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December 1991

HEALTH POLICY BULLETIN

FOCUS: MDPH REORGANIZATION

In recent years many public health professionals and other observers have perceived the MDPH as lacking clear direction. Vernice Davis Anthony's reputation as a strong administrator, her extensive experience and knowledge of public health, and her strong capabilities in health policy were the principal reasons for her appointment as director of the state's public health department. When she accepted the job, Davis Anthony made it very clear that her first priority was service delivery and that additional dollars for services could be found by streamlining the department's administrative structure. Nearly one year after her appointment, the MDPH has been reorganized.

● ***Realigned Bureaus, Offices, and Centers*** Reorganization started at the top with Davis Anthony's office: The Chief Medical Officer, Ronald Davis, M.D., reports directly to her and is in charge when she is away. The two deputy director posts (which had been unfilled for some time) were abolished. The MDPH now has an associate director for state/local relations—Robert Scranton, registered sanitarian, formerly health officer, Livingston County Health Department—and a special assistant to the director—Susan Garcia. Garcia, prior to her appointment to the MDPH, had been with the Michigan Association for Local Public Health (MALPH). The two appointments can be said to reflect fairly Davis Anthony's determination to redirect MDPH priorities. Also reporting directly to her office are five offices—legislative policy, management and support services, minority health advisor, finance and administrative services, and policy, planning, and evaluation; four bureaus—health systems, child and family services, laboratories and infectious disease control, environmental and occupational health; and two centers—health promotion and chronic disease and substance abuse services.

Garcia described the relationships between the offices, bureaus, and centers as "interlocking with informal reporting arrangements." The heads of bureaus and centers meet with the director's staff (composed of the chief medical officer, the special assistant to the director, the associate director for state/local relations and the heads of the five offices) every two weeks while the director's staff meets weekly. Bureau and center heads report to members of the director's staff depending upon areas of expertise, e.g., the Bureau of Laboratories and Infectious Disease Control and the Center for Health Promotion and Chronic Disease report to the chief medical officer, while the Bureau of Environmental and Occupational Health reports to the associate director for state/local relations.

Space limitations preclude a discussion of all changes within the MDPH; instead, PSC has selected those changes that we believe are of the greatest interest to our readers.

➤ ***Principles and Priorities of Reorganization*** The following principles guide the reorganization:

- Reduce the MDPH administrative structure and transfer the dollars saved to local service delivery
- Create a structure focused on prevention and prioritizing specific programs
- Reduce the gaps between the health of minorities and whites, especially those caused by violence and infant mortality
- Centralize like functions such as environmental health, contract management, and maternal and child health programs
- Develop the Office of Policy, Planning, and Evaluation so that the duties and responsibilities of the Office of Health and Medical Affairs are encompassed and expanded
- Consolidate all disease control functions
- Maintain centers of public health expertise for consultation and departmentwide support in specific areas such as epidemiology, substance abuse, and minority health
- Support health systems development, both locally and regionally
- Develop the Public Health Institute
- Position the MDPH to perform its responsibilities as the lead state agency for health planning and environmental health risk assessment

Susan Garcia stressed that the reorganization was "done with a great deal of planning and thought. Advocacy groups such as the Michigan Association of Local Public Health, the Michigan Council for Maternal and Child Health, and the Emergency Medical Services Coalition all provided input."

➤ ***Office of Policy, Planning, and Evaluation*** According to Garcia, the new Office of Legislative Policy and Office of Policy, Planning, and Evaluation reflect the director's determination to bring together all the elements necessary to ensure consistency with her vision of what the MDPH should be doing. All the statewide planning functions previously performed by the OHMA are now located in the MDPH. Policy decisions will be made in the central office not in individual bureaus. This office also is

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developing a statewide health structure that will provide access to health care for all Michigan residents. Another responsibility is coordinating Medicaid program activities with those of the MDPH.

A major winner in the reorganization is Denise Holmes, who heads the new office of Policy, Planning, and Evaluation in MDPH. Following the lead of the director, Holmes will be the principal spokesperson for health policy in the state both within and outside the department.

➧ ***Office of Legislative Policy*** The Office of Legislative Policy, headed by Catherine Virskus, has a high priority function and should lead to better coordination of legislative policy. The MDPH hopes to be providing leadership in public health legislation and taking a more active role in the formation of public health policy. Garcia indicated that these objectives could be accomplished best if they are coordinated from the director's office.

➧ ***Bureau of Health Systems*** Two of the four bureaus are new. The Bureau of Health Systems differs in some important ways from its predecessor, the Bureau of Health Facilities, which has become a division in the new bureau. When PSC asked if the new name and structure meant that CON regulatory functions would be less important, we were told that those functions were still important but that the new bureau had a fundamentally different focal point, that of looking at how health systems are designed and how they function in the community. In short, health systems development will be actively encouraged by the MDPH.

When we asked what examining health systems' role in the community meant, Garcia commented that it means "getting all the players to sit at the table. Who are the major players? Where are services being duplicated? Who is providing particular services in an efficient cost-effective manner?" In her view it is not unreasonable for us to infer that a desire to survive is driving cooperation among providers. She also pointed out that the way health care services are delivered varies from community to community. "What we need to do is to find out what works best from the grassroots up, and then, to encourage the development of systems that build on that knowledge," she said.

The new division of managed care within the bureau replaces the division of health maintenance organizations. Its primary function is to encourage actively all those forms of managed care that are efficient and cost-effective. When asked whether this policy would actually work, Garcia laughed and observed, "We'll find out, won't we?"

➧ ***Bureau of Child and Family Services*** Child and Family Services replaces the Bureau of Community Services, which was the largest bureau in the department and had been organized by geographical divisions. Child and Family Services is not organized geographically but by functions: Infant and maternal health; child, adolescent, and family health services; children with special needs, and special supplemental food programs for women, infants, and children (WIC). Garcia noted that the bureau is now organized by program lines because the health services are being delivered with a reemphasis on local primary care. In other words, the emphasis is on delivering services to significant populations not individuals. The acting bureau chief is Ronald Uken, formerly deputy chief of the Bureau of Community Services.

➧ ***Center for Health Promotion and Chronic Disease Prevention*** The name change to the Center for Health Promotion and Chronic Disease Prevention from the Center for Health Promotion reflects two events: The shifting of AIDS-related activities to the division of disease control within the Bureau of Laboratories and Infectious Disease Control and the increased emphasis on the prevention of chronic diseases in Michigan. The center now has two divisions—programs and surveillance and analysis.

Garcia stressed that the shift of AIDS-related activities from the center to the division of disease control means the innovative approaches to education and prevention that characterized the AIDS prevention program will be extended to other programs to prevent and control the epidemic of sexually transmitted diseases in the state.

➧ ***Center for Substance Abuse Services*** The center lost its status as an autonomous agency within the MDPH through an executive order and is now an integral part of the department with its head, Karen Schrock, appointed by the director. According to Garcia, the center's two divisions are essentially unchanged from its previous organization.

➧ ***A Summing Up*** What was accomplished in the MDPH reorganization? How much money was saved and what did the director do with it? In answer to these questions, Garcia observed that twenty-five deputy positions, all classified executive service, were abolished throughout the department for a savings of $1.025 million. She also noted carefully that these savings were achieved prior to the 4 percent salary increase and provided enough money to reinstate funding for local regional health department teams in the Upper Peninsula. In Garcia's view, the two biggest bonuses of the reorganization are the emphasis on support, which she defines as "what it takes to run a health department—a doctor, a nurse, a place for people to come," and the establishment of local focal points—"where do people [from local health departments] call in the MDPH to get an answer to a question?"

OF INTEREST

The conference committee on SB 154, the auto insurance bill, met on December 12, exchanged criticism, and adjourned without reaching an agreement. The stumbling block is tort reform. The micromanagement of health care for auto accident injuries that characterized some earlier drafts is absent from the drafts currently being considered.

—Frances L. Faverman, Editor