

Mississippi

Mississippi faces a number of significant challenges, but none is more daunting than trying to reverse the unhealthy lifestyle habits and reduce the preventable illnesses and injuries that compromise the health of the state's population.

Strengths. Although Mississippi suffered greatly from the devastating effects of Hurricanes Katrina and Rita, Mississippi receives the fifth lowest level of federal disaster preparedness funding (\$7.06 per person). Despite this, Mississippi has instituted a number of plans and systems to improve disaster preparedness throughout the state. Mississippi has a written plan for special needs patients and receives emergency and public health physician input into the state planning process. The state also has a real-time notification system in place to notify identified health care providers of an event. While the state lacks any burn unit beds or verified burn centers, Mississippi ranks 12th with respect to its bed surge capacity (856.5 beds per 1 million people) and 9th for the number of ICU beds (358.0 per 1 million).

Regarding the *Medical Liability Environment*, the average malpractice award in Mississippi is lower than the average across the states (\$244,127 versus \$285,218), as are average insurance premiums for primary care physicians (\$12,065 versus \$16,042) and specialists (\$63,802 versus \$65,489). The state has also enacted a number of medical liability reforms. Mississippi has abolished joint and several liability, provides for case certification by an expert witness, and has instituted a medical liability cap on non-economic damages.

Challenges. Mississippi is ranked among the five poorest performing states for multiple indicators in *Public Health and Injury Prevention*, including traffic fatalities, fatal occupational injuries, and unintentional deaths from fires and firearms. In addition, the state has low rates of childhood immunization (76.2 versus 80.5 percent nationally) and influenza vaccination

among older adults (65.4 versus 69.6 percent nationally). The state also has the second worst infant mortality rate in the nation (11.4 deaths per 1,000 live births), much higher than the national rate (6.9 per 1,000). Mississippi has the highest percentage of adults who are obese (31.4 percent) and the third highest percentage of adults who smoke (25.1 percent).

Mississippi earned a C- in *Access to Emergency Care* and faces a number of challenges. The state has the second lowest rate of physicians accepting Medicare (1.9 physicians per 100 beneficiaries) and exceptionally high rates of uninsured residents. Nearly 19 percent of children lack insurance compared to 11.7 percent nationwide, while 21.4 percent of adults are uninsured compared to 17.2 percent nationally. Mississippi also faces a severe workforce shortage with regard to emergency physicians, plastic surgeons, orthopedists and hand surgeons, and primary care providers. In addition, less than 60 percent of the population lives within 60 minutes of a Level I or II trauma center, ranking among the bottom ten states for this indicator.

There is a critical need for greater investment in prevention of unintentional injuries and promotion of healthy behaviors and activities.

The state's grade for the *Quality and Patient Safety Environment* reflects some negative factors such as a low proportion of patients receiving PCI for myocardial infarction within 90 minutes of arrival (49 percent compared to 59 percent across the states). In addition, there are low hospital utilization rates of electronic medical records and computerized practitioner order entry.




Recommendations. Mississippi's low scores in *Public Health and Injury Prevention* suggest a critical need for greater focus and investment in this area, particularly

	RANK	GRADE
ACCESS TO EMERGENCY CARE	27	C-
QUALITY & PATIENT SAFETY ENVIRONMENT	24	C
MEDICAL LIABILITY ENVIRONMENT	19	C
PUBLIC HEALTH & INJURY PREVENTION	49	F
DISASTER PREPAREDNESS	27	C+
OVERALL	34	C-

regarding the prevention of unintentional injuries and promotion of healthy behaviors and activities (e.g., healthy eating, physical activity, seat belt use, smoking cessation).

While Mississippi has shown some commitment toward improving the *Quality and Patient Safety Environment* by providing funding for a state EMS medical director position and quality improvement within the EMS system, the state would benefit significantly from further improvement efforts. Quality and patient safety might be improved with the application of system-wide standards to ensure effective response (e.g., regarding application of PCI for myocardial infarction). Mississippi would also benefit from efforts to increase the number of emergency medicine residents in the state, helping to address the state's low rates of emergency physicians and board-certified emergency physicians.


ACCESS TO EMERGENCY CARE C-

Board-certified emergency physicians per 100,000 pop.	 4.8
Emergency physicians per 100,000 pop.	7.9
Neurosurgeons per 100,000 pop.	2.1
Orthopedists and hand surgeon specialists per 100,000 pop.	6.5
Plastic surgeons per 100,000 pop.	1.6
ENT specialists per 100,000 pop.	3.6
Registered nurses per 100,000 pop.	 874.4
Additional primary care FTEs needed	176.0
Additional mental health FTEs needed	23.7
Level I or II trauma centers per 1M pop.	1.7
% of population within 60 minutes of Level I or II trauma center	56.6
Accredited chest pain centers per 1M pop.	0.7
% of population with an unmet need for substance abuse treatment	7.3
Pediatric specialty centers per 1M pop.	9.3
Physicians accepting Medicare per 100 beneficiaries	1.9
Medicaid fee levels for office visits as a % of the national average	116.2
% change in Medicaid fees for office visits (2004-05 to 2007)	0.7
% of adults with no health insurance	21.4
% of children with no health insurance	18.9
% of adults with Medicaid	11.8
Emergency departments per 1M pop.	 30.0
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	574.4
Hospital occupancy rate per 100 staffed beds	61.7
Psychiatric care beds per 100,000 pop.	46.1
State collects data on diversion	No



MEDICAL LIABILITY ENVIRONMENT C

Lawyers per 10,000 pop.	12.3
Lawyers per physician	0.7
Lawyers per emergency physician	15.5
ATRA judicial hellholes (range 0 to -7)	-1
Malpractice award payments/100,000 pop.	1.8
Average malpractice award payments	\$244,127
Databank reports per 1,000 physicians	21.4
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	11.1
Average medical liability insurance premium for primary care physicians	\$12,065
Average medical liability insurance premiums for specialists	\$63,802
Pretrial screening panels	No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	At judge's or court's discretion
Medical liability cap on non-economic damages	\$350,001-500,000
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	Yes
State provides for case certification	Yes
Expert witness required to be of the same specialty as the defendant	No
Expert witness must be licensed to practice medicine in the state	No

QUALITY & PATIENT SAFETY ENVIRONMENT C


Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	 9.6
Adverse event reporting required	No
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	92.7
Uniform system for providing pre-arrival instructions	Yes
State has or is working on a stroke system of care	Yes
State has or is working on a PCI network or a STEMI system of care	NR
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	12.5
% of hospitals with electronic medical records	33.7
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	49
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	14


PUBLIC HEALTH & INJURY PREVENTION F


Traffic fatalities per 100,000 pop.	31.3
% of traffic fatalities alcohol related	 41.0
Front occupant restraint use (%)	71.8
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (10 points possible)	6
% of children immunized, aged 19-35 months	 76.2
% of adults aged 65+ who received flu vaccine in the last 12 months	 65.4
% of adults aged 65+ who ever received pneumococcal vaccine	 68.7
Fatal occupational injuries per 1M workers	83.9
Homicides and suicides (non-motor vehicle) per 100,000 pop.	21.2
Unintentional fall-related fatal injuries per 100,000 pop.	6.8
Unintentional fire/burn-related fatal injuries per 100,000 pop.	3.2
Unintentional firearm-related fatal injuries per 100,000 pop.	0.9
Gun-purchasing legislation (8 points possible)	0
% of tobacco settlement funds spent on health-related services and programs	98.2
Total injury prevention funds per 1,000 pop.	\$200.43
Unintentional injury prevention funds per 1,000 pop.	\$200.43
Intentional injury prevention funds per 1,000 pop.	\$0.00
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	11.4
% of adults with BMI > 30	31.4
Current smokers, % of adults	25.1
Binge alcohol drinkers, % of adults	9.5

DISASTER PREPAREDNESS C+

Per capita federal disaster preparedness funds	\$7.06
Disaster preparedness funds used specifically for health care-related preparedness are tracked	Yes
All-hazards medical response plan or ESF-8 plan?	Yes
Plan shared with all EMS and essential hospital personnel?	Yes
Public health and emergency physician input into the state planning process	Yes, Yes
Public health and emergency physician input into the daily operations of the SEOC	No, No
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	Yes
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	9
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	Yes
Written plan to supply medications for chronic conditions	No
Written plan to supply dialysis for patients	Yes
Real-time notification system in place to notify identified health care providers of an event	Yes
"Just-in-time" training systems in place	Statewide
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	No
Statewide victim tracking system	No
Statewide real-time or near real-time syndromic surveillance system	Yes
Real-time surveillance system in place for common ED presentations	No
Bed surge capacity per 1M pop.	856.5
Burn unit beds per 1M pop.	0.0
ICU beds per 1M pop.	358.0
Verified burn centers per 1M pop.	0.0
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	8.6
Physicians registered in ESAR-VHP per 1M pop.	2.4
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	Yes, Yes
State or regional strike teams or medical assistance teams	Yes
Additional liability protections for health care workers during a disaster	Civil, not clearly defined
% of RNs that received any emergency training	44.8
State requires EMS and essential ED personnel to be NIMS compliant	Yes

 Improved since 2006

 Worsened since 2006

 No change since 2006

NR Not reported

N/A Not applicable

See Summary Statistics for State Comparisons