enter into agreements and joint programs with various local entities in order to carry out such health education programs (the school nurse intervention program).	State Board of Health		37-13-21	Authorized	· Coordinates population-based intervention (e.g., tobacco prevention and control, injury/violence prevention, promotion of physical activity) in health care settings, worksites, communities, and schools. · Contractors coordinate a health promotion clearinghouse, local tobacco initiatives, and conduct training at the district and local level; · Provide technical assistance to MSDH districts and programs, communities, schools, worksites, and individuals on smoking prevention and control policies/practices; · Serve on a regional tobacco control network and as liaison to state, federal, voluntary, and non-profit agencies; · Coordinate functions of the Mississippi Tobacco-Free 2000 Coalition, whose mission is to accomplish Year 2000 goals related to tobacco prevention.
Health Care Planning, Systems Development, and Licensure					
Health Planning and Certificate of Need					
Determine whether applicant for certificate of authority for the establishment and operation of a health maintenance organization has complied with policies and procedures as dictated by law	Licensure and Certification, State Health Officer	Dept. of Insurance, Division of Medicaid	83-41-305, 83-41-307, 83-41-313	Mandated	

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Consult with Commissioner of Insurance to approve the grievance procedure for enrollees (covered individuals) established and maintained by each health maintenance organization	License and Certification, State Health Officer	Dept. of Insurance, Division of Medicaid	83-41-321	Mandated	
Examine grievance procedures of, quality assurance programs of, and administer oaths to health maintenance organizations	Licensure and Certification, State Health Officer	Dept. of Insurance, Division of Medicaid	83-41-321, 83-41-337	Authorized	
Impose penalties for violations on health maintenance organizations	Licensure and Certification, State Health Officer	Dept. of Insurance, Division of Medicaid	83-41-349	Authorized	
Contract with qualified persons to make recommendations concerning the determinations required by state health officer (regarding health maintenance organizations)	Licensure and Certification, State Health Officer	Dept. of Insurance, Division of Medicaid	83-41-357	Authorized	
Develop and implement a statewide health certificate of need program	Planning Division		41-7-187	Authorized	
Administer and supervise all responsibilities of the state health planning and development agency	Planning and Resource Development		41-7-173, 41-7-185	Mandated	· Identify priority health needs; · Inventory available health facilities, services and personnel; · Recommend corrective actions; · Establish criteria and standards for Certificate of Need (CON) review (access, quality, and cost); · Conduct CON review of proposals for health facilities and services.
Primary Care Development					
Establish dental health program	Dental Health Program		41-3-15 (5)(a)(viii)	Authorized	
Rural Health Care Development					
Establish office of Rural Health	Rural Health		41-3-15(2)	Authorized	· Address rural health care needs of the state; · Serve as an information clearinghouse for rural health issues and activities; · Monitor rural health conditions and needs; · Engage in rural health planning and policy development; · Provide technical assistance; · Assist with rural health workforce retention and recruitment.
Collect and evaluate data on rural health conditions; develop and analyze policy and plans	Rural Health		41-3-15(2)	Mandated	
Emergency Medical Services					
Establish EMS program; regulate and license emergency medical services and technicians	Emergency Medical Service Division		41-59-5	Mandated	· Conduct EMS driver training; · Coordinate basic and advanced EMT training programs; · Certify all EMS personnel; · License public and private ambulance services; · Coordinate and monitor the state EMS regionalization effort; · Maintain a statewide record keeping program; · Serve as a liaison between the MSDH and the MS Emergency Management Agency (MEMA);
Promulgate and enforce rules and regulations to provide for the best emergency medical care and to comply with national standards	Emergency Medical Service Division, State Board of Health		41-60-13	Authorized	
Create, implement, and manage the statewide trauma care system	Emergency Medical Service Division		41-59-5	Mandated	· Monitor the occurrence (both in-state and out-of-state) and cause of spinal cord injuries and traumatic brain injuries among Mississippi residents; · Develop, implement, promote and evaluate injury prevention strategies.
Health Facilities Licensure					
Provide health materials to women considering an abortion including characteristics of an unborn child and alternatives to abortion; regulate abortion facilities.	State Dept. of Health, Licensure and Certification		41-41-31 to 41-41-39; 41-75-1 to 41-75-29; 41-41-51 to 41-41-63	Mandated	
Regulate ambulatory surgical facilities	State Dept. of Health, Licensure and Certification		41-75-1 to 41-75-29	Mandated	

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Regulate birthing centers	Licensure and Certification		41-77-1 to 41-77-25	Mandated	
Grant/deny license to birthing centers	Licensure and Certification		41-77-9, 41-77-19	Authorized	
Regulate and supervise nonprofit dental service corporations	Licensure and Certification		83-43-7	Mandated	
License and certify nonprofit dental service corporations	Licensure and Certification		83-43-9	Authorized	
Issue license to home health agencies upon compliance with provision of the law; regulate home health agencies	Bureau of Home Health, Licensure and Certification		41-71-1 to 41-71-21	Mandated	
License, regulate, and inspect hospices	Licensure and Certification		41-85-1	Mandated	
Regulate and license hospitals and nursing homes	Licensure and Certification		41-9-1 to 41-9-65	Mandated	· Certify health care facilities for participation in the Medicare and Medicaid program through periodic inspections and certify admission to and continued stay in a nursing home for Medicaid patients; · License institutions for the aged or infirm, hospitals, home health agencies, ambulatory surgical centers, hospices, utilization review agents, abortion facilities, and birthing centers.
Provide continuing education for member of boards of trustees of hospitals who bear legal responsibility for the operation of such hospitals	Licensure and Certification		41-7-140	Mandated	
Issue certificate to applicant (agent) that has met requirements associated with the "Utilization Review of Availability of Hospital Resources and Medical Services;" adopt rules and regulations to implement provisions.	Licensure and Certification		41-83-3	Mandated	
Issue and renew licenses for aged or infirm institutions and personal care homes to those places meeting the requirements as dictated by law; enforce rules and regulations; make inspections; prepare annual report of its activities and operations	Licensure and Certification		43-11-9, 43-11-13, 43-11-17, 43-11-21	Mandated	
Regulate child care facilities; require that a background check be performed on any childcare facility owner or resident; require inspections of facility to be made	Childcare Licensure		43-20-8, 43-20-15	Mandated	
Issue or deny license of child care facility	Childcare Licensure		43-20-8	Authorized	
Receive annual report from the Office of the State Long-term Care Facilities Ombudsman regarding long-term care facilities	Licensure and Certification		43-7-57	Mandated	
Professional Licensure					
Regulate licensure of athletic trainers	Professional Licensure		73-55-1 to 73-55-21	Mandated	· License speech-language pathologists, audiologists, dietitians, hearing aid dealers, occupational therapists and assistants, physical therapy and assistants, respiratory care practitioners, and athletic trainers; · Certify eye nucleators; · Register audiology aides, apprentice athletic trainers, speech-language pathology aides, radiation technologists, tattoo artists, and tattoo parlors.
Regulate and license dietitians	Professional Licensure, State Board of Health		73-10-21	Mandated	
Examine, license, and regulate hearing aid dealers	Professional Licensure, State Board of Health		73-14-1	Mandated	
Examine, license, and regulate persons who provide services of occupational therapy	Professional Licensure, State Board of Health		73-24-5	Mandated	
Regulate physical therapy practice	Professional Licensure, State Dept. of Health		73-23-31	Authorized	
Appoint members of Respiratory Advisory Council; examine, license, and renew the license of duly qualified applicants of respiratory care practice; maintain up-to-date list of all licensed individuals; determine job functions; prosecute violators; maintain up-to-date list of all individuals with suspended licenses.	Professional Licensure, State Board of Health		73-57-7, 73-57-11	Mandated	
Examine, license, and regulate persons who provide services in the areas of speech-language pathology and audiology	Professional Licensure, State Board of Health		73-38-1	Mandated	
Examine, license, and regulate persons who perform body piercing	Professional Licensure, State Board of Health		73-51-1	Mandated	
Examine, license, and regulate professional art therapists	Professional Licensure, State Board of Health				

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Promulgate rules and regulations relating to sanitation, sterilization, and disease prevention within the facilities or premises in which tattooing is performed or to be performed	General Environmental Services, District Epidemiology Nurses, Professional Licensure, State Board of Health		73-61-1	Mandated	
Ensure compliance with tattooing requirements by visiting any facility or premises in which tattooing is performed	General Environmental Services, District Epidemiology Nurses, Professional Licensure, State Board of Health		73-61-1	Authorized	
Promulgate and regulate necessary rules to provide for the proper certification of funeral service licensees and for enucleation of eyes	Professional Licensure, State Board of Health		41-39-11	Mandated	
Childcare Facility Licensure					
License child care facilities	Childcare Licensure		41-3-15 (5)(a)(vi)	Authorized	· License child care facilities, kindergarten programs, school age extended day care programs, youth camps, and summer day camps and maintain records on residential child care homes.
Promulgate rules and regulations concerning youth camp safety and health	General Environmental Services, Childcare Licensure		75-74-1 to 75-74-17	Authorized	
Report abused or neglected children to the Dept. of Human Services	Childcare Licensure		43-21-353	Mandated	
Offer opportunity for any person maintaining a family child care home to register such home; suspend, deny, revoke, or refuse to renew certificate of registration	Childcare Licensure		43-20-59, 43-20-61, 43-20-63	Authorized	
Issue certificate of registration to childcare (family) homes which seek registration and meet requirements dictated by law; adopt rules and regulations.	Childcare Licensure		43-20-63	Mandated	
Issue acknowledgment of notification (for beginning operation of a child residential home) upon the filing of a properly completed notification form; provide copies of the notification form to the chancery court or the youth court of the county; make health inspection once per year; enforce notification requirements.	Childcare Licensure		43-16-7, 43-16-11, 43-16-15, 4-16-19	Mandated	
Support Services					
Submit budget to Medicaid agency	Administration and Technical Support		43-13-111	Mandated	
Appoint county health officer for each county	State Health Officer/ State Board of Health		41-3-37	Mandated	
Remove county health officer for improper conduct	State Health Officer/ State Board of Health		41-3-45	Authorized	
Contract with the Mississippi State Medical Association for the purpose of establishing a statewide program for providing needed medical services at no charge to persons who have no form of health insurance and are unable to pay.	State Dept. of Health/ District Offices of MSDH		41-3-101	Authorized	
Petition a circuit judge, chancellor, or county judge to perform autopsy on the body of deceased person in order to determine if the cause of death was due to a communicable disease	Exec. Officer of Board of Health/ county health officer		41-37-23	Authorized	
Receive medical information about patients even though patient has a medical privilege	State Board of Health, county health department, all departments within the agency		13-1-21, 41-41-11	Authorized	
Provide hearing for physician regarding the suspension of license	State Board of Health		73-25-63	Authorized	
MSDH Representation on Boards and Committees					
Big Black River Basin District, health director is appointed to	Represented by Keith Allen, district environmentalist		51-17-5		

Appendix C
State and Local Government Responsibilities for Public Health Mandated or Authorized by MS Law

Board of Health, general duties, organization, report to Governor, rules and regulations, and violations	State Health Officer's Staff		41-3-1 to 41-3-59
Chiropractor Board of Examiners, member of	State Health Officer or designee		73-6-3 to 73-6-19
MARIS, Mississippi Automated Resource Information System, serve on policy committee	Dr. David Lohrisch coordinates for MSDH (IS)		57-13-23
Mosquito control, director BOH member of	Director, BOH		41-27-1 to 41-27-133
Natural Resources Department, environmental health director member to serve on permit board	Rick Herrington represents MSDH		49-17-28
Nuclear waste technical review committee, health officer a member of	Bob Goff, a district environmentalist, represents MSDH		57-49-11
Pearl River Valley Water Supply District, director appointed to	Board of Health		51-9-107
Tombigbee River Valley Water Management District, director appointed to board	Jesse Shields - District II environmentalist to represent MSDH		51-13-105 (b)
Public Health Services maintained by other agencies			
Air quality control		Department of Environmental Quality	49-17-1 et. seq.
Alcoholics and drug addicts, commitment of		Department of Mental Health	41-31-5
Child services, for abused and neglected children		Department of Human Services	43-15-1 43-21-1 43-27-1
Drug rehabilitation programs, may conduct		Department of Mental Health	41-29-150
Hazardous waste management		Department of Environmental Quality	17-17-53
Nursing		Board of Nursing	73-15-1 to 73-15-35
Occupational health and safety program		Transferred to Workers' Comp, then to Cooperative Extension	71-1-1 to 71-1-53 and 41-3-15 (5)(a)(x)
Medical examiner act, rules and regulations		State Medical Examiner's Office	41-61-59
Social workers, licensure		Social Worker Licensure Board	73-53-11
Chiropractor Board of Examiners, health examination of qualifications		Board of Chiropractors	73-6-13
Controlled substances, scheduling of	Pharmacy (advisory)	Bureau of Narcotics	49-29-111 41-29-111
Solid waste management		Department of Environmental Quality	DEQ-17-17-1 et. seq.
Dentists		State Board of Dental Examiners	73-9-1
Nursing Home Administrators		Board of Nursing Home Administrators	73-17-1
Optometry		Board of Optometry	73-19-1
Pharmacists		Board of Pharmacy	73-21-75
Physicians		State Board of Medical Licensure	73-25-1 73-43-1
Podiatrists		State Board of Medical Licensure	73-27-1
Licensed Professional Counselors		State Board of Examiners for Licensed Professional Counselors	73-30-1
Psychologists		State Board of Psychological Examiners	73-31-5
Veterinarians		Board of Veterinary Medicine	73-39-1

Appendix D
FY 1999 Actual Expenditures by Program

Program	State	Federal	Other	Total
Maternal and Child Health				
Family Planning	$4,636,639	**$7,231,225**	$6,893,281	$18,761,145
Women, Infants, & Children	$3,352,845	**$46,645,422**	$3,311,846	$53,310,113
Infant and Toddler	$2,388,164	**$4,017,421**	$342,696	$6,748,281
Maternity	$2,040,903	$2,752,052	**$3,913,263**	$8,706,218
Child Health	**$1,632,854**	$1,628,069	$1,529,075	$4,789,998
Child Medical Program	$1,189,843	**$2,759,988**	$2,067,978	$6,017,809
Total	$15,241,248	**$65,034,177**	$18,058,139	$98,333,564
Disease Control				
Immunization	$2,763,861	**$3,024,464**	$2,006,118	$7,794,443
Tuberculosis	**$2,433,359**	$1,214,329	$895,676	$4,543,364
Sexually Transmitted Diseases	**$2,041,243**	$1,864,612	$529,385	$4,435,240
AIDS	$1,068,380	**$5,541,939**	$128,567	$6,738,886
Epidemiology	$844,157	**$1,414,365**	$561,975	$2,820,497
Health Statistics	$403,374	$109,162	**$2,834,697**	$3,347,233
Cancer	$176,073	**$549,097**	$56,390	$781,560
Health Promotion	$97,217	$1,047,965	**$2,872,336**	$4,017,518
Domestic Violence	$11,085	**$994,821**	$304,269	$1,310,175
Total	$9,838,749	**$15,760,754**	$10,189,413	$35,788,916
Environmental Health				
General	**$3,109,873**	$64,725	$1,537,955	$4,712,553
Food	**$1,073,727**	$0	$730,439	$1,804,166
Milk	**$809,402**	$44,163	$164,549	$1,018,114
Water	$455,855	$1,181,210	**$1,305,654**	$2,942,719
Radiological Health	$236,314	$131,180	**$718,647**	$1,086,141
Boiler & Pressure Vessel	$35,547	$0	**$322,514**	$358,061
Total	**$5,720,718**	$1,421,278	$4,779,758	$11,921,754
Support Services	**$4,986,083**	$2,956,822	$4,234,104	$12,177,009
Chronic Illness				
Home Health	$969,448	$0	**$6,936,094**	$7,905,542
Hypertension	$140,728	**$179,878**	$136,859	$457,465
Diabetes	$109,996	**$229,452**	$49,035	$388,483
Total	$1,220,172	$409,330	**$7,121,988**	$8,751,490
Licensure and Research Development				
Emergency Medical Services	$341,193	$114,048	**$2,127,857**	$2,583,098
Child Care Licensure	$107,298	**$865,537**	$157,513	$1,130,348
Health Care Planning	$57,456	$244,006	**$624,618**	$926,080
Health Care Licensure	$0	**$3,013,162**	$437,269	$3,450,431
Professional Licensure	$0	$0	**$303,974**	$303,974
Total	$505,947	**$4,236,753**	$3,651,231	$8,393,931
TOTAL	$37,512,917	$89,819,114	$48,034,633	$175,366,664

SOURCE: MSDH Expenditure Analysis

Note: Program and subprogram data are sorted in descending order by general funds expenditure. The largest revenue source is highlighted for each program and subprogram.

Appendix E:

Mississippi Deaprtment of Health
Federal Grants

	Match Federal/State	*Actual $ Income FY99*	*Estimated $ Income FY2000*
Infants and Toddlers		3,882,621	3,461,456
Child Care Development Block Grant		846,509	1,000,000
Water Supply	75 /25	1,194,546	1,320,924
Sexually Transmitted Disease		1,246,668	1,056,939
Immunization		2,830,576	1,911,711
Preventive Health Services Block Grant		2,454,377	2,653,242
Maternal and Child Health Block Grant	57 /43	9,532,399	10,794,759
Family Planning Title X		3,913,955	4,146,953
Maternal and Child Health Abstinence Education	57 /43	379,337	1,062,752
Maternal and Child Health Categorical Grants			
Hemoglobinopathy		117,181	100,000
State System Development Initiative		115,152	39,910
Family Violence Prevention	50 /50	500,371	594,365
Breast and Cervical Cancer	75 /25	147,370	690,931
FIMR		86,694	160,229
Family Planning SSBG	75 /25	363,725	556,275
TEAM		57,315	59,683
AIDS Grants			
HOPWA		682,801	769,000
AIDS Ryan White Care		3,337,872	4,995,545
AIDS Prevention		1,810,514	1,667,592
AIDS Surveillance		257,367	220,000
Environmental			
EPA- Radon	50 /50	30,990	45,000
DOE- Tatum Dome Oversight		74,391	131,686
Family Day Care Home Inspection		62,025	60,000
DEQ Wastewater Systems Training		16,504	0
Health Care Licensure			
OASIS		3,344	33,351
CLIA		164,459	250,000
HC- Title XVIII		1,311,496	1,314,200
HC-Title XIX		1,552,133	1,618,702
Wedge		2,635	33,894
WIC			
WIC Certification		7,956,907	7,900,000
WIC Administration		7,464,311	10,370,278
WIC Breastfeeding Grant		97,449	118,625
WIC Food and Warehouse		35,818,020	43,974,868
Other			
Rural Health	25 /75	18,044	41,000
Indirect Cost		84	0
MISHIN		11,261	0
EMSC Planning Grant		56,704	50,000
HOP Clearinghouse		27,588	30,000
EMS Highway Safety		62,325	51,500
Tobacco Control		342,237	350,000
Cardiovascular Disease		35,236	325,000
Fire Injury Prevention		42,083	142,292
BLS Annual Survey	50 /50	12,266	14,700
DOL Data Collection	50 /50	13819	16,612
Diabetes Prevention		229,583	258,913
Surveillance Hazardous Substance Events		58,462	65,825
Cancer Registry		225,085	352,924
TB Project		920,219	1,166,819
BRFSS Chronic Disease Prevention		67,170	75,654
Methyl Parathion		50,884	0
Primary Care		195,339	140,347
NHSC Search		10,307	145,000
Injury Intervention		44,429	74,937
	Totals	90,735,139	106,414,393

SOURCE: MSDH FY2001 Budget Request

Appendix F
Nationally Notifiable Diseases as designated by the Centers for Disease Control

AIDS	E.Coli	Lyme disease	Rubella
Anthrax	Gonorrhea	Malaria	Salmonellosis
Botulism	Haemophilius influenzae	Measles (rubeola)	Shigellosis
Brucellosis	(invasive disease)	Meningoccocal disease (2)	Streptococcus disease
Chancroid	Hansen disease (leprosy)	Mumps	Syphilis
Chlamydia	Hantavirus pulmonary syndrome	Pertussis (whooping cough)	Tetanus
Cholera	Hemolytic uremic syndrome	Plague	Toxic-shock syndrome
Coccidioidomycosis	Hepatitis A	Poliomyelitis, paralytic	Trichinosis
Cryptosporidiosis	Hepatitis (other) (1)	Psittacosis	Tuberculosis
Diptheria	HIV infection	Rabies	Typhoid Fever
Encephalitis	Legionellosis	Rocky Mountain Spotted Fever	Yellow Fever

1. Includes Hepatitis B, C, non-A, and non-B
2. Also known as "neissera meningitidis" and is what causes meningitis

SOURCE: Centers for Disease Control

Appendix G
Mississippi 1997 Status in Comparison with Healthy People 2000 National Objective

Rates and Objectives for Negative Indicators (where a high ranking is considered bad)

		Healthy People 2000 Objective (goal)	MS 1997 Rate/ Status	Percent Deviation From Objective
1	**Physical Activity and Fitness**			
1.1	Coronary Heart Disease- per 100,000	100.0	129.4	29%
1.1a	***Coronary Heart Disease for Blacks- per 100,000***	***115.0***	***168.1***	***46%***
1.2	Reduce prevalence of overweight adults (based on BMI)	20%	34%	70%
1.5	No leisure-time activity (prevalence of physical activity)- 1996	15%	40%	167%
2	**Nutrition**			
2.2	Cancer Deaths- per 100,000	130.0	140.7	8%
3	**Tobacco**			
3.2	Lung Cancer Deaths- per 100,000	42.0	45.7	9%
3.3	Chronic Obstructive Pulmonary Disease Death- per 100,000	25.0	22.5	-10%
3.4	Cigarette Smoking	15%	23%	53%
3.4a	***Cigarette Smoking with a high school education or less***	***20%***	***28%***	***40%***
3.4d	***Cigarette smoking Blacks Aged 20 and Older***	***18%***	***18%***	***0%***
4	**Alcohol and Other Drugs**			
4.1	Alcohol-related Motor Vehicle Crash Deaths per 100,000	8.5	30.7	261%
4.1b	***Alcohol-related Motor Vehicle Crash Deaths for people aged 15-24- per 100,000***	***18.0***	***47.4***	***163%***
4.2	Cirrhosis Deaths- per 100,000	6.0	7.6	27%
4.2a	***Cirrhosis Deaths for Black males- per 100,000***	***12.0***	***9.1***	***-24%***
4.3	Drug-related Deaths- per 100,000	3.0	2.3	-23%
5	**Family Planning**			
5.1	Pregnancies 15-17 years old per 1,000*	50	63.1	26%
5.1a	***Black Pregnancies 15- 19 years old per 1,000***	***120***	***113.1***	***-6%***
6	**Mental Health and Mental Disorders**			
6.1	Suicides per 100,000	10.5	11.6	10%
6.1a	***Suicides for 15-19 year olds per 100,000***	***8.2***	***11.8***	***44%***
6.1b	***Suicides for men 20-34 years old- per 100,000***	***21.4***	***22.5***	***5%***
6.1c	***Suicides for white men 65+ years old per- 100,000***	***39.2***	***55.9***	***43%***
7	**Violent and Abusive Behavior**			
7.1	Homicides- per 100,000	7.2	14.6	103%
7.1a	***Homicide children ages 3 years old and younger- per 100,000***	***3.1***	***6.4***	***106%***
7.1c	***Homicide Black males 15-34 years old per 100,000***	***72.4***	***82.2***	***14%***
7.1e	***Homicide Black females 15-34 years old per 100,000***	***16***	***14.7***	***-8%***
7.3	Weapons related violent deaths- per 100,000	12.6	22.2	76%
9	**Unintentional Injuries**			
9.1	Unintentional Injury Deaths- per 100,000	29.3	50.6	73%
9.1b	***Unintentional Injury Deaths for Black males- per 100,0***	***51.9***	***85.9***	***66%***
9.1c	***Unintentional Injury Deaths for White males- per 100,000***	***42.9***	***74***	***72%***
9.3	Unintentional Injury Deaths related to Motor Vehicle Crashes- per 100,000	16.8	31	85%
9.3a	***Unintentional Injury Deaths related to Motor Vehicle Crashes 14 years old and younger- per 100,000***	***5.5***	***9.8***	***78%***
9.3b	***Unintentional Injury Deaths related to Motor Vehicle Crashes youth aged 15-24- per 100,000***	***33***	***47.6***	***44%***
9.3c	***Unintentional Injury Deaths related to Motor Vehicle Crashes people age 70+ per 100,000***	***20***	***46.2***	***131%***
9.3e	***Motorcyclist deaths caused by Motor Vehicle Crashes per- 100,000***	***1.5***	***0.4***	***-73%***

9.4	Falls and Fall-related Deaths- per 100,000	2.3	3.3	43%
9.4a	***Falls and Fall-related Deaths 64 - 84 years old- per 100,000***	***14.4***	***26.6***	***85%***
9.4b	***Falls and Fall-related Deaths 85+ years old- per 100,000***	***105***	***177.8***	***69%***
9.4c	***Falls and Fall-related Deaths Black males 30-69 years old- per 100,000***	***5.6***	***7***	***25%***
9.5	Drowning Deaths- per 100,000	1.3	2.7	108%
9.5a	***Drowning Deaths aged 4 and younger- per 100,000***	***2.3***	***3***	***30%***
9.5b	***Drowning Deaths males 15-34 years old - per 100,000***	***2.5***	***5.9***	***136%***
9.5c	***Drowning Deaths Black males- per 100,000***	***3.6***	***5.6***	***56%***
9.6	Fire Deaths- per 100,000	1.2	3.3	175%
9.6a	***Fire Deaths aged 4 and younger- per 100,000***	***3.3***	***10.9***	***230%***
9.6b	***Fire Deaths 65 years and older- per 100,000***	***3.3***	***11.7***	***255%***
9.6c	***Fire Deaths Black males- per 100,000***	***4.3***	***7.6***	***77%***
9.6d	***Fire Deaths Black females- per 100,000***	***2.6***	***7.7***	***196%***
13	**Oral Health**			
13.7	***Oral Cavity and Pharynx Cancer Deaths males 45-74 per 100,000***	***10.5***	***12.1***	***15%***
	Oral Cavity and Pharynx Cancer Deaths females 45-74 per 100,000	***4.1***	***3.3***	***-20%***
14	**Maternal and Infant Health**			
14.1	Infant Mortality rate- per 1,000 live births	7	10.6	51%
14.1a	***Black Infant Mortality rate- per 1,000 live births***	***11***	***14.8***	***35%***
14.1d	***Neonatal Mortality Rate- per 1,000 live births***	***4.5***	***6.5***	***44%***
14.1e	***Black Neonatal Mortality rate- per 1,000 live births***	***7***	***9***	***29%***
14.1g	***Postneonatal mortality rate per- 1,000 live births***	***2.5***	***4.1***	***64%***
14.1h	***Black Postneonatal mortality rate- per 1,000 live births***	***4***	***5.8***	***45%***
14.2	Fetal Deaths- per 1,000 live births	5	12.4	148%
14.2a	***Black Fetal Deaths- per 1,000 live births***	***7.5***	***18.4***	***145%***
14.3	Maternal Mortality rate- per 100,000 live births	3.3	26.5	703%
14.3a	Black Maternal Mortality rate- per 100,000 live births	5	36.9	638%
14.5	Births of Low Birthweight (<2,500g.) as a percent of live births	5%	10.10%	102%
	Births of Very Low Birthweight (>1,500 g.) as a percent live births	***1%***	***2%***	***100%***
14.5a	***Black Births of Low Birthweight as a percent of live births***	***9%***	***13.40%***	***49%***
	Black Births of Very Low Birthweight as a percent of live births	***2%***	***2.80%***	***40%***
14.8	Cesarean Deliveries as a percent of live births	15%	26.10%	74%
15	**Strokes**			
15.2	Stroke Deaths- per 100,000	20	35.1	76%
15.2a	***Black Stroke Deaths- 100,000***	***27***	***52.8***	***96%***
16	**Cancer**			
16.3	Breast Cancer Deaths- per 100,000 females	20.6	20	-3%
16.4	Uterine Cervix Cancer Deaths- per 100,000 females	1.3	3.2	146%
16.5	Colorectal Cancer Deaths- per 100,000	13.2	12.3	-7%
17	**Diabetes and Chronic Disabling Conditions**			
17.9	Diabetes-related Deaths- per 100,000	38	50.2	32%
	Diabetes-related Deaths for Blacks- per 100,000	58	82.7	43%
19	**Sexually Transmitted Disease**			
19.1	Gonorrhea- per 100,000	225	337.5	50%
19.3	Primary and Secondary Syphilis- per 100,000	10	14.2	42%
20	**Immunization and Infectious Disease**			
20.3	Hepatitis A- per 100,000	23	3.2	-86%
20.4	Incidence of Tuberculosis- per 100,000	3.5	9	157%
20.7	Bacterial meningitis- per 100,000	4.7	2.6	-45%

* MS rate is for pregnancies 15-19 years old.

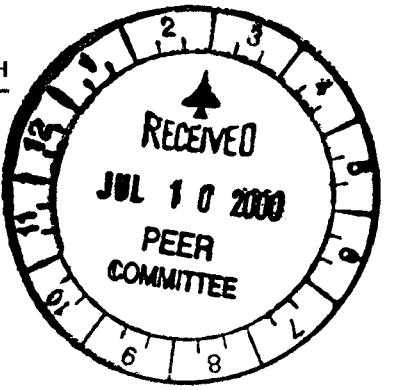
Rates and Objectives for Positive Indicators (where a low ranking is considered bad)

		Healthy People 2000 Objective/Goal	MS 1997 Rate/Status	
1	**Physical Activity and Fitness**			
1.3	Light to Moderate Physical Activity- 1996	30%	17%	-43%
1.4	Vigorous Physical Activity- 1996	20%	11%	-45%
9	**Unintentional Injuries**			
9.12	Safety Belt Usage	85%	57%	-33%
14	**Maternal and Infant Health**			
14.10	Abstinence from Tobacco Use as a percent of live births	90%	87.20%	-3%
	Abstinence from Alcohol Use as a percent of live births	95%	99%	4%
14.11	Prenatal Care- 1st Trimester as a percent of live births			
15	**Strokes**			
15.14	Cholesterol checked within the past 5 years (percent)	75%	60%	-20%
16	**Cancer**			
16.11	Ever received a CBE and mammogram (women age 40+)	80%	70%	-13%
16.12	Ever received a pap test (women age 18+)	95%	96%	1%
16.13	Ever had a proctosigmoidoscopy (person age 50+)	40%	35%	-13%
20	**Immunization and Infectious Disease**			
20.11	Influenza Immunization in the past 12 months (persor aged 65+)	60%	61%	2%
	Ever had a pneumococcal immunization (persons aged 65+)	60%	44%	-27%

SOURCE: MSDH

Agency Response

MISSISSIPPI STATE DEPARTMENT OF HEALTH



July 10, 2000

Max K. Arinder, PhD
Executive Director
Joint Committee on Performance Evaluation and Expenditure Review
P.O. Box 1204
Jackson, MS 39215-1204

Dear Dr. Arinder:

The Mississippi State Department of Health has reviewed the preliminary draft of PEER's report entitled "A Review of the Mississippi State Department of Health". We provided updated statistical information to the PEER staff at an exit conference on June 30. The purpose of this letter is to provide a response to the executive summary and recommendations as we reviewed them in draft form.

We appreciate the manner in which the review was conducted and are pleased that the draft report accurately reflects the basic functions and responsibilities of a state public health system. The draft report's recommendations are generally constructive, concrete, and practical. The review process has been beneficial to the Department, and, together with the report itself, will help us in making important improvements in several aspects of our operations. Despite the fact that the review required a year and a half and consumed a great deal of time on the part of PEER staff and our own, it was worth the effort.

We concur with the report's observation that protecting and promoting public health in Mississippi is a challenge given the state's demographics. We are pleased that the full text of the report reflects the work of an agency that has been successful in conducting those essential public health activities well, especially given the limited resources available.

Two general points that need clarification are addressed below. Then, since the recommendations for needed actions are relatively few, we have provided specific responses to each of them individually in Attachment B.

The report notes that the agency has received an increase in state general funds of $17.1 million over the past decade. PEER should be aware that most of those funds have been legislatively

F. E. Thompson, Jr., MD, MPH, State Health Officer

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earmarked for specific purposes. As you can see from the information in Attachment A, from FY 1994-1999 the Department received total earmarked funds of $14,743, 349. As PEER is aware, these funds are not available to the agency for purposes other than those stated in the respective appropriations bills. When these earmarked funds are subtracted from the $17.1 million, it becomes apparent that the Department has received only about $2.4 million in increased state funding in the past decade that was not earmarked for a specific purpose and unavailable for general operations.

PEER staff stated that their review of three MSDH regulatory programs identified "deficiencies in enforcement which compromise the ability of those programs to protect the public". While we agree that most of the identified deficiencies exist, and will move to correct them, the conclusion that the agency's ability to protect the public's health in these three programs has been compromised is unsupported by evidence contained in the report or elsewhere. The agency strives to ensure that, when choices have to be made regarding resource allocation, the most critical activities that serve to protect the public's health are conducted.

Specific responses to each of the recommendations are included in Attachment B. Please do not hesitate to contact me if you have questions or need additional information.

Sincerely,

F. E. Thompson Jr MD

F.E. Thompson, Jr., M.D., M.P.H.
State Health Officer

ATTACHMENT A

Mississippi Department of Health
Earmarked State Funds
FY1994-1999

Employee Salary Increases	5,477,817
Breast and Cervical Cancer Match	236,271
Infant Mortality Task Force	75,000
Lorenzo's Oil	50,000
AIDS	1,243,737
Travel Reimbursement Increase	131,386
Tort Claims Fund Assessment	575,000
Osteoporosis	50,000
Medicaid Match Funds	3,750,000
Infant and Toddler	3,154,138
Total	14,743,349
Total Increase	13,312,559

Note: During three fiscal years, 1996, 1997, and 1999, there were reductions to the State General Fund appropriated amount from the prior year. This served to reduce the amount of state funds available for ongoing operations. As a result the amount of earmarked funds received over the 6 fiscal years shown was greater than the net amount of increase actually contained in the appropriation bill after adjustment for the reductions. For the period noted in the PEER report, FY90-99, the total state fund increase cited is $17.2 million. The earmarked funds noted for FY94-99 above total $14.7 million.

ATTACHMENT B
RESPONSE TO PEER RECOMMENDATIONS
MISSISSIPPI STATE DEPARTMENT OF HEALTH
JULY 2000

Collection and Analysis of Public Health Data

1. To improve accuracy and timeliness in the reporting of communicable disease data, MSDH should:

a. facilitate reporting by printing the phone number, fax number, and MSDH's mailing address on Form 135, the form used to report communicable disease;

MSDH concurs with this recommendation and will implement it..

b. Investigate the possibility of online reporting of data;

MSDH staff have been considering this approach and will continue to pursue the potential.

c. add to Form 135 the date that the laboratory results were available, as this is a more accurate date to assess timeliness;

d. track, document, and contact every physician who reports more than 7 days after the stated deadline for all classes of communicable disease ro encourage more timely reporting;

e. identify physicians who rarely report communicable diseases and pro-actively contact a specified number per month to inform them of the reportable diseases and proper reporting procedures.

2. The Legislature should consider amending MS Code §41-32-1 to provide for several levels of penalties for late reporting and failure to report communicable diseases (e.g., suspension of license, revocation of license, $100 for the first violation, and $500 for the second violation.

The report contains no evidence that the accuracy of communicable disease surveillance data is problematic in any material sense. Allowing for the inherent limitations of any reportable disease surveillance system, it provides epidemiologically sound data adequate for disease monitoring and response.

MSDH concurs that methodologies to assess and improve the timeliness of reporting should be developed. 1(c.) and 1(d.) are likely to have a poor effort-to-gain ratio and may be counterproductive. 1(e.) and 2 may be potentially useful. These recommendations, along with other potential strategies to improve reporting timeliness, will be considered.

3. MSDH should add streptococcus disease and toxic shock syndrome to its list of reportable diseases since these diseases are on the CDC's nationally notifiable list and are not regional diseases.

No state has adopted all of the nationally notifiable diseases as their list of reportable diseases. Since disease patterns vary among populations, the reportable diseases are best identified by states for their specific population.

"Streptococcus disease" is not on the nationally notifiable disease list. Invasive group A streptococcal disease, invasive and drug-resistant *Streptococcus pneumoniae*, and streptococcal toxic shock syndrome are.

MSDH was already planning to add *Streptococcus pneumoniae* in children under 5 years of age to the list of reportable diseases since there is now a vaccine available for it. MSDH will consider adding drug resistant and invasive *Streptococcus pneumoniae* in all ages.

MSDH epidemiologists are evaluating the utility of adding invasive group A strep and toxic shock syndrome to the list.

4. To address the problem of MSDH not having chronic disease data, the Legislature should consider mandating hospitals to report discharge data to MSDH.

MSDH concurs with and strongly supports this recommendation.

5. MSDH should explore ways of improving the accuracy of reporting causes of death. For example, the Department might consider changing the death report

form to allow for more than one cause of death and should train doctors, funeral home directors, hospitals, and coroners in the importance of accurate reporting.

MSDH concurs that improving the accuracy of reporting cause of death is important. It is a chronic problem with death reporting in all states.

Changing the death reporting form would not be advisable. The MSDH death certificate form is the National Center for Health Statistics national death certificate. Standard reporting of deaths using the nationally approved form is critical to the validity of the system. The current form provides for the primary cause of death to be listed, along with a number of contributing causes. This is the most accurate means for obtaining cause of death information.

MSDH does agree that accuracy in utilizing the standard reporting form could be improved with training.

6. In order to improve the timeliness of vital statistics reporting, the Legislature should consider imposing penalties parallel to those established for the reporting of communicable diseases (see recommendation 2).

MSDH concurs that methodologies to assess and improve the timeliness of reporting should be developed. If the Legislature decides to pursue this recommendation, the MSDH will work with them on the most appropriate strategy.

Food Protection

7. MSDH should establish a maximum number of inspections a food establishment can fail within a given time frame, regardless of whether or not they pass followup inspections, before suspending their permit for a specified period of time.

MSDH believes this idea has significant merit. We will consider including it in the Food Service regulations.

8. MSDH should inspect food establishments with the frequency required by regulation and more strictly enforce policies governing the Certified Food Manager Program.

MSDH concurs that inspections should be done with the frequency specified by

regulation. We have repeatedly requested appropriation of funding for adequate staff to accomplish this, and will continue to do so.

With respect to the recommendation regarding more strict enforcement of the Certified Food Manager Program requirement, the Food Program Staff reminded the district staff about strict enforcement of this requirement in April 2000. The Food Program Staff are in the process of obtaining lists of all facilities in each county that are not in compliance so that appropriate followup can be done.

9. When conducting internal audits of the food protection sub-program, MSDH internal auditors, not the district, should select the counties to be evaluated and the files within the counties to be reviewed.

10. MSDH internal auditors should ensure correction of deficiencies cited in internal audit reports by continuing to followup until the deficiencies are corrected.

The procedures described in the body of the PEER report are not those of the internal audit staff, rather are those of the Field Services Quality Assurance team. The procedures are currently being reviewed for their effectiveness in assuring quality of the services provided at the county level. For the Food Protection program, the revised procedures will be conducted by a combination of Field Services staff and Food Protection Program staff, both at the state level.

Overall, with regard to food protection, MSDH food program staff will use the Retail Food Program Standards (national standards) as the criteria for program assessment/validation in all counties and districts. An assessment will be conducted at least once every two years in each district. The results of the food program assessment will be discussed with the District Environmentalist and District Health Officer at the conclusion of the assessment. A written report will be provided to the District Health Officer, and a response will be requested within 30 days.

The Food Program staff will work with the district staff to develop an acceptable plan of action whenever a deficiency is found and a standard is not being met. When deficiencies are noted, a followup review will be made within 60 days to assure that the deficiencies are corrected. If that followup visit reveals that the deficiencies have not been corrected in a satisfactory manner, a report will be issued to the State Health Officer indicating the status of the review. The State Health Officer will ensure appropriate followup from the District Health Officer.

Milk Sanitation

11. MSDH should update its Milk Plant inspection form to correspond with the Grade A pasteurized Milk Ordinance.

MSDH concurs with this recommendation and has begun work on this update.

Child Care Facility Licensure

12. MSDH should reallocate staffing resources in order to meet the NAEYC staffing standard for child care facility inspectors of a maximum of 75 facilities per inspector.

MSDH concurs that the staffing standard for child care inspectors should more nearly approach the NAEYC staffing standard. However, the reallocation of staff to accomplish this ratio is not feasible. It would require that staff positions be removed from other MSDH service delivery areas, potentially compromising those programs. MSDH is preparing a budget request for additional child care inspector positions in order to accomplish this objective.

13. MSDH should formalize its hearing process for violations of child care licensure regulations.

MSDH has a formal hearing process available for violations of child care regulations. The child care regulations will be revised over the next several months, and additional changes in the hearing process regulations will be considered during that process.

14. MSDH should implement its planned quality assurance function in order to ensure that child care facility inspectors uniformly enforce regulations.

MSDH staff are already working on implementation of the quality assurance processes for the child care program.

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