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

Report to
the Mississippi Legislature

A Limited Management Review of the Department of Health

Within a period of twenty-three months (October 2002 through August 2004), the Department of Health implemented four organizational changes in the structure of the department, at least two of which were major revisions in the structure of the organization. When making the organizational changes, the department's management team did not obtain formal approval of the Board of Health for the organizational change plans, which is required by state law, nor did they consult with many of the key staff members who would be responsible for implementing the changes.

During and subsequent to the organizational changes, the department's management team changed the channels of communication for staff members without clearly stating the intent of or goal for the changes and without documenting the desired communication procedures in formal, written policies. The management team has also restricted traditional professional channels of communication and relationships with external information sources and with public health providers, a situation that could affect the staff's ability to promote and protect public health.

PEER also found the following:

- Since October 2002, the Department of Health has reduced its accountability controls over programs and services.

- Due to implementation problems, the Department of Health's recent efforts at improving the quality of its programs and decisions have not been successful, resulting in wasted staff resources and employee frustration.

- The department's epidemiology function has lost much of its public health knowledge base and experience due to a reduction in the number of staff positions, departure of experienced employees, and changes in the communication flow between the central office and field staff. The loss of experienced and key staff in other departmental areas has compromised the agency's ability to deliver services and improve performance.

- Contrary to requirements of state law, the State Health Officer has made district administrators, who are not licensed physicians, responsible for directing public health programs at the district level and has relegated district health officers to the role of medical consultants.

November 8, 2005

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 joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker and seven 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 four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

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.

PEER Committee
Post Office Box 1204
Jackson, MS 39215-1204

(Tel.) 601-359-1226
(Fax) 601-359-1420
(Website) http://www.peer.state.ms.us

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

SENATORS
LYNN POSEY
Vice Chair
RICHARD WHITE
Secretary
MERLE FLOWERS
ROBERT (BUNKY) HUGGINS
SAMPSON JACKSON
DEAN KIRBY
EZELL LEE

TELEPHONE:
(601) 359-1226

FAX:
(601) 359-1420

Post Office Box 1204
Jackson, Mississippi 39215-1204

Max K. Arinder, Ph. D.
Executive Director

www.peer.state.ms.us

REPRESENTATIVES
DIRK DEDEAUX
Chair
ALYCE CLARKE
WILLIE BAILEY
JOEY HUDSON
HARVEY MOSS
WALTER ROBINSON
RAY ROGERS

OFFICES:
Woolfolk Building, Suite 301-A
501 North West Street
Jackson, Mississippi 39201

November 8, 2005

Honorable Haley Barbour, Governor
Honorable Amy Tuck, Lieutenant Governor
Honorable Billy McCoy, Speaker of the House
Members of the Mississippi State Legislature

On November 8, 2005, the PEER Committee authorized release of the report entitled **A Limited Management Review of the Department of Health.**

Representative Dirk Dedeaux, Chair

This report does not recommend increased funding or additional staff.

Table of Contents

Table of Contents (Continued)

List of Exhibits

A Limited Management Review of the Department of Health

Executive Summary

Introduction

The PEER Committee conducted this review in response to a citizen's complaint alleging that management decisions of the current State Health Officer, who assumed the office in October 2002, have negatively impacted the department's operations.

Background

Definition of Public Health

The Future of Public Health[1] defines public health as "what society does collectively to assure the conditions in which people can be healthy." 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 (including state departments of public health), other public and private entities, and the people of a community.

The U. S. Public Health Service's 1994 Essential Public Health Services Working Group of the Core Public Health Functions Steering Committee identified the following core functions of public health:

- prevents epidemics and the spread of disease;

- protects against environmental hazards;

- prevents injury;

- promotes and encourages healthy behaviors;

- responds to disasters and assists communities in recovery; and,

- assures the quality and accessibility of health services.

---

[1] *The Future of Public Health* was a seminal work on "public health" published in 1988 by the Institute of Medicine.

The Mississippi Board of Health: Powers, Duties, and Responsibilities

MISS. CODE ANN. §41-3-1 (1972) specifies the composition of the Mississippi Board of Health and Section 41-3-15 authorizes the board to establish programs to promote public health and to mitigate threats to public health in Mississippi. Subsection (4) (m) of that CODE section authorizes the Board of Health to employ, subject to the regulations of the State Personnel Board, qualified professional personnel in the subject matter or fields of each bureau and other technical and clerical staff as may be required for the operation of the department.

MISS. CODE ANN. §41-3-5 (1972) authorizes the Board of Health to elect an executive officer (the State Health Officer) to a six-year term of office. The State Health Officer must be a physician with a graduate degree in public health or health care administration, or a physician the board believes to be fitted and equipped to execute the statutory duties of the position. The board selected the current State Health Officer, Dr. Brian Amy, at its meeting on May 17, 2002. He began his term of office in October 2002.

Subsection (2)(a) of MISS. CODE ANN. §41-3-43 (1972) authorizes the Board of Health to create public health districts of two or more counties for the purpose of administering health programs and supervising public health workers in the district. The statute directs the board or its executive officer to appoint for each such district a district director who must be a licensed physician well trained in public health work and who works full-time for the district.

Conclusions

Multiple Organizational Changes Since October 2002

Within a period of twenty-three months, the Department of Health implemented four organizational changes in the structure of the department, at least two of which were major revisions in the structure of the organization. Making this number of organizational changes within such a short period precludes departmental personnel from developing the working relationships necessary to accomplish the organization's mission.

Prior to October 2002, the organizational structure at the Department of Health had been in place for at least six years. Since the current State Health Officer began his term of office in October 2002, the department has experienced at least four organizational changes. (See Appendix D, page 45 of the report, for details on the specifics of the organizational changes and Appendix E,

page 51 of the report, for copies of the organization charts for each of the organizational changes.) The primary changes to the organizational structure were in the number and composition of offices created to carry out programs and in the creation of offices to emphasize specific support functions such as internal evaluation/quality assurance, planning, and budgeting.

During this period of frequent organizational change, the department's staff hardly had time to adjust to one organizational change before another took its place. The result was confusion among the staff members, including several key staff members expected to implement the changes, concerning their roles and responsibilities and the reasons for the changes.

Failure to Obtain Formal Board Approval or to Consult Several Key Staff Prior to Organizational Changes

When making the organizational changes, the Department of Health's management team did not obtain formal approval of the Board of Health for the organizational change plans, which is required by state law, nor did they consult with many of the key staff members who would be responsible for implementing the changes.

Although MISS. CODE ANN. Section 41-3-15 (1) (1972) states that the Department of Health's staff organization is subject to the approval of the Board of Health, the official minutes of the board for the last four years do not reflect that the board reviewed or formally approved any of the organizational change plans prior to their submission to the State Personnel Board for approval. By failing to obtain the Board of Health's formal approval prior to implementing the changes, the department has failed to comply with the law and has denied the board the opportunity to exercise its responsibility for overseeing and administering organizational changes at the department.

Also, prior to implementing the organizational changes, the Department of Health's management team did not consult with some of the staff members who would be responsible for implementing the changes. The effect of this situation is that staff members may not have the same understanding of the changes, do not understand how the changes promote the objectives of the department, and see some of the changes as a hindrance rather than a help to improving program quality and efficiency.

Restriction of Internal and External Communications

The Department of Health's management team has changed the channels of communication for staff members without clearly stating the intent of or goal for the changes and without documenting the desired communication procedures in

formal, written policies or staff memoranda. The management team has also restricted traditional professional channels of communication and relationships with external information sources and with public health providers, a situation that could affect the staff's ability to promote and protect public health.

Since October 2002, the department's management team has changed its philosophy regarding professional communication between and among managers and staff at every organizational level of the department and between the department's staff, citizens, and health care providers. The management team has restricted traditional professional channels of communication and relationships with external information sources. These changes in the department's internal and external communication patterns have been identified, described, and confirmed in similar, consistent ways by program staff at every level of the department.

PEER found that :

- The department's management team has changed the channels of communication for staff members without clearly stating the intent of or goal for the changes.

- The department's management team has changed the channels of communication for staff members without documenting the desired communication procedures in formal, written policies.

- The department has also altered its communication of information to the public health community.

Focus groups of field and central office staff members reported to a consultant that communication at the department was a major issue for concern. The consultant was studying ways to enhance service at all levels of the Department of Health.

County Planning and Budgeting Model Not Used for Resource Allocation or Performance Measurement

The department's Chief Science Officer developed the county planning and budgeting model to be used for planning and policy formulation, as well as resource allocation. However, the Chief Science Officer resigned before the model was made functional in terms of planning health services for counties or allocating resources for the delivery of health services.

The Chief Science Officer developed the county planning and budgeting model in 2003. The department identified twenty indicators of a county's "health capacity," then weighted each indicator based on its "importance for transforming public health status." Although the department has placed an interactive version of the model on its website that allows the public to change indicator values to test their impact on a county's public health standing, the model is not linked to any program or source

to be used for planning or allocating resources. According to MSDH staff, although the model exists, the department does not use it for planning health services for counties or allocating resources for the delivery of health services. Thus the department lost an opportunity and has wasted the resources devoted to the model's development.

Fewer Accountability Controls

Since October 2002, the Department of Health has reduced its accountability controls over programs and services by eliminating its Bureau of Service Quality and by not implementing its Internal Management System.

The Department of Health's Bureau of Service Quality, charged with some of the quality assurance functions formerly performed by the Office of Field Services, was eliminated during the department's recent organizational changes. The Internal Management System, set forth in the department's FY 2004 five-year strategic plan, incorporates a process to monitor program service delivery at the county and district level. However, the agency is not carrying out this process.

The loss of these two accountability measures has left the agency without a specialized central office staff that can make unbiased assessments and recommendations on the agency's efforts in achieving program goals. This leaves the evaluation of programs to those who are directly involved in administering them.

Unsuccessful Implementation of Quality Improvement Efforts

Due to implementation problems, the Department of Health's recent efforts at improving the quality of its programs and decisions have not been successful, resulting in wasted staff resources and employee frustration.

Since assuming office in October 2002, the focus of the State Health Officer has been on improving the quality of the department's programs and decisions. While these are laudable objectives, the current management team has been unable to achieve the desired improvement, in large part because of implementation problems similar to those encountered with the organizational changes.

Specifically, the MSDH management team imposed utilization of performance improvement tools (e.g., the Performance Measures Action Plan and a pilot program utilizing ISO 9000) on the department's staff with unrealistic time frames for achievement and under the threat of termination for failure to achieve performance improvement targets. As a result of the abandonment of efforts without results, the resources devoted to their development have been wasted and employees are

frustrated with the frequent initiation and then abandonment of the efforts.

Loss of Public Health Experience and Knowledge

The epidemiology function, recognized as one of the core functions of public health, has lost much of its public health knowledge base and experience due to a reduction in the number of staff positions, departure of experienced employees, and changes in the communication flow between the central office and field staff. Also, the loss of other experienced and key departmental staff has compromised the department's ability to deliver services and improve performance.

The Epidemiology function and the public health districts are important components of the Department of Health's service delivery structure. Controlling disease through epidemiology is a core function of public health and the public health districts are "front-line" contacts with the state's citizens.

PEER found that the Department of Health has lost much of its experience and knowledge base in the Office of Epidemiology. In July 2002, the Epidemiology Office had thirty authorized and twelve filled positions. As of July 1, 2004, the office had ten authorized and six filled positions.

Due to the departure of experienced employees, including the State Epidemiologist, the Epidemiology staff has lost much of its institutional memory and the capacity to respond to health care practitioners both inside and outside the department. The department has also lost a Deputy State Health Officer with twenty-six years of departmental experience, the Chief Science Officer, the Director of the Office of Evaluation, and the State Epidemiologist, as well as several central office nurses with responsibilities for oversight of field staff.

Contrary to requirements of state law, the State Health Officer has made district administrators, who are not licensed physicians, responsible for directing public health programs at the district level and has relegated district health officers to the role of medical consultants.

MISS. CODE ANN. Section 41-3-43 (1972) requires the Board of Health or State Health Officer to appoint for each public health district "a district director, who shall be a licensed physician, well trained in public health work, who shall give his entire time to the work." However, beginning in 2002 and continuing into 2003, the Department of Health's management team changed the role of the district health officers from district directors to that of medical consultants, placing the district administrators, who are not licensed physicians, into the position of district director in violation of state law.

The effect of these restrictions on the role of the district health officers is that they may be constrained in their ability to protect public health.

Recommendations

1. To increase the likelihood of success of any future reorganizations at the Department of Health, the department's management team should:

    - clearly communicate to all affected employees the perceived problem(s) driving the need for organizational change;

    - obtain input from key affected employees concerning perceived organizational problems and ways to address the perceived problems;

    - develop a vision statement that concisely clarifies the direction in which the organization needs to move to help direct the change effort and then communicate the vision statement clearly; and,

    - develop and clearly articulate an implementation strategy for change.

2. In its role as governing authority for the department, and as required by MISS. CODE ANN. Section 41-3-15 (1972), the Board of Health should review any proposal for departmental reorganization and vote on any such reorganization prior to its becoming effective. The Board of Health should record the outcome of such vote in its minutes.

    In the event that the board approves future reorganizations of the department, it should make clear to the State Health Officer and his management team that reorganizations should not be modified or overturned until such time as the board can assess the reorganization for its achievement of the agency's goals.

3. In the future, the Department of Health should put all policy changes in writing prior to their implementation and distribute these policies to the personnel involved.

4. The Department of Health's management team should examine the effects of its restrictions on staff communications, including the flow of data from the field to central office staff and the flow of advice and direction from the central office to the field. Should the management team alter these restrictions, the department should document any changes, as well as

all other requirements regarding staff communications, in written policies and distribute them to appropriate staff.

5. The Department of Health should evaluate the content, frequency, and means of distribution of information on public health trends (e.g., the morbidity report) and determine how to get this information into the hands of practitioners in the most efficient and timely manner possible.

6. The Department of Health should review its management and oversight of district health officers and cease any management practices that do not conform to the requirements of MISS. CODE ANN. Section 41-3-43 (1972) regarding district health officers' duties and responsibilities. Any revised management practices should recognize that the district health officers are required to enforce all health regulations within their districts and should have the authority to manage and control all district health staff.

If the Department of Health's management team wants to request a change in the requirements of MISS. CODE ANN. Section 41-3-43 (1972) regarding the district health officers' duties and responsibilities, the management team should present written evidence of need for the change to the appropriate legislative committees for debate and consideration. Unless and until the Legislature changes these requirements, the department should comply with the law regarding this issue.

For More Information or Clarification, Contact:

PEER Committee
P.O. Box 1204
Jackson, MS 39215-1204
(601) 359-1226
http://www.peer.state.ms.us

Representative Dirk Dedeaux, Chair
Perkinston, MS 228-255-6171

Senator Lynn Posey, Vice Chair
Union Church, MS 601-786-6339

Senator Richard White, Secretary
Terry, MS 601-373-2827

A Limited Management Review of the Department of Health

Introduction

Authority

Pursuant to the authority granted by MISS. CODE ANN. § 5-3-57 et seq. (1972), the PEER Committee conducted a limited management review of the State Department of Health (MSDH).

Purpose and Scope

PEER conducted this review in response to a citizen's complaint alleging that management decisions of the current State Health Officer, who assumed the office in October 2002, have negatively impacted the department's operations. PEER addresses this issue with this report.

Method

In conducting this study, PEER:

- reviewed relevant sections of state laws regarding the Department of Health and public health;

- analyzed program, staffing, and financial data from the Department of Health, the Department of Finance and Administration, the State Personnel Board, and the Joint Legislative Budget Office;

- interviewed former and current employees of the Department of Health, as well as staff of the Centers for Disease Control and Prevention in Atlanta; and,

- reviewed the literature on public health, including the literature on specific public health concerns.

Background

Definition of Public Health and Essential Public Health Services

The Future of Public Health[1] defines public health as "what society does collectively to assure the conditions in which people can be healthy." 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 (including state departments of public health), other public and private entities, and the people of a community.

The U. S. Public Health Service's 1994 Essential Public Health Services Working Group of the Core Public Health Functions Steering Committee identified the following core functions of public health:

- prevents epidemics and the spread of disease;

- protects against environmental hazards;

- prevents injury;

- promotes and encourages healthy behaviors;

- responds to disasters and assists communities in recovery; and,

- assures the quality and accessibility of health services.

The Working Group also identified the following services that it deemed "essential" to the promotion of public health:

- monitor health status to identify community health problems;

- diagnose and investigate health problems and health hazards in the community;

- inform, educate and empower people about health issues;

- mobilize community partnerships to identify and solve health problems;

- develop policies and plans that support individual and community health efforts;

---

[1] *The Future of Public Health* was a seminal work on "public health" published in 1988 by the Institute of Medicine.

- enforce laws and regulations that protect health and ensure safety;

- link people with needed personal health services and assure the provision of health care when otherwise unavailable;

- assure a competent public health and personal health care work force;

- evaluate effectiveness, accessibility, and quality of personal and population-based health services; and,

- research for new insights and innovative solutions to health problems.

Public Health Challenges in Mississippi

With approximately one-fifth of its population living below 125% of the poverty level,[2] Mississippi has long been confronted with the many public health challenges associated with poverty (e.g., poor nutrition, limited access to healthcare).

While Mississippi does not rank the lowest on all indicators of public health, it has historically ranked very poorly on many important health indicators. In the 2005 edition of *Health Care State Rankings*, Mississippi ranked 49th, ahead of Louisiana, on twenty-one indicators selected to reflect access to health care providers, affordability of health care and a generally healthy population.[3] Appendix A on page 35 shows Mississippi's data and rankings for these indicators.

Based on a second source of state health rankings data provided by the Henry J. Kaiser Family Foundation, Mississippi ranked first in the following indicators (the data for Mississippi and the year of the data are noted parenthetically):

---

[2] The source for this information is the Table for Poverty Status by State for 2003, according to the March 2005 supplement of the Annual Demographic Survey, conducted as a joint project between the U. S. Bureau of Labor Statistics and the U. S. Bureau of the Census.

[3] *Health Care Rankings* is published annually by Morgan Quitno Press. This publication uses government (e.g., U. S. Department of Health and Human Services, National Center for Health Statistics) and private sector (e.g., American Medical Association) sources for its data. In addition to providing extensive health-related data (a total of 512 indicators) by state, each year, the publication ranks the states based on twenty-one of the indicators selected to reflect access to health care providers, affordability of health care, and a generally healthy population.

- child death rate per 100,000 (35; 2001);

- preterm births as a percent of live births (17%; 2001);

- prevalence rate of diagnosed diabetes among adults (11%; 2003); and,

- number of heart disease deaths per 100,000 population (329; 2001).

However, Mississippi has improved in relation to the national average on certain public health indicators. For example, according to data published by the Centers for Disease Control and Prevention of the U. S. Department of Health and Human Services, Mississippi ranks 21st in its 2003 tuberculosis case rate per 100,000 population (4.4 cases per 100,000 population; below the national rate of 5.1 cases per 100,000 population).

The Board of Health: Membership, Powers and Duties, and Responsibilities

Board Composition and Membership

MISS. CODE ANN. §41-3-1 (1972) specifies the composition of the Board of Health. The board has thirteen members appointed by the Governor with the advice and consent of the Senate. Members serve six-year terms.

This CODE section requires that the board have three members from each of the state's four congressional districts as constituted on January 1, 2003, and one member from the state at large. All members are either to be engaged professionally in rendering health services or consumers of health services with no financial interest in any health services provider. Nine of the members are to be engaged professionally in rendering health services; no more than four of these may be engaged in rendering the same general type of health services or possess the same type of professional license and no two may be associated or affiliated with, or employed by, the same entity or employer. (By inference, the other four members of the board would be consumers of health services with no financial interest in any health services provider.)

Exhibit 1, page 6, shows the membership of the board as of January 1, 2005.

Powers and Duties of the Board

MISS. CODE ANN. §41-3-15 (1972) authorizes the board to establish programs to promote public health and to mitigate threats to public health.

Exhibit 1: Members of the Board of Health as of January 30, 2005

Name	End of Term	City of Residence	Congressional District	Profession	Health Care Consumer/ Provider
Board Members Appointed Prior to July 1, 2003					
R. A. Foxworth, DC	7/01/06	Brandon	3rd	Private Practice, Chiropractic	Provider
H. Allen Gersh, MD	7/01/06	Hattiesburg	State at-large	Private Practice, Nephrology	Provider
Ted Cain	7/01/06	Diamondhead	5th	Nursing Home Administrator	Provider
Walter C. Gough, MD	7/01/06	Drew	2nd	Private Practice, Emergency Medicine, Family Practice and Pediatrics	Provider
Ruth Greer, RN	6/30/08	Holly Springs	1st	Director of Nursing	Provider
Alfred E. McNair, Jr., MD	6/30/08	Ocean Springs	State at-large	Private Practice, Gastroenterology	Provider
Norman Marshall Price	6/30/08	McComb	4th	Hospital Administrator	Provider
Mary Kim Smith, RN	6/30/08	Brandon	3rd	Nursing Home Administrator	Provider
Board Members Appointed After July 1, 2003					
Larry Calvert, RPh	7/01/10	Gulfport	4th	Pharmacist	Provider
Deborah Griffin	7/01/10	Belzoni	2nd	Hospital Administrator	Provider
Cass Pennington, EdD	7/01/10	Indianola	2nd	Executive Director, Delta Health Alliance	Provider
Randy Russell, MD	7/01/10	Ridgeland	3rd	Private Practice, Ophthalmology	Provider
Ellen Williams, RN	7/01/10	Senatobia	1st	Nursing Instructor/Level Coordinator	Provider

SOURCE: Department of Health, Secretary of State, and Marshall County Tax Collector and Assessor

NOTE: The current composition of the Board of Health reflects the 2003 amendments to MISS. CODE ANN. Section 41-3-1 (1972). These amendments phase in a board composed of appointments from Mississippi's current four congressional districts and at-large appointments. By 2008, all appointments must be from the current districts or be from the state-at-large. Board members serving on the effective date of the amendments continue to serve until their terms expire. Consequently, there are still appointees representing the five congressional districts that existed in Mississippi prior to the post-2000-census redistricting. Mississippi lost a congressional district following the 2000 census.

Management and Organizational Responsibilities of the Board

Creation and Organization of the Department

Subsection (1) of MISS. CODE ANN. §41-3-15 (1972) provides for the creation and organization of the Department of Health:

> *There shall be a State Department of Health which shall be organized into such bureaus and divisions as are considered necessary by the executive officer, and shall be assigned appropriate functions as are required of the State Board of Health by law, subject to the approval of the board.*

Subsection (4) (m) of MISS. CODE ANN. §41-3-15 (1972) authorizes the Board of Health to employ, subject to the regulations of the State Personnel Board, qualified professional personnel in the subject matter or fields of each bureau, and other technical and clerical staff as may be required for the operation of the department. The section further provides that the executive officer (state health officer) shall be the appointing authority for the department and shall have the power to delegate the authority to appoint or dismiss employees to appropriate subordinates, subject to the rules and regulations of the State Personnel Board.

Exhibit 2 on page 8 shows the Department of Health's revenues and expenditures for budget years 2000-2004.[4] Appendix B on page 36 lists the programs and subprograms currently operated by the department, as well as the percentage of total budget and staff devoted to each program in FY 2004.

Election of the State Health Officer

MISS. CODE ANN. §41-3-5 (1972) authorizes the Board of Health to elect an executive officer (the State Health Officer) to a six-year term of office. The State Health Officer must be a physician with a graduate degree in public health or health care administration or a physician the board believes to be fitted and equipped to execute the statutory duties of the position. The State Health Officer cannot be engaged in the private practice of medicine.

According to MISS. CODE ANN. §41-3-5 (1972), the State Health Officer is vested with all of the authority of the board when it is not in session and is subject to the rules and regulations prescribed by the Board of Health. The

---

[4] The term "budget year" in reference to an agency includes all actual revenues recognized during that fiscal year and all actual expenditures made from all funds encumbered during that fiscal year.

board can remove the State Health Officer for cause by majority vote of its members.

Exhibit 2: Revenues and Expenditures of the Department of Health, BY 2000 through BY 2004

	BY 2000	BY 2001	BY 2002	BY 2003	BY 2004
Revenues					
General Funds	$43,467,358	$42,226,635	$32,771,294	$29,137,495	$29,891,091
Federal Funds	106,401,793	114,131,568	118,059,451	138,097,552	140,651,523
Other Funds	61,924,600	62,814,815	69,616,305	69,535,470	75,735,468
Total Revenues	$211,793,751	$219,173,018	$220,447,050	$236,770,517	$246,278,082
Expenditures					
Personal Services	$92,262,165	$90,822,314	$88,095,361	$90,961,720	$93,278,894
Contractual Services	22,900,248	24,853,153	28,818,607	28,812,086	34,314,761
Commodities	46,543,486	46,241,746	46,237,047	54,790,073	53,052,267
Capital Outlay	2,827,712	3,161,784	2,715,648	3,833,800	5,324,958
Subsidies. Loans & Grants	41,159,785	41,369,764	49,095,471	55,605,119	58,487,562
Total Expenditures	$205,693,396	$206,448,761	$214,962,134	$234,002,798	$244,458,442

SOURCE: Department of Finance and Administration Revenue and Expenditure Reports by Major Object Budget Year 2000 – 2004

The board selected the current State Health Officer, Dr. Brian W. Amy, at its meeting on May 17, 2002. He began his term of office in October 2002. Dr. Amy holds a Doctorate of Medicine from the Louisiana State University School of Medicine. He completed a residency in general surgery at LSU Medical Center Charity Hospital and a residency in General Preventive Medicine and Public Health at Tulane Medical Center. He also earned a Master of Public Health degree and a Master of Health Administration degree from Tulane University School of Public Health and Tropical Medicine, as well as a Master of Science degree in Microbiology from the University of Louisiana at Lafayette. He has one and a half years of public health experience as a Regional Medical Director for the Louisiana Department of Health and Hospitals' Office of Public Health.

Exhibit 3: Map of Public Health Districts in Mississippi
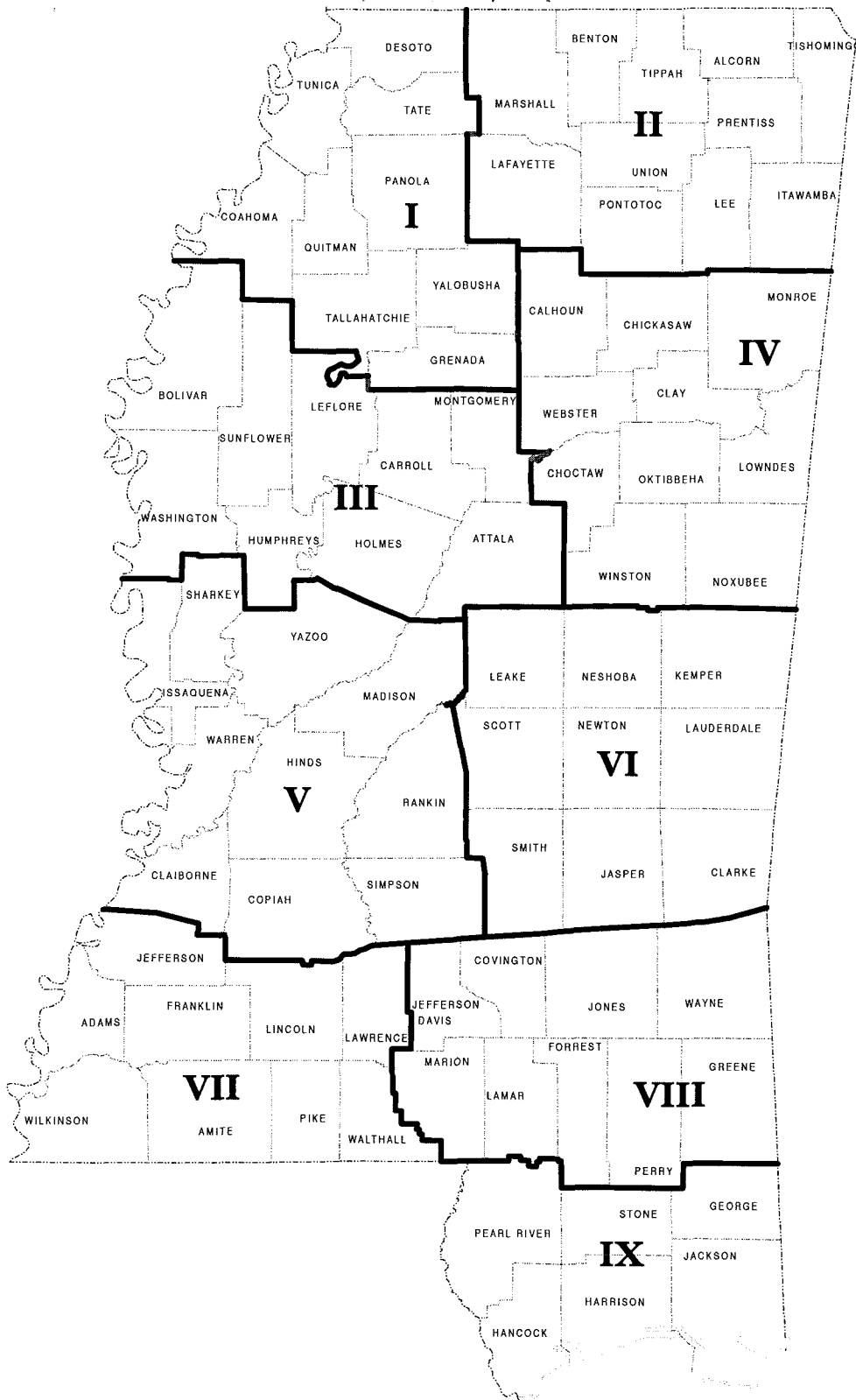
Source: Department of Health Annual Report

Subsection (2)(a) of MISS. CODE ANN. §41-3-43 (1972) authorizes the Board of Health to create public health districts of two or more counties for the purpose of administering health programs and supervising public health workers in the district (refer to Exhibit 3 on page 9

for a map depicting the Department of Health's nine public health districts). The statute directs the board or its executive officer to appoint for each such district a district director who must be a licensed physician well trained in public health work and who works full-time for the district.

Revenues and Expenditures of the Department of Health

The Department of Health receives revenues from federal grants, state general funds, and other funds. As shown in Exhibit 2 on page 8, the Department of Health's total revenues grew steadily from budget years 2000 through 2004, from approximately $212 million to approximately $246 million. This growth was primarily driven by an increase in federal funds and, to a lesser extent, growth in other funds.

The Department of Health's largest source of federal grant money in BY 2000 through BY 2004 was federal grants in support of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), followed by bioterrorism grant funds and the Maternal and Child Health block grant. MSDH generated federal funds primarily through approximately sixty federal grants.

General fund revenues declined from approximately $43 million in BY 2000 to approximately $30 million in BY 2004.

The department's primary sources of other funds are health care expendable funds, tobacco settlement funds, and fees. These funds increased from approximately $62 million in BY 2000 to approximately $76 million in BY 2004.

Exhibit 2, page 8, also shows the Department of Health's expenditures for BY 2000 through FY 2004. Expenditures have increased in all five major categories: personal services; contractual services; commodities; capital outlay; and subsidies, loans and grants.

Conclusions

Since Dr. Brian Amy assumed the duties of State Health Officer in October 2002, the Department of Health has experienced the following:

- multiple organizational changes, which were made without prior formal approval of the Board of Health or prior consultation of several key staff members responsible for implementing the changes;

- restriction of communications within the department's staff and between the departmental staff and public health providers;

- development of at least one management initiative, the county planning and budget model, that was never used for planning health services for counties or allocating resources for the delivery of health services;

- fewer accountability controls, due to the loss of the Bureau of Service Quality and lack of use of the Internal Management System;

- unsuccessful implementation of quality improvement efforts;

- significant loss of experienced staff and institutional memory; and,

- removal of licensed physicians from their responsibilities of directing public health districts.

The following sections contain discussions of these management actions and their effects.

Multiple Organizational Changes Since October 2002

Within a period of twenty-three months, the Department of Health implemented four organizational changes in the structure of the department, at least two of which were major revisions in the structure of the organization. Making this number of organizational changes within such a short period precludes departmental personnel from developing the working relationships necessary to accomplish the organization's mission.

The organization structure in effect prior to October 2002 had been in place at the Department of Health for at least six years. (Appendix C, page 44, illustrates the department's organization structure prior to October 2002.) The department was organized into five offices, with programs grouped according to their primary purposes--i.e., regulatory programs, community health programs, and personal health services. Support services

were provided by the Office of Administration and Technical Support and the Office of the State Health Officer. The department had nine public health districts, roughly equivalent in size, and eighty-two county health departments under the direction of nine district health officers who were all medical doctors. The District Health Officers were responsible for overseeing all district operations, both medical and administrative, including the hiring and supervision of a District Administrator who functioned as the Deputy Director in each district.

Since October 2002, the Department of Health has experienced at least four organizational changes, represented by the following organization charts:

- an organization chart dated November 21, 2002, approved by the State Personnel Board on December 19, 2002;

- an organization chart dated December 1, 2002, that fits the State Personnel Board's definition of a minor restructuring;

- an organization chart dated July 1, 2003, that meets the State Personnel Board's definition of a reorganization (SPB staff did not bring this reorganization before the State Personnel Board because they believed MSDH to still be in the process of making organizational changes and not ready to commit to the July 1, 2003, structure); and,

- an organization chart dated July 1, 2004, that was approved by the State Personnel Board on August 19, 2004.

Appendix D, page 45, gives details on the specifics of the organizational changes. Appendix E, page 51, contains a copy of the organization chart for each organizational change.

The primary changes to MSDH's organizational structure under Dr. Amy have been in the number and composition of offices created to carry out the programs and in the creation of offices to emphasize specific support functions such as internal evaluation/quality assurance, planning, and budgeting.

During the course of PEER's fieldwork, many MSDH staff members expressed confusion as to the department's organization structure, given the ongoing changes.

Because so many organizational changes took place within such a short period, the department's staff hardly had time to adjust to one organizational change before another took its place. The result was confusion among the staff members, including some key staff members expected to implement the changes (see page 13), concerning their roles and responsibilities and the reasons for the changes.

These frequent organizational changes within a short period prevented departmental personnel from developing the working relationships necessary to accomplish the organization's mission of delivering quality public health

services. During the course of PEER's fieldwork, many MSDH staff members expressed confusion as to the department's organization structure, given the ongoing changes. This was made especially difficult because of the lack of written information distributed to the staff concerning the changes (see page 18). When PEER asked for written documentation of the changes in procedures or job responsibilities that would be necessary to implement the organizational changes, the department's staff could not provide copies of any internal memoranda explaining the nature and purposes of the organizational changes to staff (see page 18). Management-level employees reported relying on agency telephone lists to try to determine who was supervising whom, until even the telephone lists were not keeping up with the changes. Another manager reported having to rely on the agency's annual report for information concerning the department's organization structure.

Failure to Obtain Formal Board Approval or to Consult Several Key Staff Prior to Organizational Changes

When making the organizational changes, the Department of Health's management team did not obtain formal approval of the Board of Health for the organizational change plans, which is required by state law, nor did they consult with many of the key staff members who would be responsible for implementing the changes.

For major organizational changes, such as those that have recently occurred at the Department of Health, to be successful, the governing board, organization head, and top and mid-level managers should be working together toward the goal of improving the organization. This necessitates communication and cooperation between all levels of the organization, including the management team and governing board.

PEER found that the Department of Health's management team did not obtain formal approval of the Board of Health prior to implementing the recent organizational changes at the department, nor did they seek the input of some of the key departmental employees (including division and program directors and district health officers) who would be responsible for implementing the changes.

Failure to Obtain the Board's Formal Approval

Although MISS. CODE ANN. Section 41-3-15 (1) (1972) states that the Department of Health's staff organization is subject to the approval of the board, the official minutes of the Board of Health for the last four years do not reflect that the board reviewed or formally approved any of the organizational change plans prior to their submission to the State Personnel Board for approval.

The organization of the Department of Health is subject to the approval of the Board of Health. MISS. CODE ANN. Section 41-3-15 (1) states:

> *There shall be a State Department of Health which shall be organized into such bureaus and divisions as are considered necessary by the executive officer [*State Health Officer*], and shall be assigned appropriate functions as are required of the State Board of Health by law, **subject to the approval of the board**. [PEER emphasis added]*

By including this section in the responsibilities of the board, the Legislature recognized the importance of an agency's organizational structure to the efficient and effective execution of public health policy. The statute makes clear that structural reorganization of the department is subject to oversight and approval of the Board of Health.

By failing to obtain the board's formal approval prior to implementing the organizational changes, the department's staff denied the board the opportunity to exercise its statutory responsibility for overseeing and administering organizational changes.

Minutes of the January 15, 2003, meeting of the Board of Health show that the State Health Officer made a quarterly report to the board in which he gave a brief description of organizational changes that had already become effective on December 1, 2002. Subsequent minutes of the board make brief references to implementation of organizational changes. PEER found no documentation in the board's minutes to show that the full board had reviewed or approved the organizational change plans prior to submission to the State Personnel Board. (Appendix F, page 55, contains a discussion of the role of the State Personnel Board in approving agencies' organizational changes.) PEER found no request in the minutes asking for the board's approval to submit any of the reorganizations to the SPB, nor did PEER find in the minutes any record of resolution for board approval that described the organizational changes.

The department's management team should have presented information concerning proposed organizational changes to the board in an official, documented manner and the board should have been involved in discussions regarding the merits of changing the staff's organization and intended purposes of the proposed organizational changes. If the board voted to

formally approve the organizational changes, the action should have been recorded in the minutes.

By failing to obtain the board's formal approval prior to implementing the organizational changes, the department has failed to comply with MISS. CODE ANN. Section 41-3-15 (1), which requires the board's approval of the department's organizational structure, thereby denying the board the opportunity to exercise its responsibility for overseeing and administering organizational changes.

Failure to Consult Several Key Staff

Prior to implementing the organizational changes, the Department of Health's management team did not consult with some of the staff members who would be responsible for implementing the changes.

Although one of the goals of the organizational changes was to improve organizational quality (see Appendix D, page 45), the department's management team undertook the organizational changes without consulting or informing some of the staff members, including division and program directors and district health officers, who would be significantly affected by and responsible for implementation of the changes and without committing the changes to written form.

The importance of seeking and utilizing input from staff members who would be instrumental in implementing the organizational changes is acknowledged in a consultant's report issued by The Whitten Group in August 2004 on ways to enhance service at all levels of the Department of Health.[5] The Methodology section of the Phase I Assessment of the report notes:

> *Organizations addressing quality initiatives and dealing with major organizational changes understand that input from the front lines plays a vital role in the identification of issues, proposed solutions, and acceptance of the outcomes and changes. This is especially true in organizations that are large, diverse in services, decentralized, and undergoing major leadership and culture*

---

[5] In the spring of 2004, the Department of Health, in partnership with The Whitten Group, P.A., began a project to "review and enhance service at all levels of the organization." Phase One of the project involved holding thirty-four focus groups comprised of MSDH staff, aggregated by function into groups of ten to twelve employees. The groups were asked to identify and isolate potential barriers to effective service as well as improvements in performance and stakeholder service. The Phase One Assessment portion of the consultant's report was issued on August 31, 2004.

changes....Having input from a variety of views leads to a better-rounded, clear, picture of the major service issues facing the organization at the various levels. It also encourages individuals to "become a part of the process," thus making them more likely to support the new initiatives and even become cheerleaders for the changes.

The effect of the department's failure to consult with several key staff members concerning the organizational changes is that staff members may not have the same understanding of the changes (refer to page 16 for discussion of confusion over internal communications), do not understand how the changes promote the objectives of the department, and may see some of the changes as a hindrance rather than a help to improving program quality and efficiency.

Restriction of Internal and External Communications

The Department of Health's management team has changed the channels of communication for staff members without clearly stating the intent of or goal for the changes and without documenting the desired communication procedures in formal, written policies. The management team has also restricted traditional professional channels of communication and relationships with external information sources and with public health providers, a situation that could affect the staff's ability to promote and protect public health.

Since October 2002, the department's management team has changed its philosophy regarding professional communication between and among managers and staff at every organizational level of the department and between the department's staff, citizens, and health care providers. The management team has restricted traditional professional channels of communication and relationships with external information sources.

The following sections summarize the communications policy changes that the department's management team has made since October 2002.

Changes in the department's internal and external communication patterns have been identified, described, and confirmed in similar, consistent ways by program staff at every level of the department.

Because of the statewide nature of the department's service delivery network, effective communication is vitally important.

Because the Department of Health's management team has not documented the desired communication procedures for its staff in formal, written policies or staff memoranda (see discussion on page 18), PEER has relied on statements of numerous departmental employees given in interviews as evidence of this condition. The changes in the department's professional communication patterns have been identified, described, and confirmed in similar, consistent ways by program staff at every level of the department.

From corroborating statements given in interviews with numerous departmental employees, PEER found the following examples of internal communications policy changes:

- *Program level*—Certain program directors are not to contact the State Health Officer or State Epidemiologist or to contact program staff at the county level.

- *Nurses*—Nurses in the Office of Epidemiology are not to contact district or county staff; district epidemiology nurses can no longer directly contact the staff of the Division of Epidemiology at the central office (including the State Epidemiologist) or the state laboratory, but are to make contacts through their district health officers.

- *Other field staff*--Central office reports are not sent to key field staff; district staff receive information from central office press releases; field staff do not receive information about disease occurrences in other areas of the state.

- *Data and statistical reports*--Electronic data and reporting are now statewide but not as targeted to counties or districts (e.g., program staff now know less about the number of homeless, the number of public health providers at a local level); county health reports are no longer updated; vital data reports are two years behind.

The following are examples of external communications policy changes:

- Field staff must obtain information from CDC/other visiting organizations' final reports from alternate routes.

- District staff are not talk to the press in their areas. (Recently, procedures were again changed to allow district staff to be able to talk to local media if the

meeting is arranged through the department's central Office of Communications and if a member of that office is present at the call or meeting.)

- Certain program directors have been told not to meet or communicate with other state agency program partners.

- Certain program staff are not to talk with any outside agencies or groups, including non-profit or volunteer organizations. Only central office managers may initiate such contacts. (Unlike other changes regarding communications, a memo was distributed to employees notifying them of this change in communication policy.)

Because of the statewide nature of the department's service delivery network, an effective communications network is vitally important. These conditions could affect the department's ability to achieve its mission of promoting and protecting public health.

The Department of Health's management team has changed the channels of communication for staff members without clearly stating the intent of or goal for the changes.

Even if the intent of the change in communications was to improve the function of the organization, the intent was lost due, ironically, to poor communication.

The department's management team never expressed a definitive statement of intent for the communications policy changes or the basis thereof. The management team did not identify how the new strategies would work at each level of the organization or identify relevant milestones in how the changes should be accomplished. The result is that many members of the department's staff perceive that the management team has restricted traditional professional channels of communication and relationships with external information sources. Thus, even if the intent of the change in communications was to improve the function of the organization, the intent was lost due, ironically, to poor communication.

The Department of Health's management team has changed the channels of communication for staff members without documenting the desired communication procedures in formal, written policies.

The lack of written instructions or procedures reduces accountability for both managers and those whom they supervise.

As noted on page 15, the Department of Health's management team has not documented the desired communication procedures for its staff in formal, written policies. PEER asked repeatedly for copies of memoranda or policies illustrating the desired communication procedures, but the department's staff emphasized in numerous interviews with PEER that the Department of Health's management team had given only oral

instructions in staff meetings or in one-on-one meetings with supervisors.

In one case, although the communications flow diagram in the epidemiology policies and procedures manual illustrates two-way communications between the Division of Epidemiology and the District Nurse Epidemiologist, district epidemiology nurses were told they could no longer directly contact the staff of the Division of Epidemiology at the central office, but were to make contacts through their district health officers. (See Appendix H, page 59).

The lack of documented instructions or procedures reduces accountability for both managers and those whom they supervise. In the absence of written policies, procedures, or memoranda, managers cannot prove that they provided specific requirements to employees and thus cannot fairly evaluate employees' compliance with the requirements. The employees that they supervise likewise cannot prove that they were told to what standards they will be held in the performance of their duties. The result is confusion and frustration about what employees can and cannot do within the limits set by management. Naturally, this condition affects employees' ability to fulfill their responsibilities and, at the program level, affects the department's achievement of its mission to promote and protect public health.

The Department of Health has also altered its communication of information to the public health community.

An example of the reduction in the amount of public health information provided to Mississippi health care practitioners is that the MSDH has discontinued issuing printed copies of the Mississippi Morbidity Report on a monthly basis. This report communicated to clinicians the disease trends and disease statistics useful in identifying and limiting disease outbreaks.

An example of the reduction in the amount of public health information provided to Mississippi health care practitioners is that the MSDH has discontinued issuing printed copies of the Mississippi Morbidity Report on a monthly basis.

The department's *Rules and Regulations Governing Reportable Disease* require that the department publish annually in the Mississippi Morbidity Report the reportable diseases and conditions. Until April 2004, the department had also published the Mississippi Morbidity Report on a monthly basis. Monthly publication was considered to be especially important given that health care providers could use the information in the report to examine trends and be aware of potential disease outbreaks. The last annual report was published in December 2003.

In August 2005, the department began publishing a portion of the information formerly contained in the monthly report--a summary table of some communicable

disease occurrences by public health district—on the department's website. However, this format lacks the accompanying detail of past reports.

Focus groups of field and central office staff members reported to a consultant that communication at the department was a major issue for concern. The consultant was studying the Department of Health's service delivery.

A consultant's report (The Whitten Group's Phase One Assessment) assessing results of thirty-four focus groups composed of MSDH staff members noted that both field staff and central office staff identified communication as "a major issue for concern." PEER views this as further evidence of the communication problems found during fieldwork for this report. Specific problems noted in the focus groups included blocks in information flow, timing lags in the communication of new practices or policies, and "general misinformation (and misinterpretation) which is common where much of the communication is about change."

County Planning and Budgeting Model Not Used for Resource Allocation or Performance Measurement

The department's Chief Science Officer developed the county planning and budgeting model to be used for planning and policy formulation, as well as resource allocation. However, the Chief Science Officer resigned before the model was made functional in terms of planning health services for counties or allocating resources for the delivery of health services.

The Department of Health's Chief Science Officer developed the county planning and budgeting model in 2003. According to MSDH staff, the model was to be used for health care planning and policy formulation, as well as allocation of resources. In developing the model, MSDH identified twenty indicators of a county's "health capacity."

Although the county planning and budgeting model exists, the department does not use it for planning health services for counties or allocating resources for the delivery of health services.

MSDH weighted each indicator in the model based on the indicator's "importance for transforming public health status." (Exhibit 4, page 21, lists these indicators.) The department assigned the highest weights to the following indicators: child immunization (0.15), child poverty and prenatal care (.09 each) and heart disease deaths (.08). The department assigned the lowest weight to motor vehicle deaths (.01), followed by Medicare enrollment, and skilled nursing facility infection rates and staff ratios (.02 each). Applying the weights to each county's actual data for the indicators, the department can calculate a total score for each county based on that county's public health risks or

Exhibit 4: Indicators of Health Capacity in the Department of Health's County Planning and Budgeting Model

Access to health care:

- physician to population ratio;
- percent of county population covered by designated Health Professional Shortage Area (HPSA);
- percent CHIP enrollment;
- percent of pregnant women receiving prenatal care in the first trimester; and,
- percent of population with Medicare enrollment in each county.

Populations at higher risk of disease and/or death:

- childhood poverty, as measured by the proportion of children under 15 years of age living in families at or below the poverty level;
- prevalence of low birth weight as measured by the percentage of live born infants weighing under 2,500 grams at birth;
- high school graduation rate;
- births to adolescents (ages 10-17 years) as a percentage of total live births; and,
- unemployed population.

Quality of care:

- percentage of nursing home residents with infections;
- cesarean section rates per 1000 live births;
- children immunization coverage;
- adult immunization coverage; and,
- mean nursing home nursing staff hours per resident per day.

Health outcomes:

- race/ethnicity-specific infant mortality rate;
- motor vehicle crash deaths per 100,000 population;
- cardiovascular disease deaths per 100,000 population;
- female breast cancer incidence per 100,000 women; and,
- potential years of life lost to age 75.

SOURCES: Centers for Disease Control and Prevention's Consensus Set of Health Status Indicators for the General Assessment of Community Health Status, United Health Group State Health Ranking-Selection of Components, and the Institute of Medicine Priority Areas for National Action: Transforming Health Care Quality.

attributes and then rank the eighty-two counties based on their scores.

MSDH has placed an interactive version of the county planning and budgeting model on its website that allows the public to change indicator values to test their impact on a county's public health standing. However, the model is not linked to any program or source to be used for planning or allocating resources and PEER has found no evidence that the department has used the model to meet service demand or allocate resources. According to MSDH's Director of Finance and Administration, although the county planning and budgeting model exists, the department does not use it for planning health services for counties or allocating resources for the delivery of health services.

The department's intention to develop and implement a weighted, risk-based model to be used in statewide healthcare planning and allocation of resources is an admirable one. However, when the department did not carry out the implementation effort or integrate the model's use into statewide planning, it lost an opportunity and has wasted the resources devoted to its development.

Fewer Accountability Controls

Since October 2002, the Department of Health has reduced its accountability controls over programs and services by eliminating its Bureau of Service Quality and by not implementing its Internal Management System.

Large agencies that deliver a diverse range of services to the public need a specialized staff capable of evaluating their programs. This is even more important at the Department of Health because the department often deals with life-and-death issues.

The loss of these accountability measures has left the agency without a specialized central office staff that can make unbiased assessments and recommendations on the agency's efforts in achieving program goals.

PEER found that two important accountability measures in place at the department—the Bureau of Service Quality and the Internal Management System—are no longer functional. The loss of these accountability measures has left the agency without a specialized central office staff that can make unbiased assessments and recommendations on the agency's efforts in achieving program goals. This leaves the evaluation of programs to those who are directly involved in administering them.

Bureau of Service Quality

The Bureau of Service Quality, charged with some of the quality assurance functions formerly performed by the Office of Field Services, was eliminated during the department's recent organizational changes.

During the organizational changes at the Department of Health, the Bureau of Service Quality (formerly known as the Office of Field Services) was eliminated. The Bureau of Service Quality had been responsible for conducting an annual review of each district to ensure systems were in place to monitor the quality of services in each county health department. The bureau also reviewed the corrective action responses to performance accountability reports and followed up to determine training needs, trends, and opportunities for improvement and policy changes. The bureau, composed of individuals representing each discipline of public health service, had served as the liaison between the central office and field and provided an important performance improvement function through the review of program records and data.

The Bureau of Service Quality was able to review district-wide performance, focusing not only on one program area, but evaluating trends across districts. Currently, no office at MSDH is serving the same function that the Bureau of Service Quality was and no office is making sure that corrective actions are taken at the district level.

Internal Management System

The Department of Health's Internal Management System, set forth in the agency's FY 2004 five-year strategic plan, incorporates a process to monitor program service delivery at the county and district level. However, the agency is not carrying out this process.

The Department of Health submits a five-year strategic plan as an addendum to its annual budget request, as required by MISS. CODE ANN. Section 27-103-129 (1972). The department's strategic plan for FY 2004-FY 2009 included a section on the department's Internal Management System, which is a process to monitor program service delivery activities carried out by local health departments within the centralized organizational structure.

The Internal Management System lists two separate quality assurance functions to be conducted at the county and district levels to review and correct program implementation and delivery:

- A review of county-level service delivery, including an on-site visit to at least two representative counties or clinics in the district prior to management discussions. An interdisciplinary team of nurses, social workers, nutritionists, and clerical staff are to review the service

delivery process using a standardized tool developed by the team. Clinical indicators for the program areas are to be considered to help determine whether a more detailed program review is required. The environmental health and home health program reviews should include site visits with field and home components. (This quality assurance function described above is similar in design to the Bureau of Service Quality process described in the previous section. The department eliminated the bureau.)

- A team of physicians, nurse practitioners and nurses are to complete clinical provider audits prior to the management discussions. The audits are to include records extracted from all physicians and nurse practitioners, both staff and contract, and the audit is to cover current standards of practice and compliance with program protocols. The plan states that staff providers will be present for the review, including discussions with providers about caseloads and specific case situations.

Currently, MSDH is not performing either of the above mentioned quality assurance functions. According to MSDH staff, some of these reviews and audits were conducted in the past, but currently these review functions are not active.

The functions set forth in the strategic plan were designed to create a flow of information between the central office and the district to improve program operations. By not performing the quality assurance functions set forth in the strategic plan, the agency is eliminating an important accountability measure.

Unsuccessful Implementation of Quality Improvement Efforts

Due to implementation problems, the Department of Health's recent efforts at improving the quality of its programs and decisions have not been successful, resulting in wasted staff resources and employee frustration.

The MSDH management team imposed utilization of performance improvement tools on staff with unrealistic time frames for achievement and under the threat of termination for failure to achieve performance improvement targets.

Since assuming office in October 2002, the focus of the State Health Officer has been on improving the quality of the department's programs and decisions. While these are laudable objectives, the current management team has been unable to achieve the desired improvement, in large part because of implementation problems similar to those encountered with the organizational changes (refer to discussion on page 11). Specifically, the MSDH management team imposed utilization of performance improvement tools on staff with unrealistic time frames for achievement and under the threat of termination for failure to achieve performance improvement targets. As a

result of the abandonment of efforts without results, the resources devoted to their development have been wasted and employees are frustrated with the frequent initiation and then abandonment of the efforts.

This section discusses the following performance improvement tools that were initiated and then abandoned by MSDH management:

- the Performance Measures Action Plan; and,

- ISO 9000.

Performance Measures Action Plan

The Performance Measures Action Plan, introduced in January 2004, was designed to improve program performance by defining acceptable levels of performance on selected indicators, monitoring performance, and assisting program staff in improving performance falling below acceptable levels. However, the department abandoned the program; thus, it never achieved its objective of continued performance improvement.

In January 2004, the Office of Organizational Quality presented a Performance Measures Action Plan and report on performance measures to the Board of Health. The plan stated that the Office of Organizational Quality would monitor and evaluate the results of the performance measures on a monthly basis and report the results to the board on a semi-annual basis. The plan also stated that the Office of Organizational Quality would use the following action plan to evaluate the performance measures:

1. *Each area is required to maintain a level of improvement.*

2. *Performance below the acceptable value will be identified.*

3. *The Office of Organizational Quality will work with District Health Officers, District Administrators, and Program personnel to develop and implement a 180 day quality improvement plan for the areas below the acceptable value.*

The first performance measure report to the board included performance measures from the following nine program areas: child care, food, water, wastewater, tuberculosis, immunization, licensure, WIC, and the PAP Smear program. Examples of performance measures included in the report were the percent of child care facility renewal inspections made timely and the percent of patients identified with latent TB current with therapy.

After the initial presentation of the performance indicator data to the board in January 2004, staff continued to

record the data for each program for approximately a year. According to program staff, the achievement of rapid improvement in performance failed because the timelines for achievement were unrealistic and there were no specific ideas offered for how to achieve improved performance. Under threat of losing their jobs, staff became creative in their reporting of program data to create the appearance of improved performance (refer to Appendix G on page 57 for a case study of the failure of this performance improvement initiative in the tuberculosis program). The performance data was presented the final time at the April 2004 meeting.

Subsequent to MSDH's abandonment of its performance measures action plan, the department hired a consultant to help develop performance measures for all MSDH programs. In early 2005, MSDH, with the help of the consultant, hired a Performance Measure Manager to develop and implement performance measures for all MSDH programs. Two months later, the Performance Measure Manager resigned and the agency decided not to replace this individual.

ISO 9000

In early 2004, the Director of the Office of Evaluation developed a pilot program utilizing ISO 9000 to implement a new testing procedure for selected sexually transmitted diseases. However, the department abandoned the pilot program soon after it began.

According to MSDH staff, at the January 2004 Board of Health meeting, a board member asked department staff to examine using ISO 9000 standards in the delivery of public health services. ISO 9000 is a series of standards developed and published by the International Organization for Standardization (ISO) that define, establish, and maintain an effective quality assurance system for manufacturing and service industries.

In order to achieve results, quality improvement tools should be in place continuously over a long term.

As a result of the board meeting, the Director of the Office of Evaluation was instructed to develop a pilot program utilizing ISO 9000. In conjunction with central office and district staff, he developed a pilot program testing the use of ISO 9000 to implement a new testing procedure for gonorrhea and chlamydia. The pilot program showed that there was not a statistically significant difference between the success of using the new testing procedure under ISO 9000 versus under existing departmental practice. The Director of the Office of Evaluation attributed this lack of difference to the detailed clinical MSDH standard operating procedures that were already in place for implementing the new test. Once these results were presented to the board, there was no further exploration of the use of ISO 9000. According to MSDH staff, this is the typical pattern of the current administration--i.e., to try

a new quality improvement tool briefly, present the results to the board, and then abandon the tool.

In order to achieve results, quality improvement tools should be in place continuously over a long term. While it is wise to conduct pilot studies of new quality improvement tools, the tools should not be abandoned without a clear explanation of their lack of applicability to the department.

Loss of Public Health Experience and Knowledge

The Epidemiology function and the public health districts are important components of the Department of Health's service delivery structure. Controlling disease through epidemiology is a core function of public health and the public health districts are "front-line" contacts with the state's citizens.

Controlling disease through epidemiology is a core function of public health and the public health districts are "front-line" contacts with the state's citizens.

PEER found that the Department of Health has lost much of its experience and knowledge base in the Office of Epidemiology, as well as in other critical staff positions. Also, the department's management team has made district administrators responsible for the public health districts and has relegated district health officers (who are licensed physicians) to the role of medical consultants.

Loss of Public Health Knowledge Base and Experience from the Epidemiology Staff

The epidemiology function, recognized as one of the core functions of public health, has lost much of its public health knowledge base and experience due to a reduction in the number of staff positions, departure of experienced employees, and changes in the communication flow between the central office and field staff.

Epidemiology plays a crucial role in protecting public health. A state's Office of Epidemiology is its first line of defense against disease outbreaks. According to the 2004 annual report of the Department of Health, the Office of Epidemiology is responsible for surveillance and detection of reportable diseases and other conditions and coordination of contact investigation and follow-up of cases that require provision of prophylactic medication, vaccines, and/or counseling.

Reduction in Number of Positions

In July 2002, the Epidemiology Office had thirty authorized and twelve filled positions. As of July 1, 2004, the office had ten authorized and six filled positions.

Prior to the organizational changes at the Department of Health, the Epidemiology Office was housed within the Office of Community Health Services and was allocated thirty positions; in July 2002, of the thirty positions, twelve were filled with permanent full-time employees. The Epidemiology Office is no longer within the Office of Community Health Services; it is now a freestanding office under the State Health Officer. The number of authorized staff positions has been reduced from thirty to ten positions, of which six are filled.

Departure of Experienced Employees

The Department of Health's Epidemiology staff has lost much of its institutional memory and the capacity to respond to health care practitioners both inside and outside the department.

The loss of public health experience at the department is exacerbated by the current administration's reluctance to take advantage of the ideas and opinions of remaining experienced public health professionals in the department.

The Epidemiology Office formerly employed infectious disease specialists, environmentalists, and public health veterinarians who worked closely with communicable disease program staffs and field staffs. These individuals have left the department and the MSDH central office has lost much of its institutional memory and the capacity to respond to health care practitioners both inside and outside the Department of Health.

This loss of institutional memory and capacity to respond to health care practitioners both inside and outside the department may be damaging the department's credibility with its own field staff and other health care professionals and compromising its ability to function effectively. The loss of public health experience at the department is exacerbated by the current administration's reluctance to take advantage of the ideas and opinions of remaining experienced public health professionals in the department.

Changes in the Communication Flow Between the Central Office and Field Staff

The MSDH management team has limited the flow of information from the central office to the field staff, which has the potential to reduce the quality of decisions made with regard to identification and treatment of cases of communicable disease.

Under the organization structure in place prior to October 2002, employees in the Office of Epidemiology worked closely together to ensure disease surveillance and treatments were successful. The State Epidemiologist was

head of the office and oversaw all positions ensuring the office meet the epidemiology needs of the state. In most cases, the clinician would call the Office of Epidemiology to report the disease. Epidemiology staff recorded disease-specific information (e.g., symptoms, lab results). If the reported disease was determined to be a case, it was entered into MSDH's surveillance records. If the case was one that required investigation or follow-up, the Epidemiology Office notified the district regarding the case and provided district staff information about the case.

Although the district was directly responsible for investigation and contact/case treatment if necessary, the Epidemiology Office provided consultation and oversight on most reported cases to ensure consistency and appropriateness of the response. There was frequent communication between the central office and district staff on a variety of issues including case management, legal issues related to treatment, and general supervisory and administrative concerns. The District Health Officer was informed of reported diseases in the districts and had a participatory role if necessary.

Under the current administration, the District Health Officer has been given more responsibility in regard to epidemiology services and investigating and responding to outbreaks in the community.

Under the current administration, the District Health Officer has been given more responsibility in regard to epidemiology services and investigating and responding to outbreaks in the community. Although the Epidemiology Office continues to receive initial calls from clinicians regarding reportable disease, the investigation and response to the disease is done at the district level. The new model continues to utilize central office staff to record the initial telephone report. The staff then contacts the District Health Officer to make them aware of the case and to start the investigation. However, the central office does not provide consultation and oversight.

Loss of Experienced and Key Staff from Other Critical Positions in the Department

The loss of experienced and key staff has compromised the department's ability to deliver services and improve performance.

Over the period of October 2002 through June 2005, the number of filled MSDH nursing positions declined by 7%, from 443 to 413. This decline included the loss of several key individuals, including the Deputy State Health Officer who had twenty-six years of experience with the department and functioned as the chief public health nurse, as well as several central office nurses with responsibilities for oversight of quality in the delivery of nursing services by field staff. Also, the number of physicians declined by 25%, from 32 to 24, including the loss of the State Epidemiologist, who had sixteen years of experience with the department.

Other critical staff who resigned included the Chief Science Officer and the Director of the Office of Evaluation. These were individuals hired by the current director to perform key roles in leading the department's efforts at quality improvement. With the loss of these individuals, the Office of the Chief Science Officer was dismantled. Also, as noted on page 26, the Performance Measure Manager resigned within two months of being hired.

While some of these individuals resigned due to problems with MSDH management decisions, others resigned for other reasons such as other employment opportunities, retirement, or personal reasons.

Removal of Public Health District Control from Licensed Physicians

Contrary to requirements of state law, the State Health Officer has made district administrators, who are not licensed physicians, responsible for directing public health programs at the district level and has relegated district health officers to the role of medical consultants.

As noted on page 10, MISS. CODE ANN. Section 41-3-43 (1972) authorizes the Board of Health to create public health districts of two or more counties for the purpose of administering health programs and supervising public health workers in the district. This section requires the board or its executive officer to appoint for each district "**a district director, who shall be a licensed physician, well trained in public health work**, who shall give his entire time to the work [emphasis added]."

In addition to the district director's responsibility for the administration of health programs and supervision of public health workers in his or her district, MISS. CODE ANN. 41-3-49 (1972) sets forth the following powers and duties of the district director:

> *. . .shall be given authority to enforce all health laws of the district or county under the supervision and direction of the state board of health, or its executive committee, and to make such investigation of health problems and recommend and institute such measures as may be necessary....and shall make report to said board of health of all matters concerning the sanitary conditions of his district...in the manner prescribed by the state board of health, or its executive committee.*

Also, CODE Section 41-3-51 requires the public health district director to:

> *. . .keep an accurate record of all activities of the department of health of the. . .district*

which he serves for use of the public and for information to the board of health, and such reports as required by the board of health shall be made to it.

The effect of these restrictions on the role of the district health officers is that they may be constrained in their ability to protect public health.

Historically, the Department of Health's district directors have been licensed physicians who worked under the job title of District Health Officer. (See Appendix I-1, page 61.) Beginning in 2002 and continuing into 2003, the Department of Health's management team changed the role of the district health officers from district directors to that of medical consultants, placing the district administrators, who are not "licensed physicians, well trained in public health work" into the position of district director in violation of MISS. CODE ANN. 41-3-43 (2) (a). (See Appendix I-2, page 62.) Dr. Amy communicated these changes to the district health officers by an oral announcement in early 2003. The only job description for District Health Officer is the SPB generic description for physician.

The effect of these restrictions on the role of the district health officers is that they may be constrained in their ability to protect public health.

Recommendations

1. To increase the likelihood of success of any future reorganizations at the Department of Health, the department's management team should:

    - clearly communicate to all affected employees the perceived problem(s) driving the need for organizational change;

    - obtain input from key affected employees concerning perceived organizational problems and ways to address the perceived problems;

    - develop a vision statement that concisely clarifies the direction in which the organization needs to move to help direct the change effort and then communicate the vision statement clearly; and,

    - develop and clearly articulate an implementation strategy for change.

2. In its role as governing authority for the department, and as required by MISS. CODE ANN. Section 41-3-15 (1972), the Board of Health should review any proposal for departmental reorganization and vote on any such reorganization prior to its becoming effective. The Board of Health should record the outcome of such vote in its minutes.

    In the event that the board approves future reorganizations of the department, it should make clear to the State Health Officer and his management team that reorganizations should not be modified or overturned until such time as the board can assess the reorganization for its achievement of the agency's goals.

3. In the future, the Department of Health should put all policy changes in writing prior to their implementation and distribute these policies to the personnel involved.

4. The Department of Health's management team should examine the effects of its restrictions on staff communications, including the flow of data from the field to central office staff and the flow of advice and direction from the central office to the field. Should the management team alter these restrictions, the department should document any changes, as well as all other requirements

regarding staff communications, in written policies and distribute them to appropriate staff.

5. The Department of Health should evaluate the content, frequency, and means of distribution of information on public health trends (e.g., the morbidity report) and determine how to get this information into the hands of practitioners in the most efficient and timely manner possible.

6. The Department of Health should review its management and oversight of district health officers and cease any management practices that do not conform to the requirements of MISS. CODE ANN. Section 41-3-43 (1972) regarding district health officers' duties and responsibilities. Any revised management practices should recognize that the district health officers are required to enforce all health regulations within their districts and should have the authority to manage and control all district health staff.

If the Department of Health's management team wants to request a change in the requirements of MISS. CODE ANN. Section 41-3-43 (1972) regarding the district health officers' duties and responsibilities, the management team should present written evidence of need for the change to the appropriate legislative committees for debate and consideration. Unless and until the Legislature changes these requirements, the department should comply with the law regarding this issue.

Appendix A: Mississippi Rates and Rankings on Twenty-one Indicators of Access to Health Care Providers, Affordability of Health Care, and a Generally Healthy Population, for Data Publication Year 2005[#]

Indicator (as a percent of a population specified)	MS Rate 2005	National Rate	Rank
Births of Low Birthweight as a Percent of All Births	11.4% (2003)	7.9% (2003)	1
Teenage Birth Rate (Live Births per 1,000 Women 15-19 Years Old)	70.5 (2003)	46.1 (2003)	1
Average Annual Family Coverage Health Insurance Premium	$7,525 (2002)	$8,469 (2002)	42
Percent of Mothers Receiving Late or No Prenatal Care	3.6% (2002)	3.1% (2002)	28
Percent of Population not Covered by Health Insurance	17.0% (2003)	15.1% (2003)	11
Percent of Children Not Covered by Health Insurance	12.1% (2003)	11.4% (2003)	16
Percent of Population Lacking Access to Primary Care	27.7% (2004)	11.6% (2004)	1
Percent of Adults Who Are Binge Drinkers	11.4% (2003)	16.5% (2003)	45
Percent of Adults Who Smoke	25.6% (2003)	22.1% (2003)	9
Percent of Adults Obese	28.1% (2003)	22.8% (2003)	2
Percent of Children Ages 19-35 Months Fully Immunized	84.0% (2003)	81.3% (2003)	16
Safety Belt Usage Rate	63.2% (2004)	80.0% (2004)	49
Percent of Adults Who Exercise Vigorously	20.2% (2003)	26.3% (2003)	45
Age-Adjusted Death Rate[*]	1036.3 (2002)	845.3 (2002)	1
Infant Mortality Rate per 1,000 Live Births	10.3 (2002)	7.0 (2002)	1 (tied with LA)
Age-Adjusted Death Rate by Neoplasms	218.3 (2002)	193.5 (2002)	3
Age-Adjusted Death Rate by Suicide per 100,000 Population	12.1 (2002)	10.9 (2002)	23
AIDS Rate (new cases)	15.1 (2004)	13.3 (2004)	10
Sexually Transmitted Disease Rate	646.4 (2003)	423.0 (2004)	3
Beds in Community Hospital per 100,000 Population	452.0 (2003)	280.0 (2003)	4
Estimated Rate of New Cancer Cases	515.7 (2005)	467.5 (2005)	16

SOURCE: *Health Care State Rankings*, Morgan Quitno Press, 2005 edition

[#] The year of actual data is noted parenthetically.
[*] This is the expected number of deaths that would occur if a population had the same age distribution as a standard population, expressed in terms of deaths per 100,000 persons. Age-adjusted rates eliminate the distorting effects of the aging of the population. In this table, the rate was based on the year 2000 standard population.

Appendix B: Department of Health Programs and Subprograms, FY 2004

Program/Subprogram	Provider	Description	Goal	% of Budget FY 04	% of Staff FY 04
Chronic Illness				5%	6%
Home Health	statewide network of regional home health agencies	comprehensive program of health care in the home for homebound impaired, elderly, or disabled patients	reduce institutionalization		
Hypertension Treatment	county health departments and joint patient management with private physicians	screening, diagnosis, treatment (including joint medical management) and follow-up	prevent premature death and undue illness due to hypertension and cardiovascular disease		
Diabetes Treatment	county health departments and joint patient management with private physicians	screening, referral, counseling as to management of health risks associated with the disease and joint medical management with private physicians	prevent or postpone complications and premature death due to diabetes		
Maternal and Child Health				51%	48%
Family Planning	over 100 local health departments and community health centers	education, counseling, contraceptive supplies, medical examinations (pap smears, pelvic exams)	improve maternal and infant health and reduce incidence of teenage pregnancies		
Maternity/ Perinatal Services	local county health departments	maternity services to low-income women include ambulatory care throughout pregnancy and postpartum period; referral to appropriate physicians and hospitals as indicated; postpartum home visits; Perinatal High Risk Management/Infant Services System Program provides targeted case management to high-risk pregnant women and infants; surveillance systems identify and examine factors associated with deaths of pregnant women and infants and low birthweights	reduce mortality of infants and pregnant women; decrease likelihood of infants being born too early or too small		

Appendix B: Department of Health Programs and Subprograms, FY 2004

Program/Subprogram	Provider	Description	Goal	Budget FY 04	Staff FY 04
Child Health	county health departments	immunizations, well-child assessments, limited sick child care, tracking of infants and high risk children; targeted to low income families; health education and assessments for adolescents; early identification of potentially handicapping conditions; dental health program provides fluoridation, health education and prevention services and purchases services for indigent children with severe problems	reduce mortality, morbidity and disability rates for infants, children and adolescents		
WIC, (Women, Infants and Children)	82 county health departments, 13 community health centers, one private agency, one community hospital on contract and 94 food distribution centers located in every county in the state	nutrition education and special supplemental food to low-income pregnant, breastfeeding, and postpartum women, infants, and at-risk children up to the age of five	reduce mortality and incidence of physical and mental deficiencies associated with poor nutrition		
Genetics		early detection through newborn screening, follow-up, diagnosis, and counseling for genetic disorders; referral to appropriate programs; professional and patient education	reduce morbidity and mortality of individuals with genetic disorders		
Early Intervention for Infants and Toddlers	MSDH is lead agency in interagency coordinated comprehensive system of early intervention services	provide infrastructure and planning assistance for development of an interagency comprehensive system of early intervention services (called "First Step") for children birth to three years old with disabilities in their families	to ensure all eligible infants and toddlers through age two receive necessary and appropriate early intervention services		
Children's Medical Program	19 MSDH specialty field clinics, staffed by MSDH nurses and contract physicians; private health providers, as necessary	medical care (clinic services, hospitalization, corrective surgery), counseling and referrals to children with physical handicaps whose parents cannot afford the cost of care	help children with physical handicaps to reach their optimal potential		

Appendix B: Department of Health Programs and Subprograms, FY 2004

Program/Subprogram	Provider	Description	Goal	Budget FY 04	Staff FY 04
Environmental Health				11%	10%
Onsite Wastewater	MSDH	inspect RV parks, on-site wastewater disposal systems, and private water supplies; provide technical assistance and training; respond to complaints from the public	reduce the potential for the spread of disease through water and improper disposal of human waste and disease vectors		
Food Protection		inspect food establishments	reduce potential for spread of disease through food establishments		
Milk Program		through inspections and sampling, regulate milk production, milk industry, and distribution of milk and milk products; also license and inspect bottled water and frozen dessert plants	reduce potential for spread of disease through milk and milk products and ensure that every producer marketing group and milk plant maintains a satisfactory rating score on state and federal ratings, which is a prerequisite to engaging in interstate commerce		
Public Water Supply		enforce requirements of federal and state Safe Water Drinking Acts, which apply to all community public water supplies in the state; enforcement includes monitoring water quality, working with engineers on final design of public water supplies, checking for operational and maintenance problems in the supply systems, licensing waterworks operators and training in the design, construction and operation of the systems	assure that public water supplies provide safe drinking water		

Program/Subprogram	Provider	Description	Goal	Budget FY 04	Staff FY 04
Radiation Control		license users of radioactive materials (e.g., x-ray operators), monitor their compliance with regulations, and sample levels of radioactivity in the environment	identify potential radiological health hazards and apply regulations to control and reduce exposure		
Boiler and Pressure Vessel Safety	MSDH and insurance company inspectors	certify the use of boilers and pressure vessels and conduct inspections of the vessels	ensure that there are no deaths, injuries, or property damage due to boiler or pressure vessel explosion		

Disease Prevention and Health Promotion				19%	20%
Epidemiology		monitor occurrence and trends of reportable diseases through statewide surveillance program	identify and control reportable disease and conditions		
Immunization		administer vaccines, monitor immunization levels, enforce immunization laws, provide immunization information and education, conduct disease surveillance and outbreak control, assure that adequate supplies of vaccine are available	eliminate morbidity and mortality from vaccine-preventable disease		
HIV/AIDS		surveillance, counseling, testing, referral, partner notification, implementation of strategies to modify risk-associated behaviors	keep number of newly diagnosed cases as low as possible		
STDs (Sexually Transmitted Diseases)		clinical services, education, screening, interviewing, partner tracing, detect and prevent new infections through comprehensive epidemiology	reduce prevalence and incidence of STDs		
Tuberculosis		early detection of persons with or at risk of developing TB, treatment, follow-up, and preventive therapy, technical assistance to high-risk health care and institutional settings (e.g., hospitals, mental health facilities, prisons); promotion of latest modalities and methodologies of TB treatment and follow-up	reduce incidence of TB by x% annually (7% in FY05 budget request; 4% in FY06 budget request)		

Appendix B: Department of Health Programs and Subprograms, FY 2004

Program/Subprogram	Provider	Description	Goal	Budget FY 04	Staff FY 04
Public Health Statistics		system of vital and health statistics and direct vital records services to the general public	collect and maintain accurate and timely vital and health data and provide data to users in a timely manner		
Statewide Health Promotion/ Education		conduct needs assessments, develop plans, implement and evaluate health promotion programs targeted at leading causes of death, illness, and injury	promote healthy communities in order to improve quality of life		
Breast and Cervical Cancer Prevention	county health departments; colposcopy/biopsy and cryosurgery performed by referral to private physicians or at one of the 12 in-house dysplasia clinics	targeted screening, referral, follow-up, public education	prevent premature death and undue illness through early detection and treatment		
Domestic Violence/Rape Prevention and Crisis Intervention	contracts with 13 domestic violence shelters, 9 rape crisis centers, and 9 private non-profit organizations	direct services to victims, public education	reduce incidence		

Program/Subprogram	Provider	Description	Goal	Budget FY 04	Staff FY 04
Health Care Planning, Systems Development and Licensure				6%	7%
Health Planning and Certificate of Need		project need in state health plan and act on applications for certificates of need based on these projections	contain costs by preventing duplication; increase accessibility and quality of health services		
Primary Care Development		primary care needs assessment and plan development, healthcare provider recruitment (including foreign trained providers), researching health care disparities, assisting in marketplace analysis for primary care delivery sites, and coordination of activities between community health centers and local health departments	analyze trends and determine need to recruit health care professionals while expanding the capacity of current staff; develop programs of retention		
Rural Health Care Development		collect and evaluate data on rural health conditions and needs, rural health policy analysis and development, technical assistance to rural community health systems, recruitment and retention of medical and health care professionals; information clearinghouse	assure availability and accessibility of quality health care services that meet the needs of residents of rural Mississippi		
Emergency Medical Services		regulation and inspection of ambulance services, training and certification of EMS personnel, development of statewide trauma care system plan, coordination of EMS communication system	ensure quality, effective, comprehensive system of emergency medical care		
Health Facilities Licensure		certify health care facilities for participation in Medicare or Medicaid program through inspections; license institutions for the aged and infirm, hospitals, home health agencies, ambulatory surgical centers, hospices, birthing centers, utilization review agents, and abortion facilities; respond to complaints concerning patient care from the public	regulate health facilities to achieve compliance with minimum standards		

Appendix B: Department of Health Programs and Subprograms, FY 2004

Program/Subprogram	Provider	Description	Goal	Budget FY 04	Staff FY 04
Professional Licensure		license speech-language pathologists, audiologists, dieticians, hearing aid dealers, occupational therapists, physical therapists, respiratory care practitioners, athletic trainers; register audiology aides, art therapists, speech-language pathology aides, body piercers, tattoo artists, and radiation technologists; certify eye enucleators	protect general public from unethical and unqualified practitioners		
Child Care Facility Licensure		license and regulate all child care facilities, youth camps, and register child residential homes and family day care homes	protect health and safety of children		

Support Services				7%	9%
Support Services		provide administrative and technical support in the areas of finance, accounting, personnel, budgets, facilities maintenance and operation, data processing, purchasing, public relations and internal audit			

				100%	100%

MSDH programs receiving separate appropriations:

FY 2004 Expenditures

Public Water Supply, Local Governments and Rural Water Systems					
		make loans to governmental and rural water systems using funds from an annual capitalization grant from the Environmental Protection Agency	provide loans, on a priority basis, to public water systems that require significant capital improvements to protect public health by complying with the federal and Mississippi Safe Drinking Water acts	$14,960,790 ($20.8 mill. in loan awards)	

Appendix B: Department of Health Programs and Subprograms, FY 2004

Program/Subprogram	Provider	Description	Goal	Budget FY 04	Staff FY 04
Bioterrorism Preparedness and Response Program					
		improve the department's capabilities to respond to all public health threats, including bioterrorism, using funds made available beginning in 1998 from the Centers for Disease Control and Prevention for preparing for and responding to bioterrorism. Also, use funds received through the federally funded Bioterrorism Hospital Preparedness Program to enhance the preparedness of the state's health care system to deal with "all hazard" emergencies, specifically terrorism	facilitate strategic leadership, direction, assessment, and coordination of related activities to ensure statewide readiness, interagency collaboration, and local and regional preparedness in the event of any public health threat or emergency	$7,831,677	
Tobacco Policy and Prevention					
		establish and monitor various environmental tobacco smoke and disparity projects across the state; administer the School Health Nurses for a Tobacco-Free Mississippi program which provides curriculum-based tobacco prevention activities for school-age children; monitor tobacco use among Mississippi's youth through Youth Tobacco Survey	create a healthier environment by reducing tobacco use among Mississippi's citizens	$2,598,422	

SOURCE: Department of Health's FY 2006 budget request to the Legislature.

Mississippi State Department of Health

Mississippi State Department of Health
Organization Chart
Agency: 90301
FY-2003
Prepared July 1, 2002

Signature

State Health Officer

District Health Officers (9)

County Health Departments (82)

Deputy State Health Officer

Office of the State Health Officer
Field Services
Communications and Public Relations
Information Systems Consultant
Internal Affairs
Policy and Planning
Public Health Nursing

Office of Administration and Technical Support

Administrative Support Division
- Building and Grounds
- Central Supply
- Copy Room
- Mail Room
- Motor Pool
- Print Shop

Information Technology
- Network/Operations
- Systems Coordination
- Tele-Communications

Bureau of Finance and Accounts
- Accounting
- Budgeting/Purchasing/Grants
- Claims/Cost/GAAP

Bureau of Technical Support
- Public Health Laboratory
- Pharmacy

Bureau of Personnel
- Classification/Compensation
- Contracts
- Employee Benefits Processing
- Staff Development

Office of Health Regulation

Bureau of Environmental Health
- Boiler and Pressure Vessel Safety
- Radiological Health Division
- Sanitation Division
- Water Supply Division

Bureau of Licensure
- Child Care and Professional Licensure Division
- Emergency Medical Services Division
- Licensure and Certification Division

Planning and Resource Division
- Certificate of Need
- Health Planning
- Rural Health

Office of Community Health Services

Epidemiology

Immunization Division

Tuberculosis Control Division

STD/HIV Division
- HIV/AIDS
- STD

Bureau of Public Health Statistics
- Birth/Death Certificates
- Data Analysis
- Labor Statistics
- Time Study

Health Promotion Division
- Chronic Illness
- Community Health Promotion
- Injury Prevention
- School Health

Office of Personal Health Services

Bureau of Child/Adolescent Health
- Children's Medical Program
- Dental Health
- Early Intervention System
- EPSDT
- Genetics

Bureau of Women, Infant and Children
- Accounting
- Data Systems
- Food Distribution
- Monitoring and Evaluation
- Nutrition Education

Bureau of Women's Health
- Breast/Cervical Cancer
- Domestic Violence/Rape Crisis
- Family Planning
- PHRM
- Prenatal Services

Bureau of Home Health
- Continuing Education
- Professional Services
- Operational Services

SOURCE: State Personnel Board.

Appendix D: Description of the Department of Health's Organizational Changes from October 2002 through August 2004

The Department's Organization Structure Prior to October 2002

The organization structure in effect at the Department of Health just prior to October 2002 had been in place for at least six years. As shown in Appendix C on page 44, under this structure, MSDH was organized into five offices, with twenty-four major subdivisions.

This organization structure grouped programs according to their primary purposes--i.e., regulatory programs, community health programs, and personal health services. Support services were housed in the Office of Administration and Technical Support (e.g., budgeting, personnel, computer support) and the Office of the State Health Officer (e.g., quality assurance and performance accountability in the divisions of Field Services, Internal Affairs, and Public Health Nursing; policy and planning).

In terms of public health district organization, prior to October 2002, the department had nine public health districts, roughly equivalent in size (refer to Appendix C on page 44), and eighty-two county health departments under the direction of nine district health officers who were all medical doctors. The District Health Officers were responsible for overseeing all district operations, both medical and administrative, including the hiring and supervision of a District Administrator who functioned as the Deputy Director in each district.

The State Health Officer's span of control under this organization structure was fourteen, which is reasonable according to the literature on public sector management. Specifically, the following individuals reported directly to the previous State Health Officer: five office directors (including the Deputy State Health Officer who oversaw the Office of the State Health Officer) and the nine district health officers.

Reorganization Approved by the State Personnel Board on December 19, 2002 (See Appendix E-1, page 51, for Organizational Chart)

On November 21, 2002, Dr. Amy submitted a proposed reorganization to SPB for approval. According to SPB staff, while it is normal practice for a new director to reorganize an agency, most new directors take approximately a year to formulate their reorganization plan and make a formal request to the State Personnel Board. It is very unusual for the new director of a large state agency to submit a formal

request for reorganization within a couple of months of assuming the position, as did Dr. Amy.

While a purpose for the requested reorganization is not explicitly stated in the justification portion of the Department of Health's 2002 request to SPB, the purpose can be inferred from the descriptions of proposed offices. For example, in the agency's request for reorganization, the department's description of its proposed Office of Science & Technology states:

> *This Office will ensure that the public health decisions are the most accurate and that the agency functions as efficiently as possible through the use of technology.*

Also, the department's description of its proposed Office of Organizational Quality states that the office "ensures that MSDH functions as a high quality organization statewide." The State Personnel Board approved the agency's request for reorganization on December 19, 2002.

The reorganization increased the number of departmental offices from five to nine and increased the State Health Officer's span of control from fourteen to nineteen. Also, the reorganization moved twelve positions out of state service to non-state service status, which is designated for "top level positions if the incumbents determine and publicly advocate substantive program policy and report directly to the agency head, or the incumbents are required to maintain a direct confidential working relationship with a key excluded official."

While one of the offices, the Office of Personal Health Services (renamed the Office of Health Services), remained basically unchanged under the reorganization, the reorganization subdivided the previous State Health Officer's other four offices. For example, the former Office of Health Regulation was split into two offices-- Health Protection (the former Bureau of Environmental Health and Bureau of Licensure) and Health Policy and Planning (the former Planning and Resource Division).

In the area of Epidemiology and Communicable Diseases, the reorganization created a separate Office of Epidemiology, comprised of four divisions of the previous State Health Officer's Office of Community Health Services (Epidemiology, STD/HIV, Immunization, and Tuberculosis Control) and two divisions of the previous State Health Officer's Bureau of Technical Support (the Public Health Laboratory and the Pharmacy).

With respect to changes in the quality assurance function, the reorganization created two new offices that reflected Dr. Amy's expressed intent to focus on improving program quality and resource allocation. Dr. Amy's Office of Science/Technology combined the previous State Health Officer's Bureau of Public Health Statistics from the Office

of Community Health Services and planning functions from the previous State Health Officer's Office of the State Health Officer. Dr. Amy's Office of Organizational Quality was comprised of two divisions: performance accountability and service quality, functions taken from the previous State Health Officer's Office of the State Health Officer (primarily field services, internal affairs, and public health nursing). This office was charged with carrying out internal audits and performance reviews. While these functions were carried out under the previous State Health Officer, Dr. Amy placed them in a separate office to highlight their importance in his administration.

With respect to district operations, Dr. Amy created an independent Office of Field Operations, which added a layer of central office management--i.e., the Director of the Office of Field Operations between the State Health Officer, the district health officers, and district and county health department staff.

Minor Restructuring on December 1, 2002 (See Appendix E-2, page 52, for Organizational Chart)

On December 1, 2002, prior to SPB's approval of the previously described organizational change, MSDH adopted a revised organization chart.

The December 1, 2002, revised organization chart changed the components of the Office of Science/Technology from operations, planning, patient information management systems (PIMS) and health informatics to decision science, knowledge management, information management, and health informatics and placed the offices under a Chief Science Officer. This was the office charged with trying to implement different tools for performance improvement and decision-making. Also, the December 1, 2002, revised organization chart created a Deputy Director for Administrative Services position and moved the Office of Administrative Services (i.e., divisions of Finance and Accounts, Human Resources, Support Services, and Legal Counsel) under this position. Under this revised organization structure, the State Health Officer's span of control remained at nineteen (ten central office staff and nine district health officers).

Reorganization Implemented July 2003 but Not Approved by the State Personnel Board (See Appendix E-3, page 53, for Organizational Chart)

The Department of Health's July 1, 2003, organization chart appears in the agency's 2003 Annual Report as well as in its 2004 reorganization proposal to the State Personnel Board. As stated previously, this organization

chart meets SPB's definition of a reorganization. However, SPB staff did not bring this reorganization before the State Personnel Board because they believed MSDH to still be in the process of making organizational changes and not ready to commit to the July 1, 2003 structure.

In terms of changes at the office level, the July 1, 2003, chart changed the Division of Disparity Elimination within the Office of Health Promotion 2003 to a separate Office of Health Disparity and moved the functions of two offices (Policy and Planning and Organizational Quality) under the State Health Officer instead of keeping them as separate offices on the organization chart.

The July 1, 2003, reorganization moved three organizational units under the supervision of the Deputy Director: the Communications Division from the Office of Health Promotion, the Office of Field Operations (renamed the division of Health Districts Administration), and moved the division of Home Health from the Office of Health Services to the newly created division of Health District Administration. Also, the July 1, 2003, organization moved the Division of Support Services into Finance and Accounts and moved the legal counsel division out from under the Deputy Director to reporting directly to the State Health Officer.

Also, the reorganization placed a Medical Director in a supervisory position over each of the Offices of Health Protection, Health Promotion, Health Disparity, and Health Services. The State Epidemiologist already was in charge of the Office of Epidemiology.

The July 1, 2003, organization chart shows the district health officers (renamed district medical directors), listing each officer in a box with the districts for which that officer is responsible, but leaving health district administration under the Office of the Deputy Director. Also, the July 1, 2003, chart shows the reassignment of two previous district health officers to central office positions (Dr. Lovetta Brown over the Office of Health Disparity and Dr. Mary Gayle Armstrong over the Office of Health Promotion) and the reassignment of health districts among the remaining five district "medical directors," following the resignations of Dr. Morrison, District VI Health Officer, effective May 30, 2003, and Dr. Waller, District IV Health Officer, effective April 30, 2003.

Under the July 1, 2003, reorganization, the divisions supervised by the Chief Science Officer were changed from Decision Science, Knowledge Management, Information Management, and Health Informatics to the Office of Science & Evaluation and the Office of Health Informatics.

Under this reorganization, the position of Deputy State Health Officer was eliminated and the State Health Officer's span of control was reduced from nineteen to

seventeen (twelve central office staff and five district health officers).

Reorganization Approved by the State Personnel Board on August 19, 2004 (See Appendix E-4, page 54, for Organizational Chart)

In July 2004, Dr. Amy submitted a second proposed reorganization to SPB for approval. SPB approved the proposal on August 19, 2004. The stated reasons for the second proposed reorganization were:

- the State Health Officer's span of control had gotten too big for him to effectively supervise; and,

- the current structure did not allow for the efficient operation of the agency.

The proposal also noted that the new structure would allow the State Health Officer to concentrate on policy development and implementation.

PEER also notes that changes reflected in MSDH's 2004 reorganization reflect a redistribution of certain functions following the loss of key personnel. For example, following the resignation of the State Epidemiologist effective February 16, 2004, there is no longer a separate Office of Epidemiology shown on the organization chart. The divisions of the Office of Epidemiology were redistributed to Health Protection (Communicable Disease and Public Health Laboratory) and the Deputy Director's Office (Public Health Pharmacy). Similarly, following the resignations of the Chief Science Officer, effective June 30, 2004, and the Director of the Office of Science and Evaluation, effective July 31, 2004, these functions were redistributed to the Deputy Director (information technology and performance accountability), the Director of Finance and Administration (Evaluation/Quality), and the remaining science officer in an organizational unit, with medical doctors reporting directly to the State Health Officer.

This reorganization combined offices into three new executive-level offices (Finance and Administration, Health Protection, and Health Services), under the direction of a new layer of executive-level management and removed medical directors (including the district health officers and state epidemiologist) from their supervisory positions into a position of system-wide advisors/consultants, along with the dentist and remaining science officer.

The newly created executive Office of Finance and Administration took the offices of Finance and Accounts and District/County Health Administration out from under the Deputy Director, the Service Quality Division of the Office of Organizational Quality from the State Health Officer, and the Office of Facilities and Property

Management, which had disappeared from the previous organization chart.

The newly created executive office of Health Protection took in the Office of Health Protection and the Public Health Laboratory and Communicable Disease divisions from the Office of Epidemiology.

The newly created executive Office of Health Services took in the Office of Health Services and presumably the Offices of Health Promotion and Health Disparity became the Health Services' division of Preventive Health, although not explicitly stated on the organization chart.

In addition to assuming responsibility for those divisions already discussed, the Deputy Director took over control of the Office of Health Policy and Planning, the division of Performance Accountability from the Office of Organizational Quality, and the Legal Counsel from the State Health Officer.

The State Health Officer's span of control under this second SPB approved reorganization increased from fifteen positions to seventeen positions (the deputy director, dentist, state epidemiologist, seven medical officers including six district health officers, chief science officer, assistant to the Board of Health, assistant to the State Health Officer, and three executive-level division directors).

In the July 2004 reorganization, responsibility for health district administration was moved from the Deputy Director to the director of the executive office of Finance and Administration and the district health officers were moved to a consultant/advisory role along with the other MSDH medical officers.

SOURCE: PEER analysis.

Mississippi State Department of Health
Agency: 0301
FY-2003
Page 1 of
(COV.GOV.2002)

Signature   Revised 12/21/2002

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Governor

Board of Health

State Health Officer

Organizational Quality
- Performance Accountability
- Service Quality

Deputy State Health Officer

State Epidemiologist

District Health Officers

Policy and Planning
- Resource Development
- MS Qualified Health Center (MQHC)
- Primary Care Development
- Policy Evaluation

Field Operations
- District Health Departments
- County Health Departments

Administrative Services
- Finance and Accounts
- Human Resources
- Support Services
- Legal Counsel

Science/Technology
- Operations
- Planning
- Patient Information Management Systems (PIMS)
- Health Informatics

Health Protection

Health Promotion
- Health Quality/Safety
- Disparity Elimination
- Health Education
- Communications

Emergency Planning and Response

Environmental Health

Licensure

Health Services
- Child/Adolescent Health
- Home Health
- Women's Health
- Women, Infants, and Children (WIC)

Epidemiology
- Communicable Diseases (IMM/TB/STD/HIV)
- Public Health Laboratory
- Pharmacy

SOURCE: State Personnel Board.

Appendix E-2: Organization Chart for Minor Restructuring of the Department of Health on December 1, 2002

APPROVED

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Mississippi State Department of Health
Agency: 0301
FY-2003
Page 1

Signature 12/01/2002

PEER Report #481

SOURCE: MSDH.
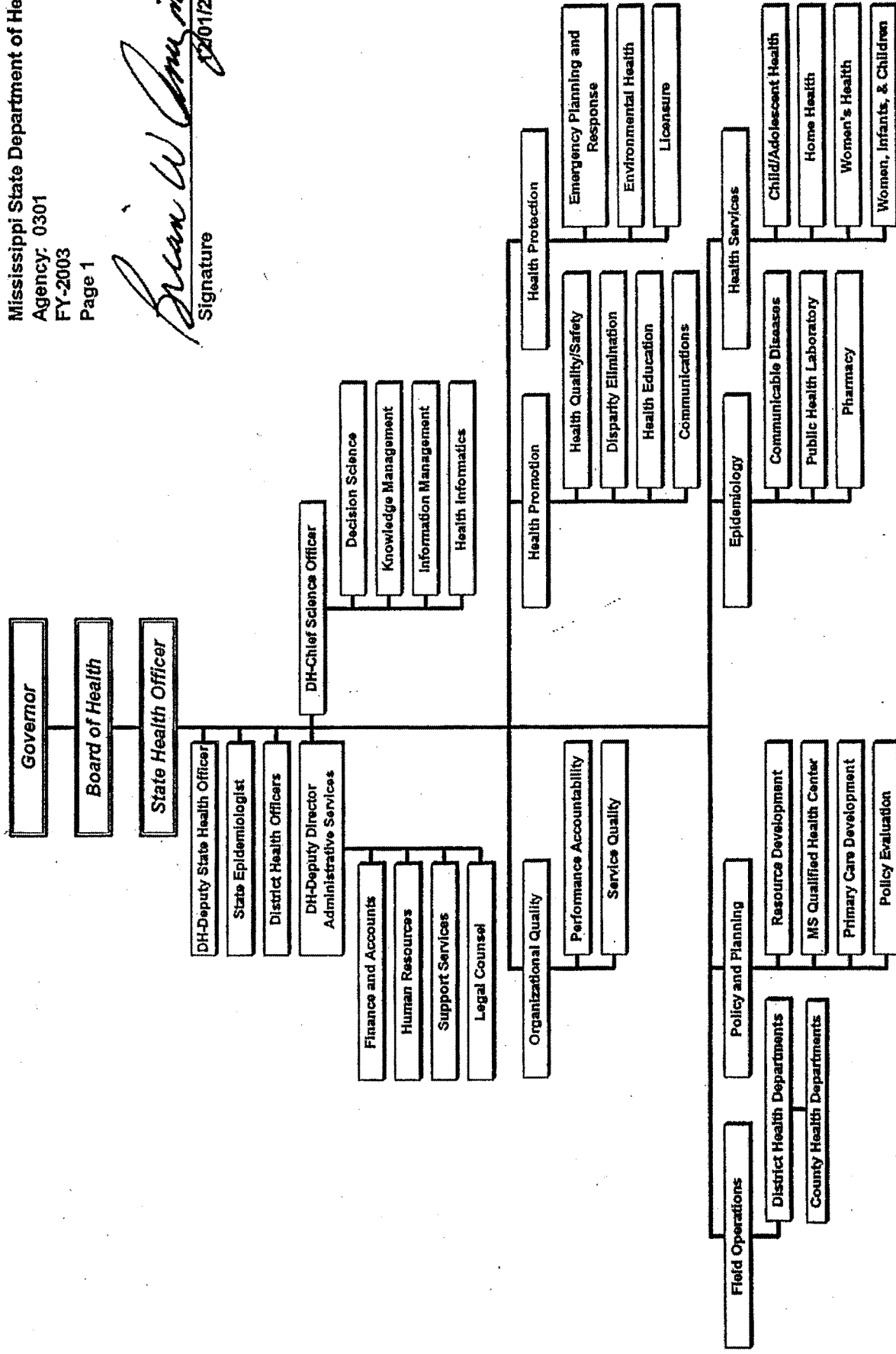
Appendix E-3: Organization Chart for Reorganization of the
Department of Health Implemented July 2003 but Not Approved by
the State Personnel Board

Mississippi State Dep—...nent of Health
Agency: 0301
FY-2004
Page GOV
Prepared July 1, 2003

Signature   7/01/2003

Mississippi State Department of Health

- Governor
- Board of Health
- State Health Officer
  - State Health Plan
  - Organizational Quality
  - Legal Counsel
  - Deputy Director
  - Chief of Staff and Operations
    - Office of Communications
    - Health Districts Administration
  - Office of Finance and Accounts
  - Office of Human Resources
  - Chief Science Officer
    - Office of Decision Science
      - Office of Evaluation
      - Office of Health Informatics
  - Medical Director
    - Office of Health Promotion
  - Medical Director
    - Office of Health Protection
  - Medical Director
    - Office of Epidemiology
    - Surveillance
    - Public Health Laboratory
    - Pharmacy
    - Emergency Response
    - Environmental Health
    - Licensure
  - Medical Director
    - Office of Health Disparity
  - Medical Director
    - Office of Health Services
    - Child/Adolescent Health
    - Women's Health
    - WIC Program
  - District Medical Directors
    - Districts I & III
    - Districts II & IV
    - Districts V & VI
    - Districts VII & VIII
    - District IX

SOURCE: State Personnel Board.

Appendix E-4: Organization Chart for Reorganization of the
Department of Health approved by the State Personnel Board on
August 19, 2004

Mississippi State Department of Health
Agency: 90301
FY-2005
Prepared July 1, 2004

Signature

Mississippi State Department of Health

Functional Organizational Chart

```
                        State Health Officer
                              |
        ┌─────────────────────┼─────────────────────┐
        |                     |                      |
  Deputy Director      Health, Science, Dental
  Chief of Staff        and Medical Officers

  Information Technology
  Health Policy and Planning
  Human Resources
  Communications
  Performance Accountability
  Public Health Pharmacy
  Legal Counsel
```

Finance and Administration	Health Protection	Health Services
Finance and Accounts	Public Health Preparedness/EMS	Child/Adolescent Health
Evaluation/Quality	Environmental Health	Women's Health
Facilities and Property Management	Licensure	WIC Program
District/County Health Department Administration	Communicable Disease	Preventive Health
	Public Health Laboratory	

SOURCE: MSDH.

Appendix F: Role of the State Personnel Board in Approving Agencies' Organizational Changes

State Personnel Board policy distinguishes between major changes or movement of positions within an agency's organizational structure and minor alterations to the same. The State Personnel Board staff refers to the former as an "organizational change" and the latter as a "minor restructuring."

SPB's Requirements for an Agency Reorganization

Subsection C of Section 6.13.3 of the *Mississippi State Personnel Board Policy and Procedures Manual* requires prior State Personnel Board approval of the reorganization of a state agency:

> *Agencies shall request the State Personnel Board to review major changes or movement of positions within the organization structure. Major alterations, movements or changes within the agency organizational structure must be approved by the State Personnel Board prior to implementation by the agency.*

Section 6.13.5 of the manual requires agencies requesting a reorganization to submit "a detailed letter of compelling justification from the agency director to the State Personnel Director" with attachments required by State Personnel Board policy--e.g., current and proposed organizational charts and required documentation for any requested realignments. The State Personnel Board's staff reviews the agency's reorganization request for compliance with relevant State Personnel Board policies and procedures in making its recommendation for approval or disapproval of the request to the board. For example, a section of State Personnel Board Policy 6.13.3.a specifies the organizational hierarchy that larger agencies with a complicated organization and span of control (such as MSDH) must adhere to: office, bureau, division, branch, and section.

SPB's Requirements for Minor Restructuring of an Agency

Subsection B of Section 6.13.3 allows agencies to make minor organizational alterations "for efficiency or to balance staffing workload," but requires the agencies to submit such requests for organizational revisions online

to the State Personnel Board staff, along with the following information in support of the requested organizational change:

• organizational chart pages signed by the appointing authority depicting both current and proposed structure; and,

• additional documentation as may be specified by the State Personnel Director.

While minor restructurings of an agency do not require approval of the State Personnel Board, the SPB's staff reviews such changes for compliance with relevant SPB policies and procedures.

SOURCE: PEER analysis.

Appendix G: Case Study of Failure of MSDH's Performance Improvement Initiative in the Tuberculosis Program

As stated on page 25, one of MSDH's performance improvement measures was the percent of latent TB patients current on therapy. In February 2003, MSDH management set a performance improvement goal of raising the number of latent TB patients "current on therapy" from 80% to 95% in ninety days.

PEER determined that, under pressure to achieve rapid improvement or risk losing their jobs:

- program staff changed the definition of "current on therapy" to increase the success reported on the performance measure; and,

- the number of latent TB cases *placed on therapy* declined during the same reporting period, which could have reflected a failure to initiate treatment for some patients with a high potential for not staying current on therapy.

Change in the Definition of "Current on Therapy"

As a consequence of the intense pressure to increase performance in the absence of concrete steps for achieving improvement, MSDH staff initiated ways of making the performance data appear more favorable. One way that they achieved this was by changing the definition of "current." Historically, the TB program staff had defined *current* as those latent TB infection patients who had received their therapy within the past five weeks. However, during the period of March 2003 through August 2004, the staff used a more lenient definition of current for eleven of the eighteen months (i.e., using the term "current" for a period longer than five weeks, varying from month to month). The more lenient definition resulted in as much as a 6% increase in the percentage of latent TB infection patients reported as current on their therapy (in August 2004) over the five-week definition of "current."

Possible Failure to Initiate Treatment for Some TB Patients

Another reported way that the field staff in some districts attempted to reach the performance improvement target was by initiating a more intensive screening of the latent TB cases that they would treat and not initiating therapy

on those cases that they knew would be difficult to maintain current on their treatment (e.g., the homeless)[6]. While none of the program staff members interviewed by PEER reported having actually participated in such screening, the number of cases placed on therapy declined from a high of 2,393 in March 2003 (when the 95% current target was announced) to a low of 1,861 cases in December 2003 and January 2004.

Concerned over the observed decline in the number of cases of latent TB infection placed on drug therapy, the TB program staff asked the department's Office of Evaluation to analyze the latent case data. After conducting a statistical analysis of the data, by district, for an eleven-month period before the department's February 2003 emphasis on improving the percentage of patients with latent TB infection current on therapy and an eleven-month period after, the Director of MSDH's Office of Science and Evaluation concluded that "the increased emphasis on 'current on therapy' could be a factor influencing the decline in the number on therapy."

As noted by the CDC in its *Core Curriculum on Tuberculosis: What the Clinician Should Know*, "Treatment of latent TB infection is essential to controlling and eliminating TB in the United States." A decline in the number of cases of latent TB infection placed on drug therapy by the Department of Health could represent a future public health threat, as untreated cases could become active.
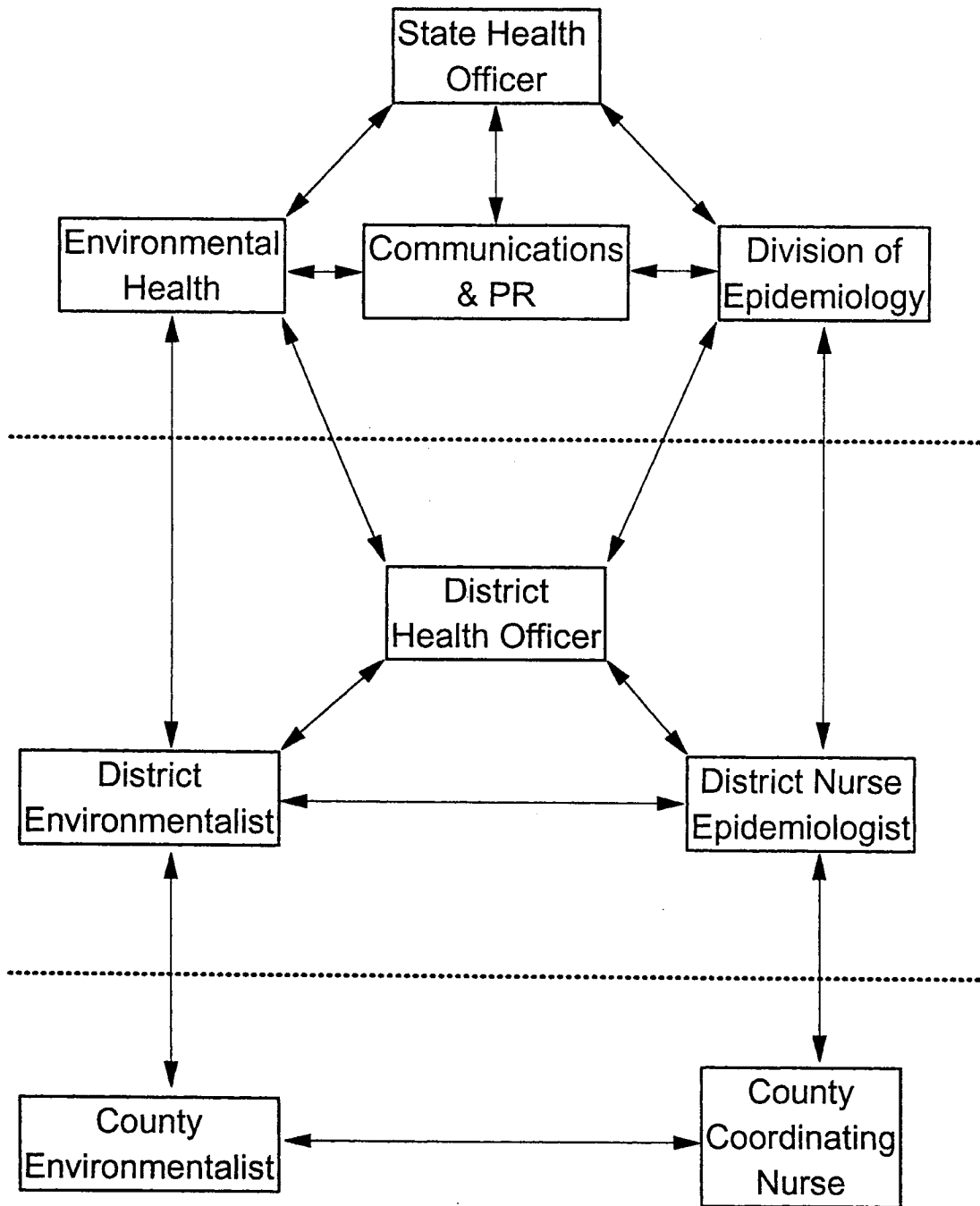
Following the report of the Office of Evaluation documenting a continuing decline in the number of patients with latent TB infection current on therapy, the department discontinued its collection of "current on treatment" data in December 2004. Despite the inefficacy of this effort at performance improvement, as recently as July 2005, the department continued to highlight on its website the 2003 "current on treatment" emphasis for patients with latent TB infection as a performance improvement success.

SOURCE: PEER analysis.

---

[6] In Mississippi, the decision of which cases of latent TB to place on drug therapy is made by MSDH staff at the district and county levels. Unless contraindicated by a drug allergy or medical condition such as hepatitis, the staff places the cases of latent TB on drug therapy in priority order of children (highest priority to those under age 5), persons who are HIV positive, and individuals who initially tested negative following exposure to the disease, but showed a significant positive result in the follow-up skin test. In addition to cases in these high priority groups, the MSDH staff carefully considers drug therapy for individuals with latent TB infection in congregate living settings such as nursing homes and prisons.

Appendix H: Diagram of the Office of Epidemiology's Required Communications Flow for Foodborne, Waterborne, and Other Outbreak Investigations

NOTE: The Epidemiology Policies and Procedures Manual's diagram for communications flow for foodborne, waterborne, and other outbreak investigations illustrates two-way communications between the Division of Epidemiology and the District Nurse Epidemiologist; district epidemiology nurses were told they could no longer directly contact the staff of the Division of Epidemiology at the central office, but were to make contacts through their district health officers.
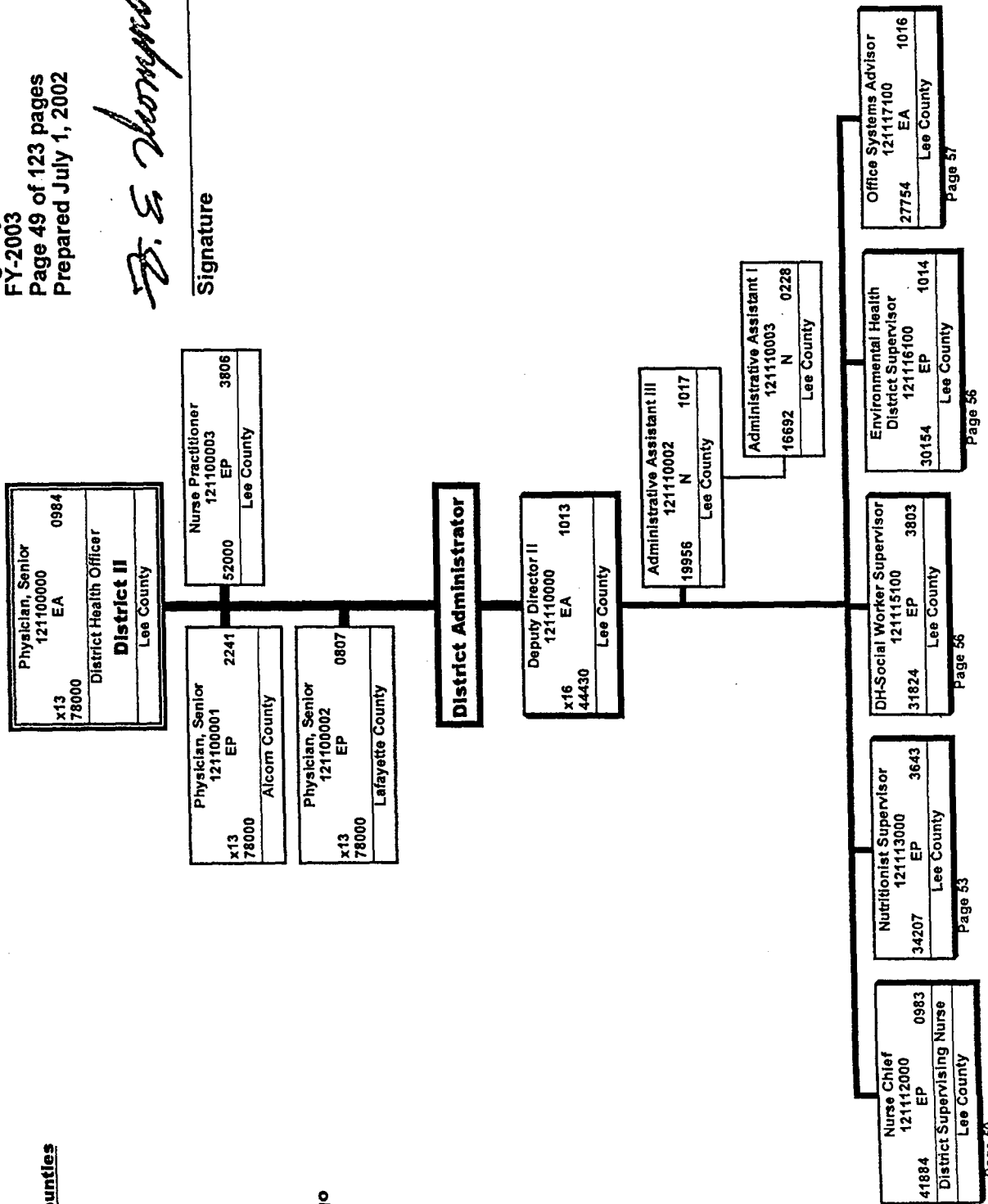
Appendix I-1: Example of District Organizational Structure, Effective July 1, 2002

Mississippi State Department of Health
Agency: 90301
FY-2003
Page 49 of 123 pages
Prepared July 1, 2002

[signature]

Signature

District II Counties

1- Alcorn
2- Benton
3- Itawamba
4- Lafayette
5- Lee
6- Marshall
7- Pontotoc
8- Prentiss
9- Tippah
10- Tishomingo
11- Union

Physician, Senior
121100000
EA   0984
District Health Officer
District II
x13
78000   Lee County

Physician, Senior
121100001
EP   2241
x13
78000   Alcorn County

Physician, Senior
121100002
EP   0807
x13
78000   Lafayette County

Nurse Practitioner
121100003
EP   3806
52000   Lee County

District Administrator

Deputy Director II
121110000
EA   1013
x16
44430   Lee County

Administrative Assistant III
121110002
N   1017
19956   Lee County

Administrative Assistant I
121110003
N   0228
16692   Lee County

Nurse Chief
121112000
EP   0983
District Supervising Nurse
41884   Lee County
Page 50

Nutritionist Supervisor
121113000
EP   3643
34207   Lee County
Page 53

DH-Social Worker Supervisor
121115100
EP   3803
31824   Lee County
Page 56

Environmental Health District Supervisor
121116100
EP   1014
30154   Lee County
Page 56

Office Systems Advisor
121117100
EA   1016
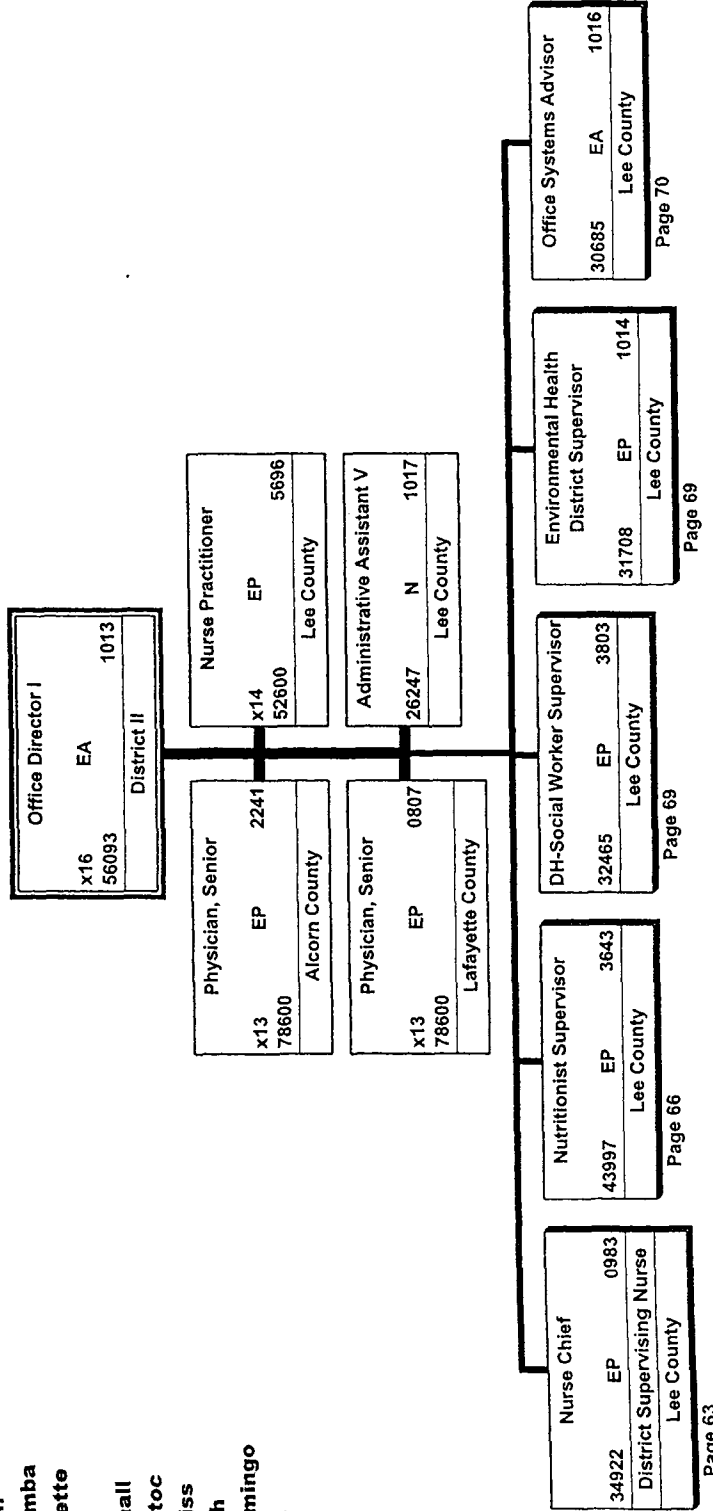27754   Lee County
Page 57

SOURCE: State Personnel Board.

61

Appendix I-2: Example of District Organizational Structure, Effective July 1, 2004

Mississippi State Department of Health
Agency: 90301
FY-2005
Page 62 of
Prepared July 1, 2004

<u>District II Counties</u>

1- Alcorn
2- Benton
3- Itawamba
4- Lafayette
5- Lee
6- Marshall
7- Pontotoc
8- Prentiss
9- Tippah
10-Tishomingo
11-Union

Office Director I
x16   EA   1013
56093   District II

Physician, Senior
x13   EP   2241
78600   Alcorn County

Physician, Senior
x13   EP   0807
78600   Lafayette County

Nurse Practitioner
x14   EP   5696
52600   Lee County

Administrative Assistant V
26247   N   1017
        Lee County

Nurse Chief
34922   EP   0983
District Supervising Nurse
        Lee County
Page 63

Nutritionist Supervisor
43997   EP   3643
        Lee County
Page 66

DH-Social Worker Supervisor
32465   EP   3803
        Lee County
Page 69

Environmental Health District Supervisor
31708   EP   1014
        Lee County
Page 69

Office Systems Advisor
30685   EA   1016
        Lee County
Page 70

MISSISSIPPI DEPARTMENT OF HEALTH

October 31, 2005

Honorable Dirk Dedeaux, Chair
Joint Legislative PEER Committee
Woolfolk Building, Suite 301-A
501 North West Street
Jackson, MS 39201

Dear Representative Dedeaux:

On behalf of the Mississippi State Board of Health, I would like to express sincere appreciation on behalf of the Board for allowing board members to appear before the Committee in relation to a draft report prepared by the PEER Committee staff. At that meeting, the PEER Committee requested that the Mississippi State Board of Health provide additional information to the Committee.

The staff of the Mississippi Department of Health (MDH) provided a written response to the draft PEER report on September 7, 2005. The MDH staff also provided all board members with a copy of the written response at that time. Subsequently, the Vice Chairman and I have contacted all board members to insure that each has received and reviewed the MDH staff response to the draft report prepared by the PEER staff.

The next meeting of the Mississippi State Board of Health is scheduled for January 11, 2006. The Vice Chairman and I have also contacted each of the other eleven members of the Board regarding the draft PEER report and advised each member regarding plans to have the Board review and study the recommendations of the PEER Committee.

Under authority of the bylaws of the Mississippi State Board of Health, the Chairman is vested with the authority to appoint committees of the Board. At the January 11, 2006 Board Meeting, I will appoint a committee to review recommendations of the draft PEER report with Agency management and provide recommendations to the full Board of Health.
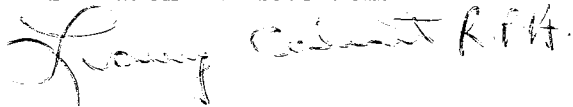
BRIAN W. AMY, MD, MHA, MPH - STATE HEALTH OFFICER

570 East Woodrow Wilson - Post Office Box 1700 - Jackson, Mississippi 39215-1700
601-576-7634 - Fax 601-576-7931 - www.HealthyMS.com

Equal Opportunity In Employment/Services

63

After a nationwide search in 2002, the Mississippi State Board of Health selected Dr. Brian Amy as State Health Officer. The Board's selection of Dr. Amy was based on concern that the Agency's management philosophy was in need of new direction. The Board felt that the Agency needed to improve its focus on access, customer service, quality improvement and accountability.

Dr. Amy and the dedicated 2,200 employees of this Agency continue to work to reshape the culture and image of the Agency. Such change does not come easy, especially in a government environment of diminishing resources and increasing demands. Much progress has been made as the MDH management team has resolved a number of inherited programmatic problems. Dr. Amy and his staff received, and continue to receive, the full support of the Board of Health during this positive transitional period.

As Chairman of this Board, please let me assure you that the Board will seriously consider recommendations of the PEER Committee as we seek to protect and promote the health of all Mississippians. The Board and the management of this Agency are committed to continuous improvement.

Education and Prevention:

Larry Calvert, R.Ph.
Chairman
Mississippi State Board of Health

Mary Kim Smith, RN
Vice Chairman
Mississippi State Board of Health

cc: Board of Health
        Max K. Arinder, Ph.D.

PEER Committee Staff

Max Arinder, Executive Director
James Barber, Deputy Director
Ted Booth, General Counsel

Evaluation
David Pray, Division Manager
Linda Triplett, Division Manager
Larry Whiting, Division Manager
Chad Allen
Antwyn Brown
Pamela O. Carter
Kim Cummins
Lonnie Edgar
Yohhana Goode
Barbara Hamilton
Kelly Kuyrkendall
Karen Land
Sara Miller
Joyce McCants
John Pearce
Brad Rowland

Editing and Records
Ava Welborn, Editor and Records Coordinator
Tracy Bobo
Sandra Haller

Administration
Mary McNeill, Accounting and Office Manager
Rosana Slawson
Gale Taylor

Data Processing
Larry Landrum, Systems Analyst

Corrections Audit
Louwill Davis, Corrections Auditor