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Details: INFORMATIONAL HEARING FOR PROPOSED PUBLIC HEALTH INSTITUTE

(FORM UPDATED: 07/12/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on ... Public Health
(AC-PH)

COMMITTEE NOTICES ...

- Committee Reports ... CR
- Executive Sessions ... ES
- Public Hearings ... PH
- Record of Comm. Proceedings ... RCP

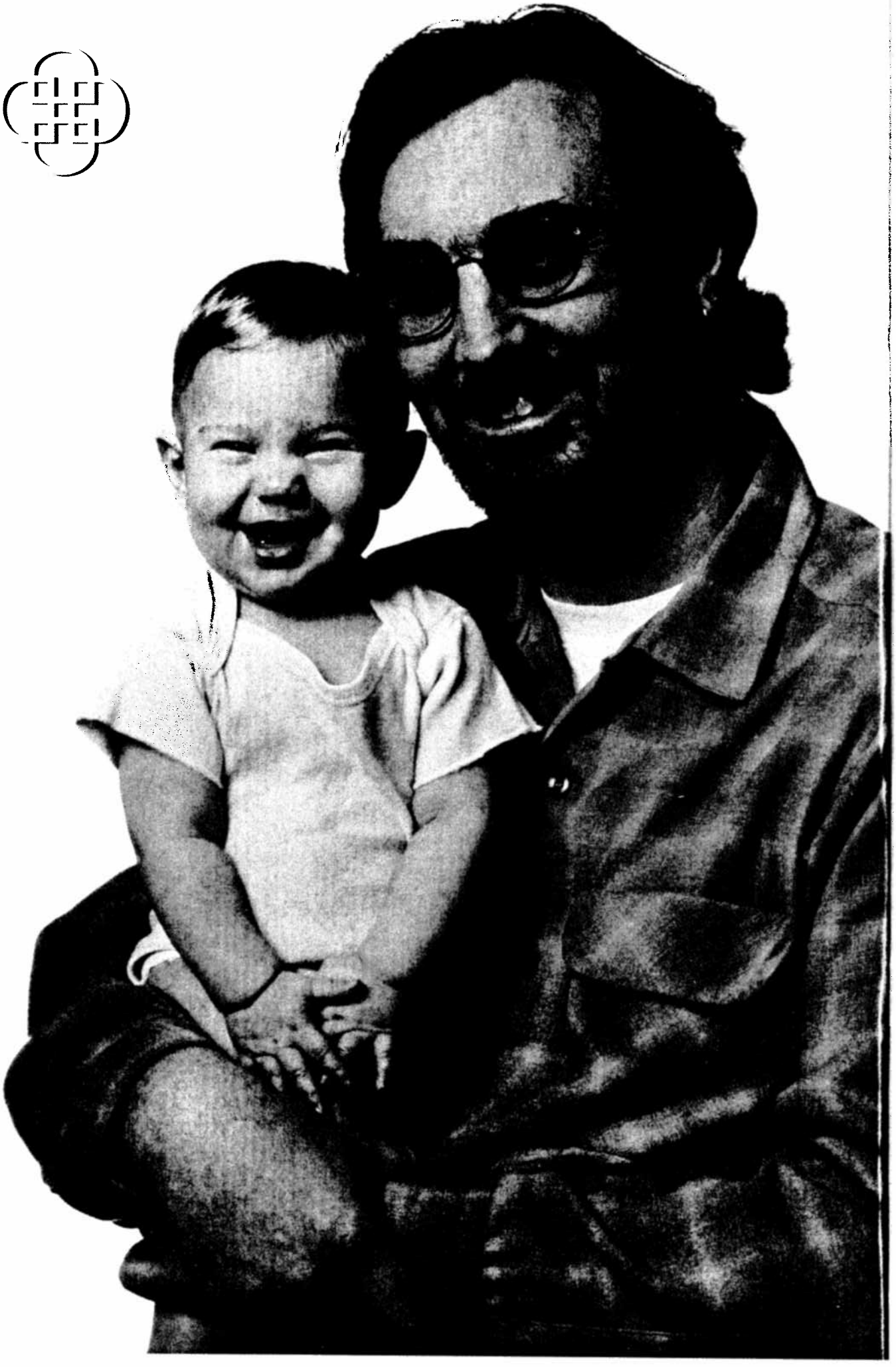
INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... Appt
- Clearinghouse Rules ... CRule
- Hearing Records ... bills and resolutions
  (ab = Assembly Bill) (ar = Assembly Resolution) (ajr = Assembly Joint Resolution)
  (sb = Senate Bill) (sr = Senate Resolution) (sjr = Senate Joint Resolution)
- Miscellaneous ... Misc

MICHIGAN PUBLIC HEALTH INSTITUTE®

2003 ANNUAL REPORT

WORKING ADDITIONS WITH YOU TO IMPROVE HEALTH



vision

MPHI will be a unique public trust which will enable communities to apply state-of-the-art community health practices.

mission

The mission of MPHI is to maximize positive health conditions in populations and communities through collaboration, scientific inquiry, and applied expertise which:

- Carry the voice of communities to health policy makers, scientists, purchasers, and funders;
- Advance the application of scientific health practices in communities; and
- Advance community capacity to improve health and reduce disparities among population groups and geographic areas.

values

MPHI's board of directors, management, and staff are committed to uphold these values in our work, relationships, and governance:

- Collaboration and inclusiveness among MPHI, government, communities, and institutions in approaching matters of the public's health.
- State-of-the-art research, education, and demonstration as vehicles for advancing health practice.
- Leadership and service for the benefit of community, rather than to advance institutions, partners, or staff.
- Prevention of disease and promotion of health.
- Ethical behavior in all scientific, professional, and interpersonal matters.
- Quality, professionalism, and integrity in the work we do, the people we hire, and the workplace we create.
- Innovation and continuous improvements in the workplace, as our assurance of maintaining our responsiveness and utility to our clients.

MICHIGAN PUBLIC
HEALTH INSTITUTE®

In my introduction to last year's annual report, I wrote that Michigan's public health community was being challenged as never before and that we were facing the prospect of making tough choices that would enable us to do more with less.

Unfortunately, the situation this year is just as challenging, at least in terms of financial resources. During 2003, budgetary shortfalls continued to place a severe strain on our infrastructure, and yet, the need for an effective, public health system remained as strong as ever. In our efforts to meet the needs of Michigan's communities, we have sought, and found, new and creative ways to address today's complex public health challenges. In the process, we have been able to maintain and, in some cases, even begin the first steps of rebuilding our state's most successful prevention-based programs.

We have found value in a variety of strategies, and we have recognized anew the power that exists when stakeholders from all corners—public health agencies, the community, business, academia, and the nonprofit sector—join together in collaboration to share resources and work side by side to build healthier communities and improve the lives of our families, friends, coworkers, and neighbors.

This kind of collaborative approach to solving problems is not new to our state. In fact, Michigan has long served as a nationally recognized model of collaborative successes in many areas of public health. The products being developed on a daily basis here at MPHI in conjunction with the Institute's four founding partners (Michigan State University, the University of Michigan, Wayne State University, and the Michigan Department of Community Health) and other stakeholders are wonderful examples of Michigan's leadership in community health. One by one, they stand in testimony of the Institute's vision statement, which is to serve as a unique public trust that will enable communities to apply state-of-the-art community health practices that will better the lives of their residents.

The National MCH Center for Child Death Review, one of the MPHI projects profiled in this year's report, is an outstanding example of our commitment to develop, and apply, such state-of-the-art community health practices.

Created in part with a grant from the Health Resources and Services Administration Maternal and Child Health Bureau, the Center is the first of its kind—a centralized, national resource base for state and local child death review (CDR) programs. Each day, Center staff members at MPHI work to promote, support and enhance CDR methodology and activities across all levels—community, state and national—and to build public and private partnerships that will take these cutting-edge CDR findings and put them into action to improve the health and well-being of our nation's children.

As part of this landmark effort, Center staffers are joining forces with state-level CDR coordinators, key community contacts, and nationally recognized experts to develop an array of training and technical resources, including standardized protocols and materials and a national Web-based reporting tool and system, that will provide invaluable assistance to all stakeholders working to stem the tide of child injuries and deaths.

In the years since the Institute was founded in 1990, MPHI has had the privilege of directing or being involved with an impressive number of groundbreaking projects that have helped prevent disease and promote public health through a mixture of policy development, planning, scientific research, service demonstrations, education, and training.

Another successful collaboration facilitated by MPHI is the Michigan Academic Consortium: Nurse Managed Primary Care. The Michigan Academic Consortium, funded by a grant from the W.K. Kellogg Foundation is comprised of MPHI and four schools/colleges of nursing at University of Michigan, Michigan State University, Wayne State University and Grand Valley State University. Dr. Joanne Pohl, Associate Dean in the College of Nursing of the University of Michigan is the Principal Investigator. MPHI is a key project partner on the steering committee, holds fiduciary responsibility for the project, and facilitates collaborative evaluation activities.

The goals for the Michigan Academic Consortium include curriculum development for nurse practitioner students, informing policy related to nursing practice, and supporting the role of nurse managed health centers in providing high quality, cost effective care to underserved patients. The effectiveness of this collaboration was recognized when the W.K. Kellogg Foundation awarded the Michigan Academic Consortium a second grant to establish a National Network for Nurse Managed Health Centers.

At the core of each and every one of these efforts is the concept of collaboration and the knowledge that, by working together, these organizations can not only stretch their limited human and financial resources, but also greatly increase the effect of their efforts, and MPHI is an integral part of these efforts.

These pages are filled with other examples of our work. I urge you to sit back, take some time, and learn about these projects, which are just a sampling of those we've undertaken during the past year. As you review these pages and the programs they feature, I also encourage you to stop and think about how you can partner with other organizations to pool your constrained resources and individual organizational strengths and work together toward realization of our common goal: generations of happy, healthy people living in vibrant, supportive communities.

For Michigan's future,

Janet Olszewski

Janet Olszewski
President, MPHI Board of Directors &
Director, Michigan Department of Community Health

2003 Board of Directors

Back row, left to right:
Jeffrey Taylor, PhD;
R. Michael Massanari, MD;
Michael Mortimore, MEd, MPH;
Mark Miller;
James Vincent, PhD, DSc;
James Randolph

Front row, left to right:
Martha Hessee, PhD;
Janet Olszewski;
Michael Ezzo, EdD;
Denise Holmes

Missing:
Gail Jensen, PhD;
Karen Aldridge-Eason, MPA;
Jean Chabut

Janet Olszewski* (President—MPHI)
Director, Michigan Department of Community Health

Karen Aldridge-Eason, MPA
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Department of Economics, Wayne State University

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Professor and Chairman, Department of Environmental
Health Sciences, University of Michigan

Alternate to Janet Olszewski:
Michael Ezzo, EdD*
Chief Deputy Director, Michigan Department of
Community Health

Ex Officio:
Jeffrey R. Taylor, PhD
Executive Director, MPHI

* = Executive Committee member

The National MCH Child Death Review Resource Center:

Building Capacity in States to Prevent Child Deaths

Children are not supposed to die

The death of a child represents unjust suffering, unfulfilled promises, and great loss to family, friends and community. Child Death Review (CDR) is a process that studies child deaths in order to prevent harm to other children. It is a collaborative approach that brings people together at a state and/or local level and from multiple disciplines to share and discuss comprehensive information regarding the circumstances leading to the death of child and the response(s) to that death.

CDR is a relatively new public health approach

CDR began in scattered communities throughout the United States in the 1970 and 1980s in an attempt to better investigate and report on deaths from child abuse. Teams sprang up independently from Los Angeles to South Carolina. There was limited but significant national support for CDR. The American Bar Association developed training resources to help establish review teams; the American Medical Association and the American Academy of Pediatrics issued policy statements supporting the premise of CDR, the U.S. Department of Health and Human Services encouraged reviews as part of its *Healthy People 2000* objectives; and the Maternal and Child Health (MCH) Bureau of the U.S. Health Resources and Services Administration (HRSA) recommended that prevention be the primary purpose of the CDR process.

Michigan established its CDR program in 1994, with a grant to the Michigan Public Health Institute. A decision was made then by the participating state agencies to focus on prevention and to broaden reviews to all child deaths.

Today, 49 states have child death review programs. There is great variance in the scope of CDR programs across the U.S, but they do share one common premise: the tragedy of a child's death should be a difference-maker and help foster positive change within a community. Most CDR programs today believe that their efforts to understand the entire spectrum of factors that led to a child's death can help prevent more deaths, as well as poor health outcomes or injuries that might otherwise be suffered by children within the community.

Michigan Serves as a National Model

Michigan was one of the first states to expand the focus of CDR to all child deaths from birth to age 18 (approximately 2,000 a year in Michigan). Managed at the Michigan Public Health Institute (MPHI) and funded by the Family Independence Agency, we were able to demonstrate that a prevention-based approach actually improves our ability to identify child abuse and neglect deaths while expanding efforts to all other preventable deaths of children. The approach is also successful in catalyzing communities to take action to prevent deaths. Since the program began, local teams in Michigan have reviewed over 4,000 deaths and made 1,500 recommendations to prevent deaths. More than 725 of these recommendations have resulted in child health and safety initiatives at the state and local level.

Michigan's program became a model for other states, and for several years staff were often asked to provide training and technical assistance to these states. In 2002, in a move to provide stronger national leadership, the HRSA Maternal and Child Health Bureau made funds available for a national resource center for child death review.[1] In part, because of our success with our public-health model, MPHI received the three-year grant from the Bureau. The Institute has since established the National MCH Center for Child Death Review.

The focus of the new Center is to promote, support and enhance child death review methodology and activities at the local, state and national levels. In its first year and a half, the Center has provided on-site training and technical support to more than 30 states, helping them review all child deaths and offering methodologies to help translate CDR findings into state and local actions for preventing child deaths and injuries.

By Theresa M. Covington, MPH, and Sara K. Rich, MPA*

Helping Build CDR Capacity Nationwide

In the fall of 2003, the Center hosted a meeting in Chicago for state CDR coordinators and CDR advocates. This inaugural event brought together more than 100 participants from 46 states to build a network of CDR advocates. Participants shared experiences, learned new skills, networked, and celebrated the successes of their CDR programs across the country.

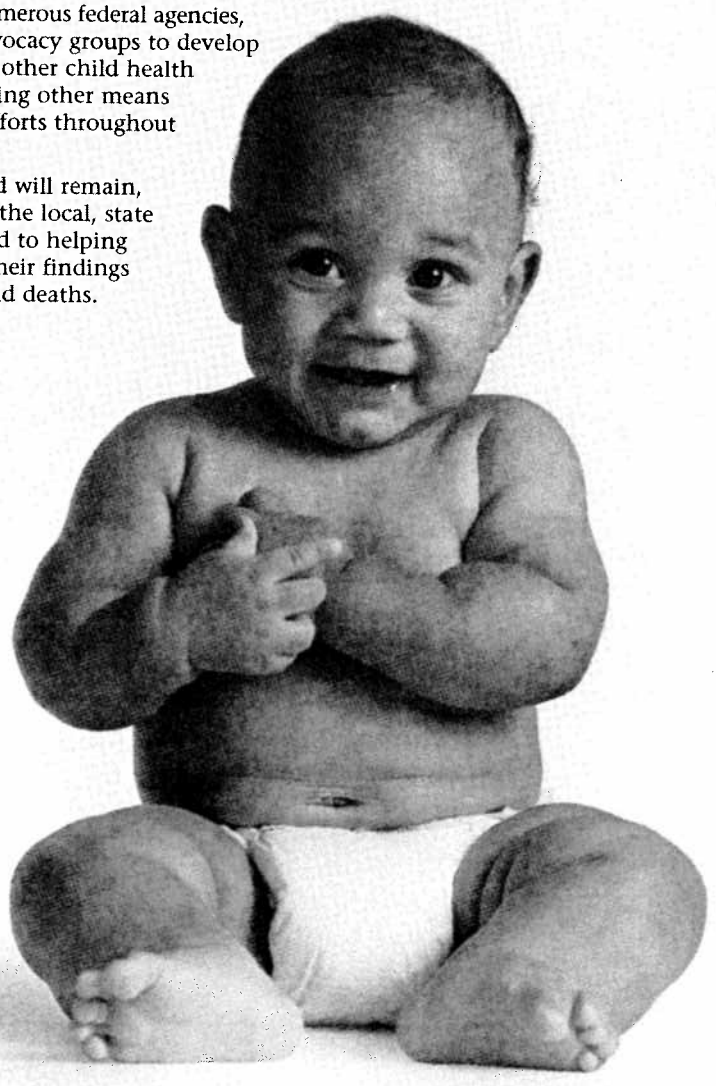
This network of CDR advocates is now working to develop resources and materials to help build capacity for CDR at both state and local levels. Two major efforts are currently underway.

One work group of 12 states is developing electronic and print resources, including a CDR program manual and training curricula.

Another group of 16 states has been working to build a national Web-based child death reporting system. Using the software programming resources of MPHI, this Web-based data reporting system will provide a mechanism for any local or state CDR teams to collect information surrounding the circumstances of the cases they are reviewing. State and local programs will have access to their own local and state data. The Center will manage the national database of CDR findings that can then be used by stakeholders advocating for national child health and safety programs, services and legislation.

The Center is working closely with numerous federal agencies, national organizations, and child advocacy groups to develop linkages between CDR programs and other child health and safety efforts and is actively seeking other means of empowering CDR programs and efforts throughout the country.

The child death review process is, and will remain, a powerful mechanism for change at the local, state and national levels. MPHI is dedicated to helping local and state CDR teams translate their findings into action to prevent infant and child deaths.



More Information:

For more information, contact the Center at: 2438 Woodlake Circle, Suite 240, Okemos, MI 48864 (toll-free: 800-656-2434) or visit the Center's web site at www.childdeathreview.org.

Information about Michigan's program, Keeping Kids Alive, can be found at www.keepingkidsalive.org.

* Theresa M. Covington, MPH, is director of the National MCH Center for Child Death Review and senior program director of Child and Adolescent Health at MPHI. Sara K. Rich, MPA, is project coordinator for the Center.

The National MCH Center for Child Death Review is supported in part by Grant No. 1 U93 MC 00225-01 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

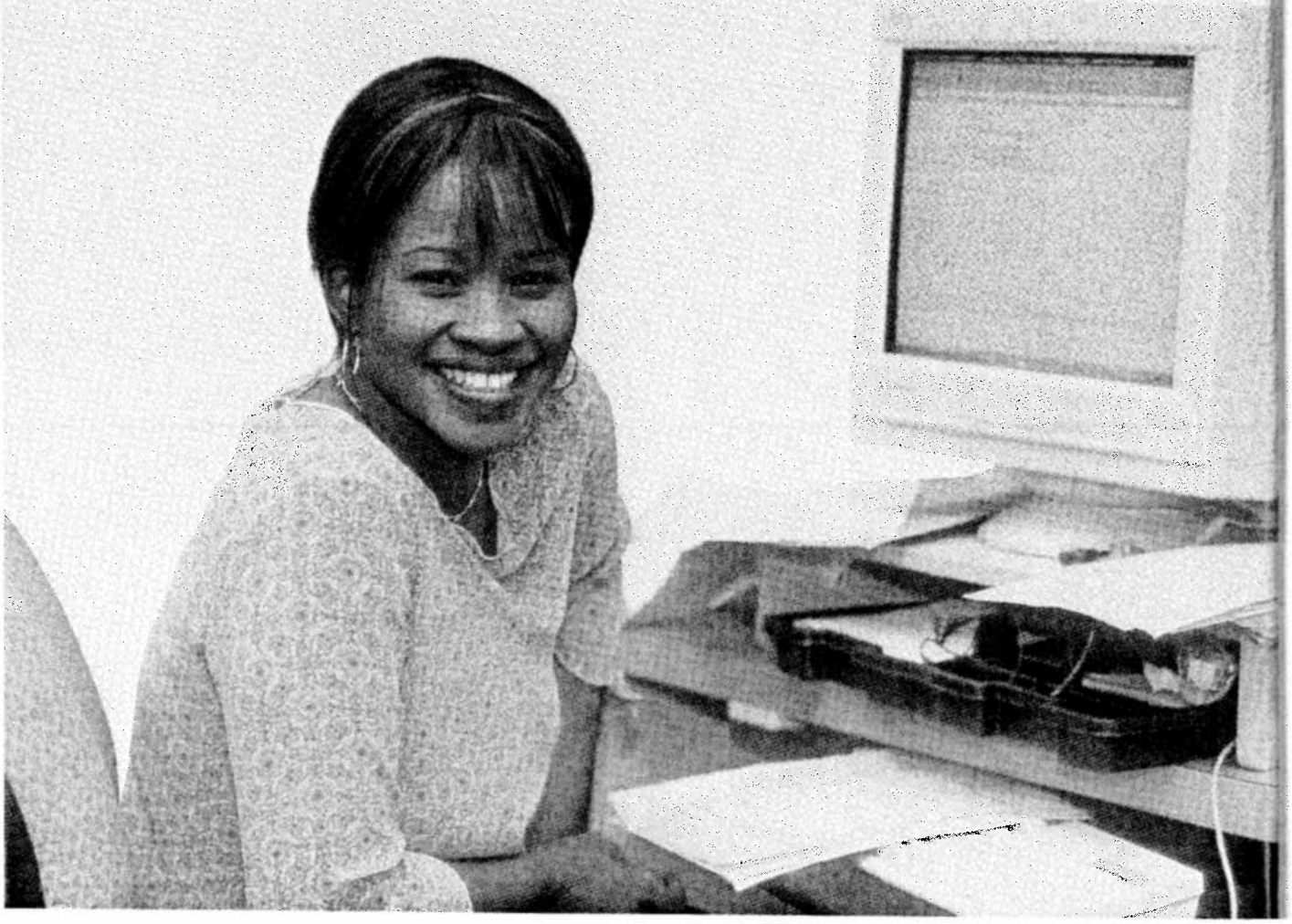
The SAP Enterprise Resource Planning System:

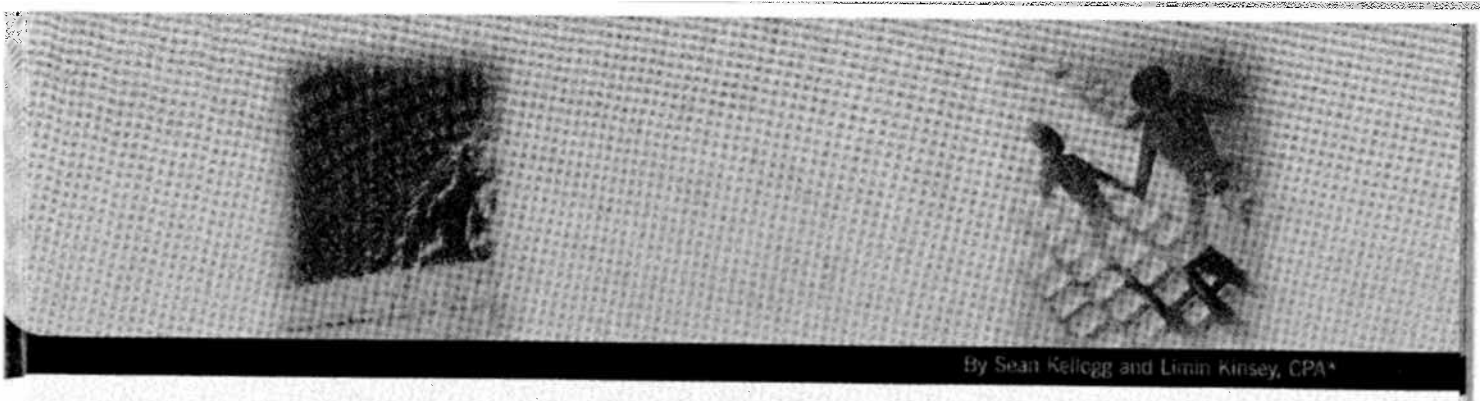
Increasing MPHI's Ability to Track and Report on Projects

Introduction

In its second year now, the Systems, Applications, and Products in Data Processing (SAP) has become an extremely useful information system for MPHI. The system provides the institute with outstanding tools for storing and extracting integrated data, as well as improving reporting, and increasing efficiency. The system will continue to meet the needs of project and administrative staff as additional features are utilized.

MPHI's SAP system has come a long way since it was launched in January of 2002. The addition of a quality assurance server has enabled MPHI to thoroughly test configuration changes using a copy of the live production system. The SAP support team has increased database storage, tightened system and server security, tuned system performance, and introduced new capabilities into the system.





By Sean Kellogg and Limin Kinsey, CPA*

How the SAP System Works

At the core of MPHI's SAP system is the Finance and Controlling (FI/CO) module, which the Finance and Contracts department uses to perform a multitude of tasks more easily and efficiently. While FI/CO is the center of the system, other modules in use include: Human Resources, Materials Management, Project Systems, and Sales and Distribution. System improvements already being planned for 2004 include the addition of tools and modules, such as Employee Self Service, Applicant Tracking, Project Management, and additional functionality within Grants Management.

The interface of the system is truly a user-friendly one. Navigation within all SAP application components is similar, making it a straightforward process for users to move from one section to another in the system's relational database. The system's easy-to-use screens enable users to work quickly and customize their own workspace, if desired.

When an Institute employee is assigned his or her individual user role within the SAP system, he or she is assigned not only the menu, but also the authorizations that are required to successfully access the information; this ensures that the data stored within the system is always secure and available only to those with the proper authorization.

The system's features mean that users can take advantage of a large repository of information and have all the data relevant to their projects readily available at the click of the mouse. Because the SAP system employs a relational database, information entered into the system by one MPHI staff member is immediately accessible to all other staff members authorized to access it, whether or not they are located within the same physical site. Thus, a project team member working on-site at one of the Institute's offices or off-site at a project or client location can enter data into the system and everyone else with the proper authorization for that project can access the information instantly, independent of physical location.

One of the most popular attributes of the SAP system is its real-time information processing capabilities, which enable users to input data and immediately observe the results. This represents a tremendous advantage for MPHI and its staff, because it allows users to track and print self-customized reports of up-to-the-minute project information that can prove invaluable when analyzing and managing project activities and outcomes. In contrast, the previous database employed by MPHI required that reports be printed by the Institute's Finance and Contracts Office and then distributed to staff members.

The SAP system makes financial management of individual projects easier by enabling users to process purchase orders and encumber the various funds against the project's budget. Managers of the funds can assign specific individuals to the projects so only those individuals are authorized to charge against the project's budget. As an added benefit, the drill-down capabilities on various transactions allow users to view the originating document right from their desktop.

Another SAP tool provides an additional mechanism of control over the allowance of costs against a specific project's budget. Through this mechanism, a set of messages are broadcast to the user based upon certain thresholds that have been set in the system to alert the user if the project budget is nearly exhausted; in some cases, the system may completely stop the user from charging expenses to a particular budget if the funds are not available for a specified budget line.

More Information:

For more information, contact the Management Information Technology department at 2501 Jolly Road, Suite 180, Okemos, MI 48864 (Phone: 517-324-8369).

* Sean Kellogg is director of Management Information Technology for MPHI. Limin Kinsey, CPA, is assistant controller for the Institute.

MPHI Center for Long Term Care:

Providing Resources for Long-Term Care Workers & Families

Introduction

The MPHI Center for Long Term Care develops and delivers unique products, resources and services that promote care and service excellence in the long-term care environment. Collaboration with a wide variety of community organizations is key to our success.

The Center strives to partner with other educational and health service entities to strengthen organizations and communities, and staff members take the Center's mission to heart: *To mentor professionals in the long-term care continuum in clinical practices, management skill building, and the art of caregiving to improve and promote quality of care and quality of life.*

The Center is dedicated to the premise that the lives of long-term care residents must be celebrated and valued, and each staff person's work reflects that dedication.

Remediation Services

For six years, the Center's Collaborative Remediation Project (CRP) has delivered valued remediation services to nursing facilities statewide as an alternative or complement to other regulatory enforcement remedies. Using a collaborative model unique to Michigan, the Center assists facility staff as they develop Directed Plans of Corrections designed to enhance the facility's current care and monitoring systems.

A variety of Directed In-Service Trainings on significant clinical issues are available. In addition to current standards of practice, these services are designed to focus on clinical systems analysis and staff education.

Center staffers are proud of the fact that nursing facilities that effectively utilize the Center's CRP services have an average compliance rate approaching 96 percent when revisited by the state survey agency.

A significant component of the CRP involves the Accredited Remediator service. The Center maintains a corps of remediators to meet state survey agency requests for temporary managers, administrative advisors, or clinical advisors for facilities needing administrative or clinical assistance. Additionally, the Center serves as an agent of the state in the facilitation of other specialized resident-focused services.

Education Services

The Center's mission is to promote educational excellence for long-term care professionals within Michigan. The Center partners with a variety of educational and health care organizations, including universities and other non-profit associations, to address the needs of these professionals. The Michigan Nurses Association has approved the Center as a provider of nursing contact hours.

From March 1998 to September 2003, the Center offered the Resident and Family Education Project through a grant from the Michigan Department of Community Health. This project offered on-site education for residents and family members on a variety of topics, including: visiting the nursing home; alternatives to physical restraints; caring for the person with dementia; and basic issues in long-term care. During the project's five and a half years, the Center delivered more than 850 programs in 356 nursing facilities statewide.

The Dementia Sensitive Care Series contains four educational programs designed to give participants the knowledge and skills needed to enhance the quality of life for a person with dementia. Developed for all caregivers, including staff, family or community members, each program provides a variety of techniques that build upon the strengths of the person with dementia and can be used to form a positive approach to care and interactions.

Through an Agreement with the Bureau of Health Systems, the Center facilitates the semi-annual Joint Provider/Surveyor Trainings. More than 800 individuals attended each of the 2003 spring and fall events, both of which featured nationally recognized speakers. These trainings are legislatively required to focus on survey compliance topics of significance within the state, and they include the rollout of clinical process guidelines.

By Carl A. Gibson, PhD, and Paula Hoegemeyer, RN, NHA*

Education Services (cont'd.)

Among the key events during 2003 was The Third Annual Long-Term Care Interdisciplinary Team Conference. Equipping managers and frontline workers with the skills to improve their performance was the recurring theme of speakers throughout the two-day conference. The Center purposefully tailors the fees and agenda for these meetings in such a way as to encourage facilities to send staff from multiple disciplines to develop their professional skills from an interdisciplinary framework.

Also during the past year, the Center offered its third Dynamics of Nursing conference, with support of the Michigan Chapter of the National Association of Directors of Nursing Administration/LTC. This three-day conference is designed to enhance the skills and knowledge base of nurse managers working in long-term care. Participants are provided with skills and background they will need to develop, implement and monitor systems that will strengthen their team's ability to deliver quality care to residents.

The Center, in collaboration with the Geriatric Education Center of Michigan (GECM), continued the exciting and innovative Continuous Quality Improvement (CQI) Project, which is designed to provide expert assistance to select facilities seeking to achieve a level of long-term care and service excellence. As part of the project, a joint team of Center and GECM CQI experts facilitates educational training (via regional videoconferencing), as well as on-site mentoring of each facility's interdisciplinary team over a period of 12 months.

As part of its work, the Center also forges partnerships with other organizations that are resident-centered in their educational objectives.

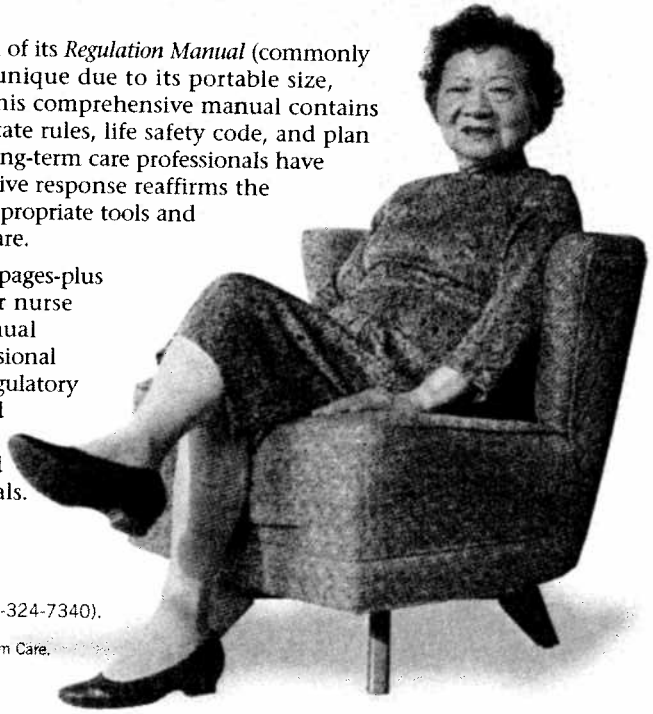
This includes faculty support to BEAM (Bringing Eden Alternative to Michigan) trainings for the Eden Alternative™ and co-sponsorship of the Lillian and James Portman Conference and the Edna Gates Conference on Dementia Care presented by Eastern Michigan University's Alzheimer Education Unit.

Through staff involvement, the Center actively supports T.E.A.C.H., a networking organization for staff development coordinators in southeast Michigan. The Center also contracts with the Michigan Society for Infection Control for conference coordination services, and Center staffers are partners within the following organizations and coalitions: Michigan Society of Gerontology, Michigan Direct Care Workers Initiative, Michigan Dementia Coalition, and the Nursing Home Quality Initiative of MPRO.

Publications

In August, the Center released the first edition of its *Regulation Manual* (commonly known as *The Little Purple Book*), which is unique due to its portable size, easy-to-read format, and low selling price. This comprehensive manual contains required survey forms, federal regulations, state rules, life safety code, and plan of correction and IDR guidelines. To date, long-term care professionals have purchased more than 550 manuals. This positive response reaffirms the Center's goal to equip caregivers with the appropriate tools and resources to enhance the quality of resident care.

In October 2003, the Center developed a 750-pages-plus *Nurse Manager Reference Manual*. Designed for nurse managers and directors of nursing, the manual includes: clinical practice guidelines; professional standards of practice and standards of care; regulatory and resource contact information; policies and procedures; organizational management strategies; staff development requirements and forms; and professional development materials.



More Information

For more information, contact the Center for Long Term Care at 2438 Woodlake Circle, Suite 200, Okemos, MI 48864 (Phone: 517-324-7340).

* Carl A. Gibson, PhD, is senior program director of the MPHI Center for Long Term Care. Paula Hoegemeyer, RN, NHA, is senior remediation specialist for the Center.

Michigan Cancer Consortium:

Spreading the Message of Cancer Control and Prevention

Introduction

The Michigan Cancer Consortium (MCC) Initiative is an innovative approach to comprehensively fight cancer. Among the many collaborative activities and interventions being undertaken by MCC member organizations are two of particular note. The first focuses on increasing awareness of the importance of colorectal cancer screening. The second addresses the need to provide men newly diagnosed with prostate cancer with the tools and information they need to make informed decisions about their treatment.

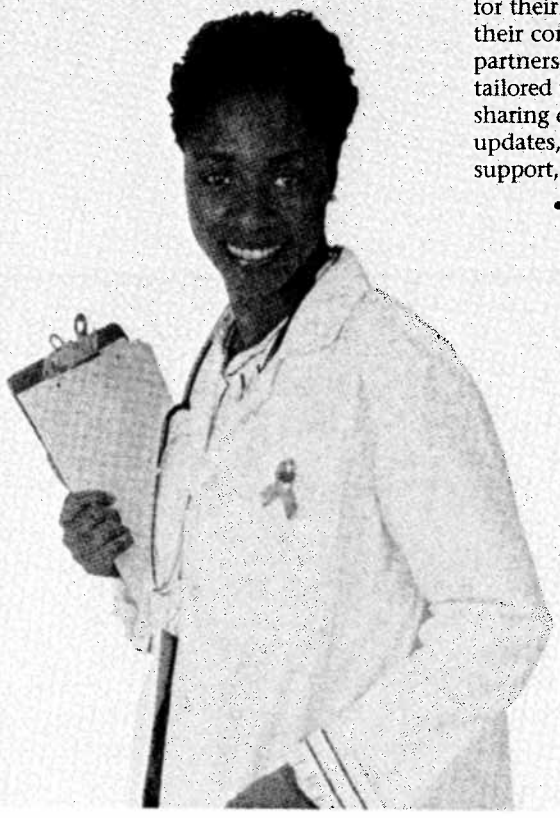
The MPHI Cancer Control Services Program is proud to be providing technical support and assistance to the MCC in these efforts.

Colorectal Cancer Awareness Network (CRAN)

Founded in October 2002, the Michigan Colorectal Cancer Awareness Network (CRAN) is comprised of individuals and representatives of groups, agencies and organizations interested in disseminating information about colorectal cancer. The network's stated mission is "To promote colorectal cancer awareness and the importance of screening among all Michigan men and women through public education."

CRAN helps participants develop community-based colorectal cancer education/awareness programs by supplying resource materials, communicating ideas for public education activities, and providing networking and partnership opportunities with individuals and organizations dedicated to raising public awareness about the benefits of colorectal cancer screening.

After one year, thanks to outreach and word-of-mouth efforts, the network includes more than 230 participants representing 145 unique organizations. During its first year, CRAN assisted network participants by:



- *Building partnerships and facilitating collaboration.* The CRAN Planning Committee organized two conferences in 2003 to inform participants of available resources for their use when planning colorectal cancer educational/awareness activities in their communities and to initiate opportunities for networking and establishing partnerships. The format of the meetings included: roundtable presentations, tailored to allow for information exchange, peer-to-peer learning opportunities, and sharing of best practices; sessions addressing a variety of topics, such as legislative updates, social marketing, program evaluations, public relations activities and support, and dissemination of sample resource materials.
- *Providing resources materials.* Brochures, fact sheets, posters, reminder stickers, bookmarks, and other resource materials are available to network participants, free of charge, through the CRAN clearinghouse. Information about colorectal cancer screening guidelines and follow-up for abnormal screening results, as well as statistics about colorectal cancer within Michigan, also are readily available. The Centers for Disease Control and Prevention "Screen for Life" materials have been translated into Arabic and are being distributed within Michigan by the Arab Community Center for Economic and Social Services (ACCESS).
- *Enhancing communication.* Network participants receive periodic e-mail communiqués to alert them to statewide colorectal cancer activities. One of these statewide activities, organized by the CRAN Planning Committee, is the colorectal cancer billboard campaign. The campaign, planned to coincide with the March observation of National Colorectal Cancer Awareness Month, targets Michigan counties that have a higher-than-state-average mortality rate for colorectal cancer. CRAN participants are also notified whenever new resource materials are posted to the CRAN WebBoard. This valuable tool provides participants with the ability to download resource materials that can be used in program planning and also includes a "chat" feature that enables participants to communicate with one another.

By Ellen Buist*

Prostate Cancer Education Materials

Prostate cancer accounts for a substantial portion of Michigan's cancer burden. Reaching the newly diagnosed prostate cancer patient with necessary treatment-related information can be a challenge when dealing with men who are part of populations that traditionally are less prone to seek treatment, have a low literacy rate, or are not comfortable talking about their health concerns.

Yet, research has shown that it is critical that men who are newly diagnosed with prostate cancer understand what treatment options exist and the significant side effects of the treatments in order to make informed decisions about their health care. The MCC Prostate Cancer Action Committee was established to ensure that Patient Education Materials with this information is available.

The group's Prostate Cancer Education project, which began in September 1999, was conducted in four phases:

- Evaluation of the knowledge and understanding of prostate cancer and treatment options among men newly diagnosed with prostate cancer;
- Review of existing prostate cancer patient educational materials;
- Development of a new educational tool in booklet, audio and Web-based versions; and
- Dissemination of materials to health professionals and newly diagnosed prostate cancer patients.

The project's initial survey of men newly diagnosed with prostate cancer identified informational needs and factors associated with informational vulnerability (e.g., level of education, race). The review of existing materials demonstrated that currently available patient education materials were not patient-centered (e.g., used medical terminology, did not fully describe treatment options or serious side effects).

To address these concerns, the project team developed "Making the Choice: Deciding What to Do About Early Stage Prostate Cancer" educational materials. The materials are written in an easy-to-read format with charts and diagrams, and complex medical information has been "translated" for a low literacy level. The team field-tested the materials throughout the development cycle to assess their efficacy in improving patient knowledge.

The materials are now available as an 8½-by-11-inch color booklet, as well as in audio (CD-ROM and cassette) and Web-based versions. The Internet version includes an easy-to-navigate Web adaptation of the booklet and an interactive tool that enables patients to determine five-year survival rates using their PSA results, tumor state, and grade. An Adobe Acrobat PDF version of the booklet is available for download from the site; the audio version can also be downloaded. The free-of-charge materials can be ordered directly from the Web site or by calling 800-249-0314.

A sample packet of the materials was recently mailed to 275 Michigan urologists. Future mailings also are being planned, and partnerships with the American Cancer Society, Great Lakes Division, Inc., and other MCC member organizations are being formed to help disseminate these educational materials.

More Information:

For more information, contact the MPHI Cancer Control Services Program at 2438 Woodlake Circle, Suite 240, Okemos, MI 48864 (Phone: 517-324-7300).

Information about CRAN can be obtained by e-mailing cranstaff@michigancancer.org or visiting the CRAN Web Board at http://cranwebboard.michigancancer.org:8081. Information about "Making the Choice: Deciding What to Do About Early Stage Prostate Cancer" materials can be found at www.prostatecancerdecision.org or by contacting Judith A. Suess, MD, MPH, Prostate Cancer Project Coordinator at jsuess@mphi.org or at 517-324-7391.

* Ellen Buist is project coordinator for the MPHI Cancer Control Services Program

The Mild Traumatic Brain Injury Project:

Tracking the Incidence, Impact and Cost of Brain Injuries

Introduction

In September of 2003, the MPHI Center for Collaborative Research in Health Outcomes and Policy (CRHOP) received funding from the Centers for Disease Control and Prevention (CDC) to determine the incidence of, and outcomes associated with, non-hospitalized, mild traumatic brain injury (MTBI) cases within Michigan.

This funding is one of the first scientific research awards that CRHOP and MPHI have received. To attain this funding, CRHOP leveraged two of its key strengths: collaboration and current project work.

Building on Expertise

CRHOP often facilitates and conducts health-related research, injury surveillance systems, and program evaluations in conjunction with researchers, state governmental departments, and community-based organizations throughout the state. CRHOP frequently draws upon these existing relationships to create partnerships or collaborative relationships for the purpose of developing new research opportunities.

For the MTBI project, CRHOP collaborated with two University of Michigan researchers and a Michigan hospital emergency department to recruit study participants. In addition, CRHOP leveraged its own expertise gained from two of its ongoing projects, the Michigan Emergency Department Community Injury Information Network (MEDCIIN) and the Traumatic Brain Injury (TBI) State Demonstration Project, to enhance its proposal.

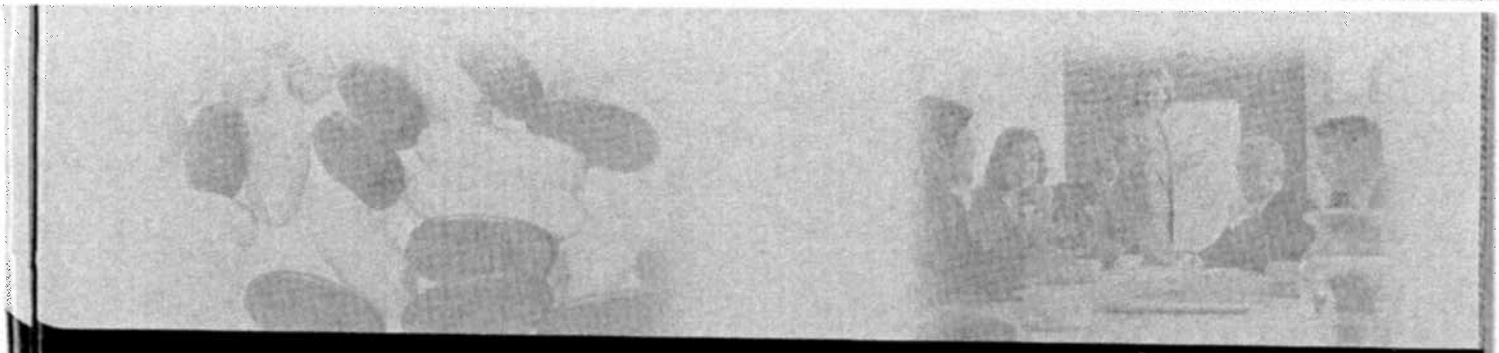
The MEDCIIN is a voluntary injury surveillance system developed and maintained in conjunction with the Michigan Department of Community Health (MDCH). MEDCIIN collects emergency department data from a representative sample of 23 sentinel hospitals around the state to study the types and causes of injuries, as well as the demographic characteristics of people presenting in emergency departments for injuries.

The research team analyzed available MEDCIIN data from 1999 and 2000 in order to present the magnitude of these injuries in Michigan in the proposal and to identify the potential number of MTBI cases in the hospital emergency department where study participants will be recruited. The team will use data collected from the MEDCIIN injury surveillance system to address several of the MTBI study goals.

In the multi-year collaborative TBI State Demonstration project, CRHOP operates under a contract with MDCH to research and promote strategies that enhance public service delivery and coordination for individuals with a TBI in Michigan. In addition to improving service delivery, the TBI project also analyzes data from various sources, including:

- Mortality and hospital discharge data to determine the frequency and causes of hospitalized and fatal TBI;
- Medicaid and private insurance claims data to identify costs and reimbursable services utilized; and
- MEDCIIN data to identify the causes of injuries and to present a picture of non-hospitalized TBI cases in Michigan.

The preliminary findings from these data sources has supplied the research team with a fairly clear picture of the magnitude of TBI in Michigan, as well as the causes, demographic characteristics, and costs related to TBI in our state.



By M. Lynn Breer, PhD*

What the MTBI Study Will Entail

Each year, approximately 1.5 million Americans suffer TBI as a result of motor vehicle collisions, falls, recreational accidents, and violence-related events. The CDC estimates that more than 50,000 people die every year due to TBI, and 5.3 million U.S. citizens-2 percent of the population-live with a disability resulting from TBI.†

Guerrero, Thurman, and Sniezek estimate the ratio of mortality, non-fatal hospitalizations, and emergency department visits associated with TBI to be 1:4:5:20.‡ Moreover, Thurman and Guerrero indicate that the rate of hospitalization for TBI is decreasing, and care for mild injuries is shifting to outpatient settings.§

Despite this, there are very few emergency department-based studies of TBI. Therefore, while it is recognized that MTBI is an important health problem, there is inadequate data to accurately determine the extent of MTBI among non-hospitalized injuries and the outcomes associated with MTBI among non-hospitalized patients. The primary aims of the MTBI study are to:

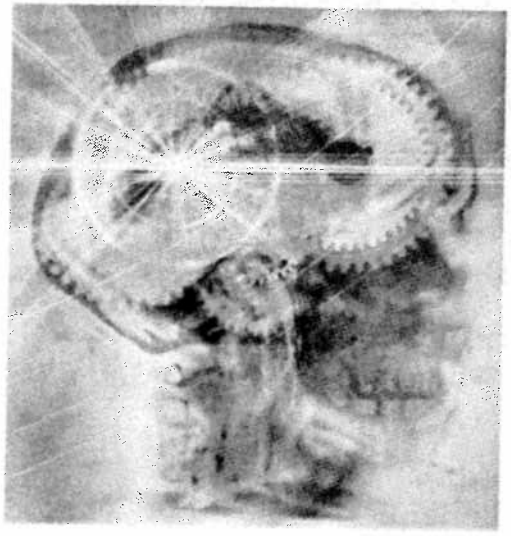
- Determine the prevalence and characteristics of non-hospitalized MTBI patients;
- Determine the outcomes associated with non-hospitalized MTBI, in particular post concussive syndrome (PCS); and
- Evaluate the level of agreement between case identification of non-hospitalized MTBI using surveillance ICD-9-CM criteria versus case identification protocols in the emergency department cohort study.

The secondary aims of the MTBI study are to:

- Determine the costs and services associated with non-hospitalized MTBI, and
- Compare hospitalized and non-hospitalized TBI cases on the basis of demographic variables and the nature and severity of injuries.

The MTBI project will be conducted using two broad study designs: 1) analysis of secondary data using Michigan emergency department data, Medicaid and private insurer's data systems to determine the incidence, nature, causes of, costs incurred by, and services utilized by non-hospitalized TBI individuals; and 2) a panel study consisting of a sample of adults treated at an emergency department for TBI and subsequently discharged home from the emergency department who will be surveyed four times within a period of one year after their injury event.

Outcomes for the cohort study will be summarized at baseline, 1 month, 3 months, and 12 months post injury, and will include: incidence and severity of PCS, service utilization and need, health status, adaptive functioning, substance abuse, productive activity, and community integration.



More Information

For more information, contact the MPHI Center for Collaborative Research in Health Outcomes and Policy at 2440 Woodlake Circle, Suite 190, Okemos, MI 48864 (Phone: 517-324-7389) or visit www.ccrhop.org.

* M. Lynn Breer, PhD, is deputy director of the MPHI Center for Collaborative Research in Health Outcomes and Policy

† CDC. National Center for Injury Prevention and Control. Traumatic Brain Injury in the United States, 2002. Available at www.cdc.gov/ncipc/didop/tbi.htm.

‡ Guerrero JL, Thurman DJ, Sniezek JE. "Emergency Department Visits Associated with Traumatic Brain Injury: United States, 1995-1996." Brain Injury. 2000; 14(2):181-186.

§ Thurman D, and Guerrero J. "Trends in Hospitalization Associated with Traumatic Brain Injury." JAMA. Sept. 8, 1999; 282(10):954-957.

Covering Michigan's Kids & Families:

Increasing the Number of Families with Health Care Coverage

Introduction

"Covering Michigan's Kids & Families" is part of a nationwide effort to enroll families in Medicaid and the State Children's Health Insurance Program (SCHIP). This initiative began in February 2002 and is sponsored by The Robert Wood Johnson Foundation. The MPHI Systems Reform Program is the statewide lead agency, guiding the work of the statewide coalition and the local sites participating in the project.

A majority of the more than eight million uninsured children in the United States are eligible for Medicaid and SCHIP, but are not enrolled. Many factors (e.g., low literacy levels, lack of awareness, the perceived complexity of the application process, the perceived stigma attached to public coverage, disruption of continuous coverage due to changes in eligibility, and the lack of seamless coordination across public and private sector programs) have contributed to under-enrollment in this program.

Work at the State Level

The mission of the Covering Michigan's Kids & Families Project is to increase the number of health care coverage-enrolled families within Michigan by focusing on the following three strategies:

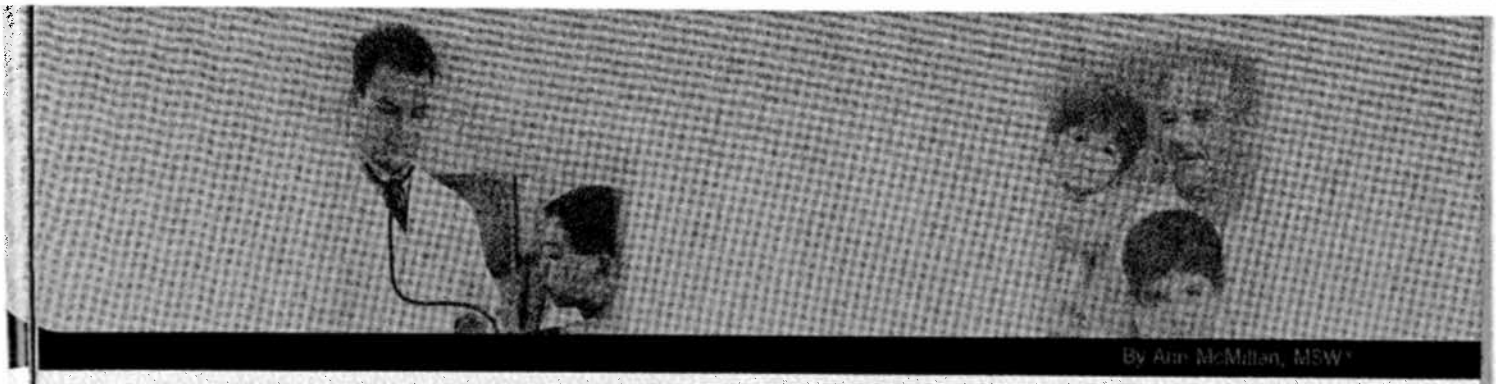
- Conducting and coordinating outreach programs;
- Simplifying enrollment and renewal processes; and
- Coordinating existing health care coverage programs.

The MPHI Systems Reform Program has established a statewide steering coalition to provide guidance and advice to the overall initiative. Membership of that group includes more than 25 organizations dedicated to improving the health and well-being of children in Michigan. The key activities of the Covering Michigan's Kids & Families Coalition are:

- to prepare and communicate policy recommendations related to outreach strategies and activities;
- to facilitate dissemination of information and networking;
- to problem-solve and provide advice to participants; and
- to monitor the progress and outcomes of the project.

Through MPHI's support as statewide lead agency, the Coalition has been able to accomplish many significant goals. Notably, it has assisted with the implementation of the state's electronic application for Medicaid and SCHIP.

Developed in 2002, Michigan's electronic application is not just an outreach strategy; it is also a simplification and coordination strategy that maximizes the self-declaration of income policy, reduces the fear and/or stigma of applying for assistance, and gains access to isolated populations. The electronic application reduces errors, prompts for incorrect or missing information, and re-uses information entered once so that it appears on all forms. It also enables increased mobility for an outreach worker or applicant through the use of a laptop and a portable printer. The application takes about 25 minutes to complete and is available to anyone with access to the Internet; eligibility is determined in two to three minutes real-time, provided the information entered is complete.

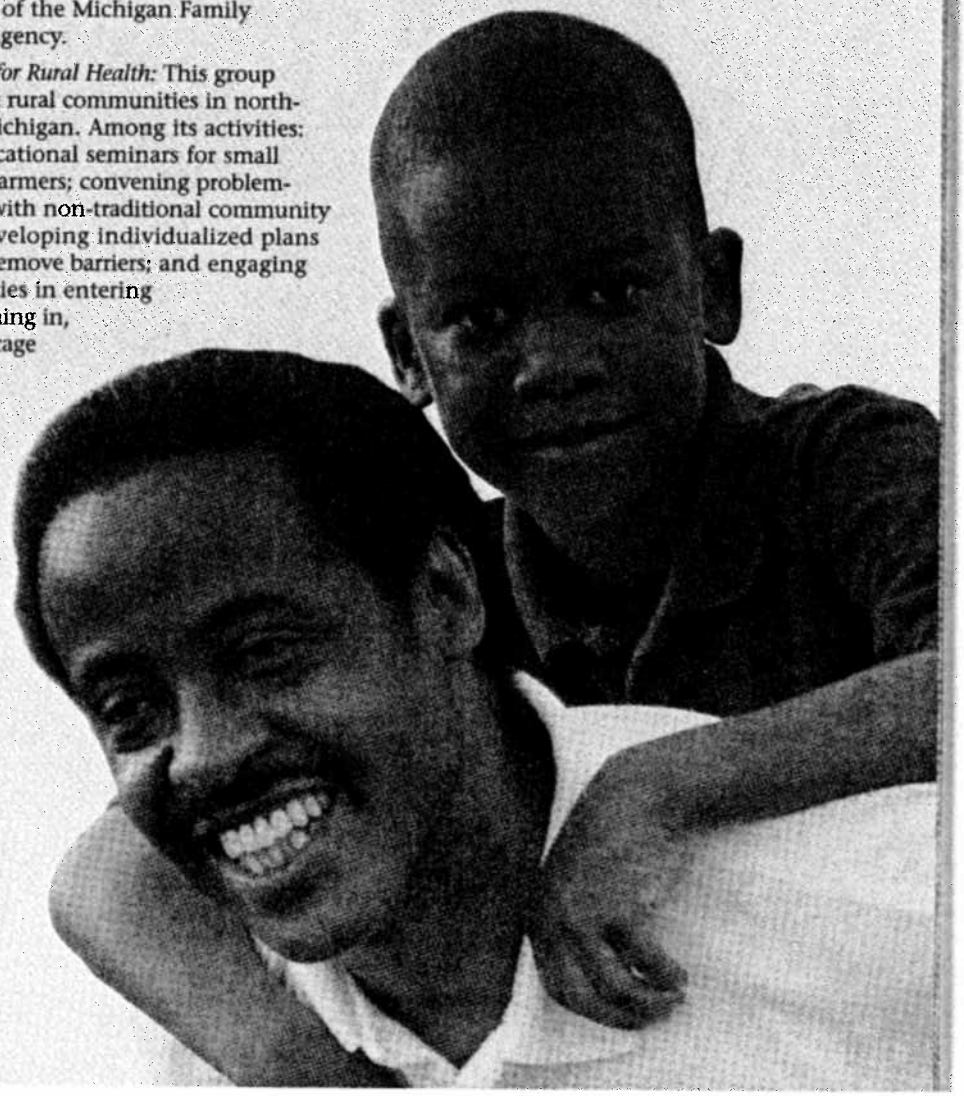


By Ann McMillan, MSW*

Work at the Local Level

As part of the Covering Michigan's Kids & Families projects, MPHI coordinates the activities of four local sites around the state that conduct retention, simplification, coordination, and outreach activities within their geographic areas. These include:

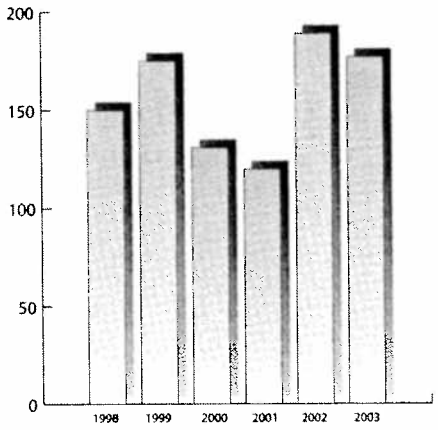
- *Muskegon Community Health Project:* This group works in Muskegon, Newaygo and Oceana counties, focusing on the Latino and migrant communities and children of the working poor. Muskegon also enhances enrollment opportunities to the parents of eligible children through a locally based coverage program for small businesses called "Access Health."
- *Catholic Social Services of the Upper Peninsula:* This group coordinates a coalition of Upper Peninsula outreach workers, with special attention to developing ways to reach out to homeless children and the Native American community. Catholic Social Services also is working with the Medical Care Access Coalition, a group providing coverage to adults in Marquette.
- *Detroit/Wayne County Child Health Care Coalition:* This group reaches out to the Detroit/Wayne County area by partnering with four organizations: Arab American Center for Economic and Social Services (ACCESS); Oakwood Teen Health Centers; and the Eastside Access Partnership. The group also enhances community relations with the local offices of the Michigan Family Independence Agency.
- *Michigan Center for Rural Health:* This group focuses on select rural communities in northeastern lower Michigan. Among its activities: conducting educational seminars for small businesses and farmers; convening problem-solving forums with non-traditional community stakeholders; developing individualized plans to identify and remove barriers; and engaging rural communities in entering into, and remaining in, health care coverage programs.



More Information:

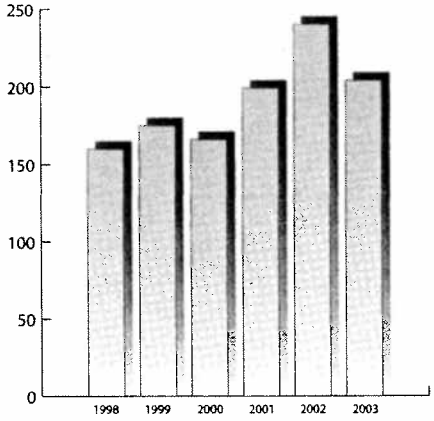
For more information, contact the Systems Reform Program at 2438 Woodlake Circle, Suite 200, Okemos, MI 48864 (Phone: 517-324-8311).

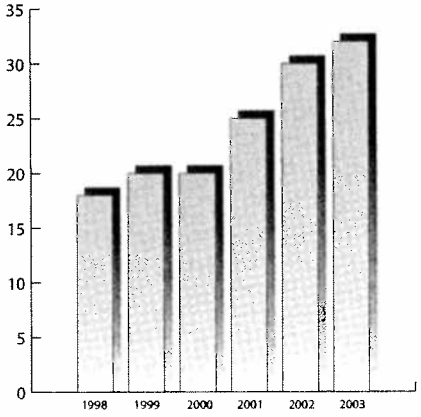
* Ann McMillan, MSW, is project coordinator for the MPHI Systems Reform Program.



Number of projects under management

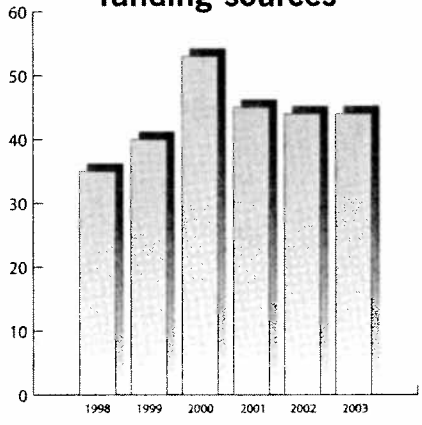
Number of employees



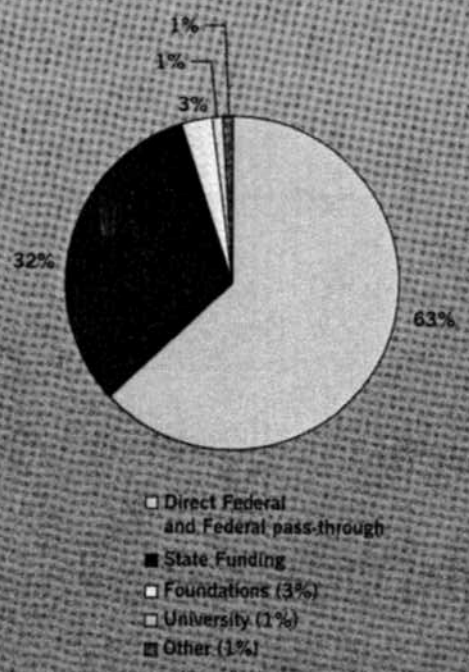


Annual income
(in millions)

Number of funding sources



2003 MPHI Project Funders



- Actors' Fund of America
- American Legacy Foundation
- Arbor Circle Corporation
- Children's Hospital of Michigan
- Council of Michigan Foundations
- Emory University
- GlaxoSmithKline
- Global Enterprise for Water Technology
- Harvard School of Public Health
- Health Management Associates
- Karmanos Cancer Center
- Meridian
- Michigan Health Professional Recovery Corporation
- Michigan Primary Care Association
- Michigan State University
- Muskegon Community Health Project
- National Association of County and City Health Officials
- Ohio Department of Health
- P&G Pharmaceuticals
- Rallying Points
- Robert Wood Johnson Foundation
- Shiawassee Regional Education Service District
- Southeastern Michigan Health Association
- State of Michigan
  - Department of Community Health
  - Department of Consumer and Industry Services
  - Department of Education
  - Department of Environmental Quality
  - Department of State Police, Office of Highway Safety Planning
  - Family Independence Agency
- State of Texas, Department of Transportation
- The University of Michigan
- U.S. Department of Health and Human Services
  - Centers for Disease Control and Prevention
  - Centers for Medicare and Medicaid Services
  - Health Resources and Services Administration
    - National Institutes of Health
    - National Cancer Institute
    - National Library of Medicine
- U.S. Department of Justice
- Walther Cancer Institute
- Wayne County Department of Public Health
- West Michigan Community Mental Health
- W.K. Kellogg Foundation
- Wyeth Pharmaceuticals

how to contact

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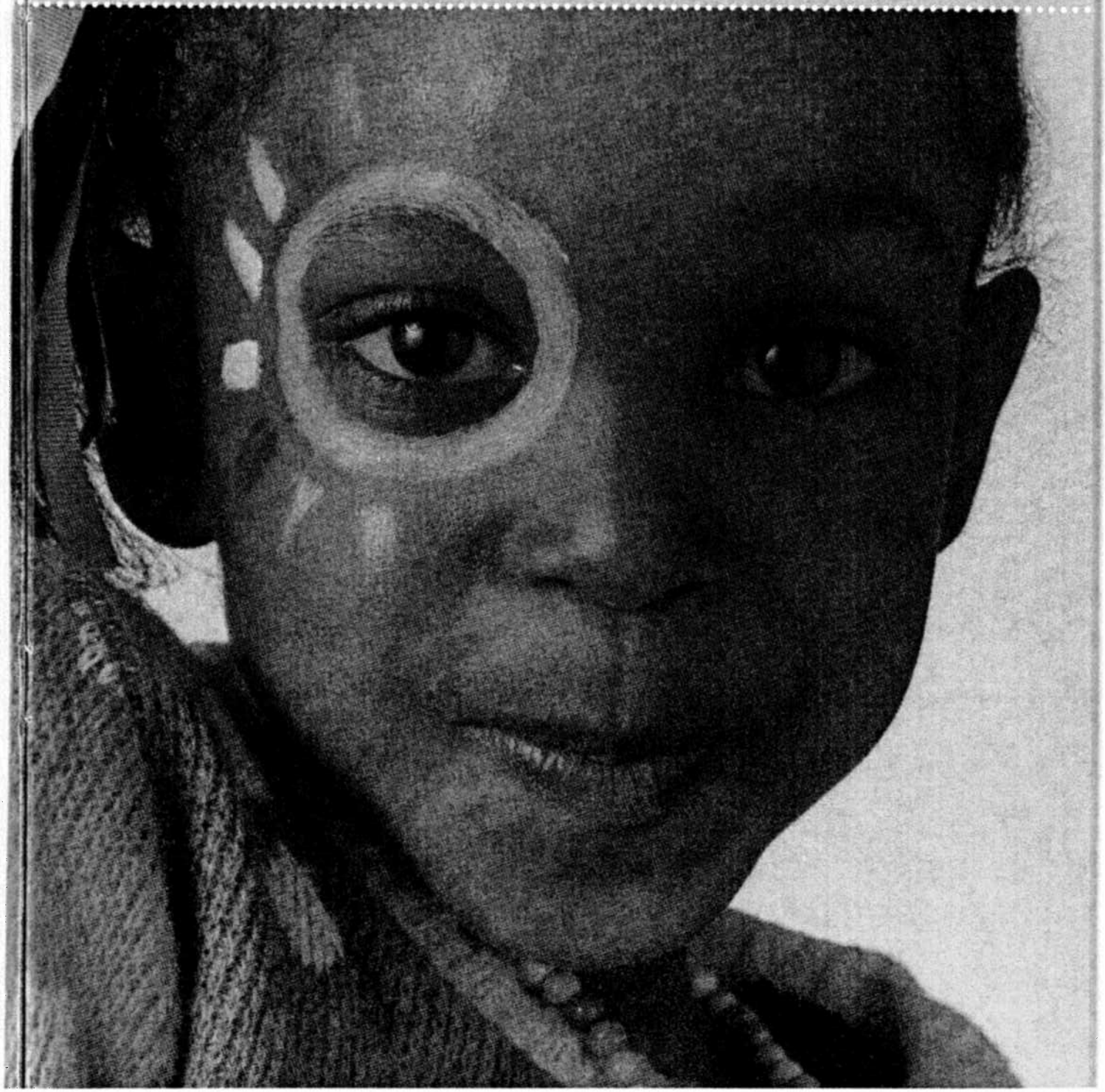


FORWARD

UNIVERSITY of WISCONSIN
UWMILWAUKEE

THE NATIONAL INSTITUTE of ENVIRONMENTAL HEALTH SCIENCES
MARINE AND FRESHWATER BIOMEDICAL SCIENCES CENTER

February 7, 2005

To: Representative Stephan Freese
State of Wisconsin Assembly

Representative Jake Hines
State of Wisconsin Assembly

Representative Sheldon Wasserman
State of Wisconsin Assembly

From: David H. Petering
UW-Milwaukee Distinguished Professor of Chemistry and Biochemistry
Director, NIH(National Institute of Environmental Health Sciences) Marine and Freshwater Biomedical Sciences Center
Director, UW-Milwaukee Institute of Environmental Health

Jeanne B. Hewitt
Associate Professor of Nursing
Associate Director, UW-Milwaukee Institute of Environmental Health

We understand that you are conducting a review of the Governor's proposal to privatize most of the public health services of the State Department of Health and Family Services in the form of a Public Health Institute. Attached you will find our testimony given at one of the DHFS's listening sessions State that focused on the idea of forming a private Public Health Institute to assume many of the duties related to public health.

In a word, this is a bad idea that reinforces Wisconsin's downward spiral in the public health arena. Now is the time to think about enhancing the State's commitment to public health not diminish it. Health promotion and disease prevention are the only viable alternatives in the present framework of discussion to staggering increases in health care (curative medicine) costs. State is prepared to commit nearly a billion dollars to biotechnology centered on stem cell research. Yet, the diseases that stem cell implants might cure (at great cost or great profit, depending on whether you are the patient or the patent holder for the treatment), such as diabetes, heart vessel and muscle injury, and brain degeneration as in Parkinson's diseases, are diseases that are known to be or may be preventable through better attendance to public health (e.g. diet, exercise, avoidance of toxic chemicals).

It makes no sense from the standpoint of health or economics for the State to get out of its responsibilities in public health. Indeed, it is high time for it to establish a School of Public Health at UW-Milwaukee at a tiny fraction of the costs for the stem cell initiative, so that like most other states in the U.S., we have a public institution dedicated to addressing the route causes of disease and its prevention.

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Dr. David H. Petering Director

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Testimony at the Milwaukee public forum on a Public Health Institute in Wisconsin
September 15, 2004

David H. Petering
University Distinguished Professor of Chemistry and Biochemistry
Director, National Institute of Environmental Health Sciences Marine and Freshwater Biomedical Sciences Center
Director, UWM Institute of Environmental Health
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Jeanne B. Hewitt
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Associate Director, UWM Institute of Environmental Health
University of Wisconsin-Milwaukee
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The cover letter to the invitation to attend this public forum opens with the following paragraph:

> We (DHFS) are giving (the idea of a Public Health Institute) serious consideration because an institute could provide additional capacity and leadership for public health in the state and serve as a bridge between the Department (of Health and Family Services), academic institutions, and other public health partners. It could also promote economic development in Wisconsin by attracting public health and medical research investment and creating high-technology jobs in the medical research and health services research industries.

As a prelude to responding to some of the questions posed for the forum, we think it is necessary to address the content of this paragraph because it makes enormous claims for the future roles of the Public Health Institute.

- As described in the Public Health Institute Report, the PHI will assume many of the duties of the public health arm of the Department of Health and Family Services and others will be off-loaded to local departments of public health. Thus as the PHI provides new capacity and leadership for public health, present capacity and leadership will be lost. We believe that the plan amounts to a transfer of activities between the State and other entities not to a creation of new capacity in public health.
- The idea that the Public Health Institute will aid economic development by attracting medical research investment is a distraction. Public health is not medical research or health services. Public health focuses on prevention and naturally leads to cost containment. Medical research and services emphasize cure and empirically can not control costs. The entanglement of the two in the cover letter for this forum only confuses the issue of the role of public health in the overall health portfolio of the State.

Turning to the issue of the Public Health Institute, itself, the basic questions for the public forum strike us as ones that should have been asked prior to undertaking a lengthy study about the details of forming a new Public Health Institute. It is very late in the game to ask for input of this sort, particularly when the Report, itself, provides answers to many of them. This leads us to consider that

the proposal to organize a Public health Institute is already a *fait accompli* and that other ideas to improve the public health outlook for Wisconsinites, such as creation of a School of Public Health at UW-Milwaukee, will not be seriously examined. In this context, we address the both the fundamental question of the advisability of creating a Public Health Institute and the secondary ones that relate to a de facto Public Health Institute.

1. Is a public health institute needed in Wisconsin?

We understand that it is proposed to functionally disband the Division of Public Health, assign some of its functions to local public health departments, and gather most of the rest in a new Public Health Institute. As far as we can tell from the Public Health Institute Report, this restructuring is motivated by a desire to down-size the governmental work-force by privatizing the State's public health staff. This proposal will not significantly reduce expenditures because the new Public Health Institute will receive both staff from the present Division of Public Health and much of its budget. We think this is a bad idea for a host of reasons.

- There is really no excuse to base fundamental decisions about the future of public health in Wisconsin on an abstract desire to down size the government workforce, particularly when it will not result in significant budgetary savings. The decision to form a Public Health Institute should be decided on the strength of the arguments that it would enhance public health in Wisconsin.
- An independent Public Health Institute with no clear link or accountability to the State can not substitute for a State of Wisconsin Division of Public Health. The reasons are clear. The public health sphere of disease prevention provides the foundation that determines the quality of the health of a society. Clean water, air, and food, uncontaminated by pathogens and chemicals, safe and healthful workplaces, and healthy life-style provide the foundation for societal population health as measured, for example, by life expectancy. Nevertheless, public health in the U.S. and in the State of Wisconsin has received relatively little fiscal or policy support in comparison with curative medical health care. To dismantle the commitment to public health within its government structure is the clearest evidence that Wisconsin State Department of Health and Family Services does not understand or accept the centrality of public health to the current and future health of our citizens and its responsibility to foster a robust public health program for the State. Nor does it recognize that in the lengthening shadow of exponentially increasing health care costs, increased attention to public health holds out the only long-term solution to this crisis short of a total reorganization of the health care system. Considering that Wisconsin currently ranks 49th among the states in support of public health and that health indices in Wisconsin are declining (see table), this proposal does not first and foremost address the public good.
- The Public Health Institute Report provides no evidence to support the merit of this proposal. It does mention in the Introduction that 18 other states have institutes that supposedly provide a whole variety of enhancements in public health. This is buttressed by an appendix entitled, "Matrix for National Network of Public Health Institutes." That appendix and a table attached to this testimony show that 10 of these institutes receive less than $2,000,000 year in state support and as such can be only minor players in the State public health picture. Furthermore, as our table shows there is no consistent relationship between the presence of a public health institute in a state and its position or improvement in public health ranking.
- There is a more serious issue for Milwaukee that arises out of this proposal. On a population

basis, the large public health issues in Wisconsin and elsewhere are primarily urban issues. Placing the primary public health institution in the state in Madison, for example, will necessarily hurt Milwaukee.

2. What kinds of activities might such an institute undertake?

The Public Health Institute Report proposes that many of the primary activities and budget of the Division of Public Health should be off-loaded to the institute. It made no argument why this change should take place and provides no illustrations to show how the new structure would improve or extend existing activities in the Division of Public Health. Most of the report focuses on nuts and bolts administrative issues as if the idea, itself, has already been accepted.

3. Who should be the primary audience for the institute's work?

The citizens of the State of Wisconsin.

4. What level of core/infrastructure funding would be required to establish and operate a Wisconsin Public Health Institute?

See question 1.

5. How should the agenda and priorities of the Institute be set?

The prior question is: who will be centrally responsible for public health in State Government, if an institute is formed and the Division of Public Health is dismantled? The State remains responsible for public health. An institute funded by the State can only support the public health goals of the State. If it operates independently, its own agenda and priorities will not necessarily be those of the State.

6. How should the institute be organized, who should sit on its board and how should it be staffed?

If an Institute is in the offing, we strongly support creating a structure analogous to that in the State of Michigan, namely, a public partnership between the State Department of Health and Family Services, UW-Milwaukee and UW-Madison. UW-Milwaukee has a decisive interest in the urban corridor of Wisconsin through its urban mission and Milwaukee Idea. It also has the academic expertise and interest to focus on the health problems of cities. In addition, the education of new public health personnel for the State, who are largely concentrated within easy driving distance of Milwaukee, can be facilitated by UWM. UWM has the necessary strength in the underlying disciplines of public health to contribute to a robust program. The fact that it has a very strong social science faculty focused on urban society and it problems is an unusual attribute. It has a highly ranked College of Nursing that produces some of the State's finest public health nurses (Margaret Schmelzer, MS, RN, Chief of the Turning Point Initiative is an alum), as well as a particularly strong basic science group in toxicology and environmental health (NIEHS Center and new Ph.D. in Health Sciences). In sum, a major locus for the new institute should be Milwaukee and UW-Milwaukee.

State Public Health Institutes[1]

State	Year of Implementation	State's Public Health Ranking[2]				Annual Operational Budget ($)	Infrastructure Funding
		Overall		Support[3]			
		1990	2003	1990	2003		
Arkansas	1998	45	47	41	36	1,400,000	Not specified
California	1964	33	18	6	28	7,000,000	CA Wellness Foundation
Colorado	1993	14	9	17	7	~ 225,000	None
Hawaii	2001	9	10	14	18	5,000,000[4]	DOH – Amt. not specified
Illinois	1997	29	30	13	9	170,000	None
Kansas	1995	11	20	33	13	2,700,000	Core grant from KS Health Foundation
Louisiana	1997	50	49	32	38	1,500,000	No core funding
Maine	1999	13	8	26	27	800,000	Limited
Maryland	2000	28	29	14	8	250,000	None
Massachusetts	1998	10	5	1	22	100,000	Yes, but not specified
Michigan	1989	27	28	2	17	20,000,000	None
Minnesota	1972	1	1	5	1	4,200,000	Symbiotic relationship-BC/BS
Nevada	1996	46	36	39	25	425,000	None
New Hampshire	1995	5	1	11	1	2,000,000	None
North Carolina	1999	32	36	34	10	Not Specified	SPH & a private foundation
New York State	2000	35	31	7	4	125,000[5]	In-kind NYSDOH & Cornell
Rhode Island	1993	12	13	10	4	1,000,000	None
Virginia	2000	22	21	22	35	No separate budget	Private foundation
WI Center for Urban Population	2001	3	14	9	49		Seed money from partner organizations

[1] From http://dhfs.wisconsin.gov/aboutDHFS/dph/restructure/PHIreport5-04.pdf.
[2] From the United Health Foundation. (2003). America's Health State Health Rankings—2003 Edition.
[3] Support for Public Health Care is the ratio of expenditures to low-income (< $15,000 per year per household) population.
[4] Seed money over three years; must be self-sustaining thereafter.
[5] $500,000 over a four year period.


FORWARD

Office of the Senior Associate Dean
for Public and Community Health

TO: The Honorable Representative J.A. Hines, Chair and
Honorable Members of the Assembly Committee on Public Health

FROM: Cheryl A. Maurana, PhD
Senior Associate Dean for Public and Community Health
Professor of Family and Community Medicine
Medical College of Wisconsin

DATE: February 8, 2005

RE: Options for a Public Health Institute in Wisconsin

As the Senior Associate Dean for Public and Community Health at the Medical College of Wisconsin (MCW), I appreciate the opportunity to comment on the November 8, 2004 Report to Department of Health and Family Services (DHFS) Secretary Helene Nelson on options for a public health institute in Wisconsin.

As background, it is important to note that the Medical College of Wisconsin was not part of the original DHFS Public Health Institute Committee (PHIC) appointed to study the feasibility of creating a public health institute. Rather, MCW was invited to participate in the PHIC when its membership was expanded to allow for additional entities to review the public health institute options put forth by the original work group.

MCW appreciated the opportunity to review and comment on the work of the PHIC. All agree that we must identify ways to strengthen the current public health system so that the state is better prepared to meet the goals identified in the state health plan. This becomes even more critical as resources are limited.

An overarching concern that we have is that as the process moves forward to consider any new models and methods to improve public health in Wisconsin, we not create an additional entity that would increase fragmentation between the various public health entities. Coordination and communication are essential in both the process to analyze the public system as well as the implementation of any changes that may result in the stakeholders' future recommendations.

In reviewing the options identified in the DHFS report and the data supporting the possible creation of a public health institute, the Medical College of Wisconsin does not believe that a strong argument has been made to establish a public health institute at this time. Rather, MCW recommends that public health stakeholders be convened to determine the best way to improve public health efforts in the state. This must be an inclusive process to ensure long-term success and real improvement.

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FORWARD

Assembly Hearing on Public Health Institutes
February 9, 2005

Thank you for the opportunity to address the committee. I am Susan Wood, Director of the Bureau of Health Information and Policy, Division of Public Health, DHFS.

Over the past year I have worked on developing ideas and options about public health institutes including the report to Secretary Nelson in November 2004 that lays out six options for creating a Wisconsin Public Health Institute. The purpose for all of this discussion and exploration of options is to identify ways to strengthen the current public health system so that we are better prepared to achieve the goals set in the state health plan and to grow public health capacity outside of the government sector.

There are six options presented in the November 8, 2004 report to Secretary Nelson:

1. Do nothing at this time, or use existing organizations to fill gaps in the current system
2. Pursue the WPHA Incubator Model
3. Develop a public/private health information network
4. Develop a fundraising/grant writing collaborative
5. Focus on public health workforce development
6. Focus on prevention research and coordination

The report provides a comparison of mission, financing, rationale, pros and cons for these options. It does not estimate costs for an institute, either for start-up or to sustain the organization. It also does not identify the potential that each of these options has to impact the number of state employees.

These options are not mutually exclusive. The Department is open to pursuing multiple options, or combining several of the options to develop an organization with broader scope, if that serves Wisconsin well

Secretary Nelson responded to the report by noting that as the steward of state government's Public Health Division, she is very interested in how an institute can "add value" to our current public health system, complementing the appropriate strong roles of state and local government, our fine academic institutions, and other public health system partners. She also recognizes that there are many key players in the public health partnership, who will continue to express their views and influence the outcome of this dialogue. Also, the Governor and Legislature will provide the policy and fiscal direction for state government's role.

In this context, she expressed her interest and willingness to work with WPHA to develop the idea of an "Idea Incubator." This includes exploring the extent to which the Incubator could also be a vehicle to attract non-state funds including federal funds, foundation funds and other outside resources to help create a stronger public health system in our state. Members of the Assembly Public Health Committee have also expressed an interest in advancing this latter mission for an institute.

She also indicated her interest in continuing to explore ideas for a new public-private health information network or partnership and indicated that she is eager to see our department and other partners find a way to shift more resources and attention to "prevention" as a highly beneficial and cost-justified health investment. Her assumption as this time is that this does not anticipate any separate structure, but diligent work by many of us to advance this priority in times when governmental resources are particularly strapped.

All of the documents from the Department on this are posted on the DHFS web site.

I will be happy to respond to your questions.

Thank you.


FORWARD

Public Health Committee Hearing
Wisconsin Public Health Institute
February 9, 2005

Persons giving the testimony: Sarah Beversdorf (WPHA), Kathy Munsey (WALHDAB)
Other WPHA and WALHDAB members/testifiers in attendance: Julie Patefield Halvorsen, Nancy Young

My name is Sarah Beversdorf, and I'm the current President of the Wisconsin Public Health Association. The Wisconsin Public Health Association (WPHA) was founded in the 1948 and is the largest public health organization in the state, representing approximately 380 members from state and local governmental public health organizations, non-profit health care provider organizations, academia, and health advocacy groups. We have a 15-person board elected by the membership that represents all geographic regions of the state. Through the years, WPHA members have talked about the idea of a public health institute, however, no formal work was done on the idea. Once DHFS started a formal study group in early 2004, WPHA became engaged in the issue.

Over the course of Spring 2004, WPHA provided input to the Division on the Public Health Institute (PHI) concept, and was invited in Fall 2004 to participate in the reconvened study group to explore PHI options. At that time, WPHA contracted with a consultant to develop a "best vision" of a public health institute. This vision is what is now called the Wisconsin Idea Public Health Incubator.

The Incubator concept was presented within the study group forum and is listed as one of the options in the report from the group to Secretary Nelson. It has received broad support and several endorsements from within the public health community and it was unanimously endorsed by the study group itself. WPHA subsequently contracted with a consultant/facilitator to continue the planning and development process over the next ten months. The planning process will ask the essential question...

"What kind of entity can provide an environment for growth of population health ideas and actions that will make Wisconsin the healthiest state in the nation?"

We'd like to provide you with a brief overview of the Incubator idea and our planning process. The purpose of the Incubator would be to "grow" new ideas. One might call it a convener or a catalyst. It would be a lean, independent entity that would seek to pull together the Division of Public Health, existing institutes and academic partners, including the two medical schools, to grow new opportunities that will help Wisconsin reach the goal of being the nation's healthiest state.

The whole public health system and the population would benefit from a WIPHI, including the Department of Health and Family Services, which would be a major "customer" to which such an entity would respond. The WIPHI could encourage development of new ideas and actions related to functions like those recommended by the first PHI committee:

- Research
- Evaluation
- Partnership promotion
- Education regarding emerging health issues
- Promotion of social and economic conditions that support good health
- Analysis of health status data
- Development of a public health workforce that is diverse and excellent

Over the next 8-10 months, a model will be drafted by a planning group and then shared with potential customers for feedback. The planning group will be comprised of academic, public and private partners who have a significant history in public health research, education and policy development. Carolyn Hughes, aide to Representative Hines, has been invited to be a member of that group. This process must be focused and creative.

The result of the planning process will be a model of an Incubator, including goals, structure, initial funding sources, outcome measures and timeline for creation. WPHA would be pleased to share the final product with the Public Health Committee.

Thank you for taking an interest in this important issue. We have a number of WPHA representatives here today and would be happy to respond to any questions you might have.

Handouts:
WPHA Proposal for a Wisconsin Idea Public Health Incubator

Contact:
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Wisconsin Public Health Association

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WISCONSIN IDEA PUBLIC HEALTH INCUBATOR PROPOSAL

Wisconsin should pursue development of a *Wisconsin Idea Public Health Incubator* (WIPHI)*. Its purpose would be to "grow" new ideas and its model would be distributive. That is, it would be a lean, independent not-for-profit** that would seek to pull together the Division of Public Health, existing institutes and academic partners, including the two medical schools, to grow new opportunities that will help Wisconsin reach the goal of being the nation's healthiest state.

Other public health institute models are interesting and important to study, but who says that Wisconsin has to pick a model from among those that already exist? We should be asking, "What would strengthen Wisconsin's public health system in ways that can lead us to becoming the nation's healthiest state?"

The whole public health system and the population would benefit from a WIPHI, including the Department of Health and Family Services, which would be a major "customer" to which such an entity would respond. The WIPHI could encourage development of new ideas related to functions like those recommended by the first PHI committee:

- Research
- Evaluation
- Partnership promotion
- Education regarding emerging health issues
- Promotion of social and economic conditions that support good health
- Analysis of health status data
- Development of a public health workforce that is diverse and excellent

The concept would need to be further developed by calling on academic, public and private partners who have a *significant* history in public health research, education, and policy development. WPHA is extremely interested in leading this *development* effort and believes that a model could be developed within a two-year period. A board made up of some of the best public health minds in Wisconsin would advise the WIPHI. One key reference for determining priorities would be Healthiest Wisconsin 2010 and subsequent comprehensive health planning documents. Blue Cross dollars could be explored as a primary base-funding source. A broader funding portfolio would be developed in the first three years of operation.

The WIPHI would not have an economic development orientation although economic development might well result. Its purpose would not be to be to house displaced DPH workers but it would work closely with DPH to plan strategies to improve public health in Wisconsin. One of the goals of a WIPHI could be finding ways to enhance large grant awards that come to Wisconsin, especially those that benefit governmental public health. The WIPHI would not be a health *systems* or health *care* research institute – this is better done by universities, federal agencies and provider groups and organizations.

**Draft title at this time – the important thing here is the concepts, not the title.*
***Preference at this time is a 501C3 or a new arm of a current 501C3, but other models might be considered*


FORWARD

The Wisconsin Institute for Public Health

Keeping Wisconsin Healthy

February 9, 2005

Dear Public Health Committee Members,

I wish to thank Representative Hines, Representative Underheim, and the other members of the Public Health Committee for allowing me to provide my testimony at this legislative hearing. My name is Susan Garman and I am the CEO of the Wisconsin Institute for Public Health and the Public Health Service Corporation of Wisconsin. I have a Bachelors Degree in Nursing and a Masters Degree in Environmental and Public Health with an emphasis in business from the University of Wisconsin, Eau Claire.

I have been a registered nurse for 17 years and worked for almost five years as a certified occupational health nurse in the Department of Health and Family Services, Division of Public Health, Bureau of Occupational Health. During this time I was the Director of the Adult Blood Lead Epidemiology and Surveillance Program, Director of the Youth Employment Training Pilot Program, and Director for the Occupational Asthma Surveillance Program. In addition to working in these positions, I also wrote several grants a year.

I have also won several awards for the work I performed while a public health nurse at the Wisconsin Division of Public Health. Some of these awards included the NIOSH Best Practices for Surveillance Award for the Youth Employment Training Pilot Program, the Wisconsin Public Health Association's 2002 Excellence in Health Promotion and Disease Prevention Award, and the William Q. Wiehrdt Award from the Department of Labor, OSHA in January, 2005.

After reading the Public Health Institute Options Final Report and reading the letter Susan Wood sent to me dated January 28, 2005, I have several major concerns. During the Public Health Forums on Options for a Wisconsin Public Health Institute, Susan Wood stated that Governor Doyle would select the best option from the list of options provided by the Division of Public Health Options Committee. This decision would then be forwarded to the legislature during this current winter session to be put into the budget bill or in a separate bill. The committee outlined six options in the final report and as they are currently written, I do not see how any of these options could be submitted into a budget or separate bill.

In the letter Susan Wood sent to me in January, she stated that my proposal was put into option number one in their report entitled, "Do not create a new organization at this time and/or use existing organizations to fill gaps in the current system." Susan Wood also said in the letter that none of the organizations put into category number one were listed by name. I do not feel that option one addresses the pros and cons of my proposal at all.

Instead, option one seems to be at best a stop-gap measure that DHFS would use while they are creating their own State developed, State funded, and State run institute. Over half of the "pros" listed are actually "cons" or do not belong in the column at all. In the "cons" column, there are statements that say that this option would "cause the State to lose the ability to expand resources", they would "lose nimbleness that other states have to attract federal and foundation grants", would be "unlikely to increase the amount of Federal funding coming to our state", and that "only a stand-alone institute could give us a competitive edge". My proposal does include a stand-alone institute and it does provide a way for our State to bring in more grant funding, increase our competitiveness when writing for grants, and strengthen our State public health infrastructure. It is due to these apparent contradictions that I do not feel my proposal should be put into this option category.

Option two of the final report discusses the WPHA incubator proposal. This proposal was created by a committee member while the committee was developing this list of options, it states right in the "con" section that it would take two to four years at best before this option could be functioning and it does not address any of the short term challenges DPH will need to deal with. WPHA also does not have funding to presently follow through with creating this option, DHFS and DPH have endorsed it as the best option even when both stated they would not endorse any option before Governor Doyle made his decision on the best option. In the "other issues" section, it also states that this model would fit well with other options, which was not the original intent of the committee. The Governor was to select the best option of those available in the State, not mix and match several options from the list that would then go to the Legislature. This option is not viable or feasible and would not be able to meet the needs that DPH will have in the near future.

Option three was to create a "public/private health information network". This option would create a tax on health care professionals and health care providers to create a new not-for-profit company. I seriously doubt that these health care professionals and providers have been asked about their willingness to be taxed to create an entity that may be duplicating other private services currently reviewing cost and quality of health care services. This new entity also has a very limited scope that would not address all of the current and future issues that DPH would need to address.

Option four is entitled "fundraising/grant writing collaborative" and originally was where I thought my companies were placed because the names of Representatives Freese, Hines, and Wasserman were incorrectly listed as recommending this model, even though they never endorsed any specific option in the final report. Their only objective was to make sure that all viable options were provided in the final report. Option four supports having DPH partner with only other University entities with grant writing activities and does not foster working with the private sector. This option will not work the way it is written because it is highly unlikely that the State institutions that could participate would be able to pay the fees or other types of charges to fund the institute. These agencies do not have extra money to spend because of the fiscal problems we are currently experiencing in Wisconsin. My proposal would promote public health, university, and

private sector partnerships with grant writing, however, we would not be charging a fee to participate.

Option five is "public health workforce development" and is extremely limited in scope. This option will only provide leadership training for public health employees. This option would meet very few, if any, of the issues that DPH will need to address in the immediate and distant future to strengthen our State's public health infrastructure. It is for this reason that this option is not feasible.

The final option is entitled, "prevention research and coordination organization" and involves another tax on health care professionals and providers who currently perform health research activities to fund a new non-profit entity or public health authority. As with option number three, I highly doubt that these individuals/health care corporations have been asked if they would be willing to be taxed in order to fund an institute. It is highly unlikely that they would consent to pay this new tax, therefore, this option is also not viable or feasible.

After reviewing all of these options, it is not hard to come to the conclusion that none of them provides the information that accurately outlines the benefits that my proposal could provide the State, DHFS, DPH and the citizens of Wisconsin. I developed my companies almost 18 months ago in order to provide an option for DPH to utilize that would maintain and strengthen our State's public health infrastructure and keep the Federal grants in Wisconsin in order to continue to provide public health services. The purpose of the Wisconsin Institute for Public Health, a private non-profit corporation, and the Public Health Service Corporation of Wisconsin, a private for-profit corporation, is to create a public/private partnership with the DHFS to complete the activities outlined by the current public health grants. With our partnership, we will be able to fulfill the three core public health functions for Wisconsin and would be able to increase the capacity for coordinating and delivering the twelve essential public health services as outlined in Healthiest Wisconsin 2010.

Some benefits this partnership would bring to the State would include having absolutely no cost to the taxpayer to form this partnership and reducing the total number of state employees. Another important benefit would to be able to start in a relatively short time frame of a few months rather than several years.

A benefit to the DHFS would include assistance with grant matching funds. It is a goal of the Wisconsin Institute for Public Health to assist DHFS with the public health grant matching funds. In addition, my companies will create pilot projects that will allow us to be more competitive with grant applications. Another benefit to DHFS would be a reduction of rent costs and other administrative costs due to the overall reduction in employees being moved offsite.

The DPH would benefit from the partnership because it would maintain and strengthen the State public health infrastructure. This proposal would allow DPH to be at an advantage when writing for their current as well as with future competitive grants. Many grants are now asking for public/private partnerships in order to apply for them and this

type of public/private partnership would provide a competitive edge to Wisconsin. The partnership would also make it easier to staff new and existing State grant positions so that the periodic hiring freezes that occur at the State level would not be an issue. The ability of both companies to provide pilot projects would give DPH another competitive edge when writing for grants by dramatically increasing our chances for new grant awards. Many funding sources are more likely to fund and expand programs that currently exist, even if they are very small in size, than to fund a program that has not been developed yet.

During the DPH Institute public forums held in September, there were four main themes of concern brought up by the participants. The first had to do with the fear that contracting will "take away" money from the grants. This will not occur with my proposal. DPH currently uses contractual agreements with the University of Wisconsin to hire university staff to complete public health grant activities due to staff shortages. This type of contract provides money from the grants to pay for staff salaries, benefits, and administrative costs in order to hire and oversee the staff. These contractual employees completing DPH grant activities have not only maintained the grants, but have been seen by DPH as enhancing the work of DHFS.

Another concern was that subcontracting would create a loss of control by the State over the grant. By subcontracting, the State would remain the awarded entity for the grant so it could not lose "ownership" of the grant. The contract between the State and my companies would be a memorandum of agreement (MOA). The MOA process would clearly outline specific activities, deadline dates, as well as budgets so the State would maintain complete control over these activities and could not be charged more than what is stated in the contractual agreement. Because the grant would continue to be held by the State, the outsourcing agreement could be discontinued if the work was not done to the specifications of the agreement. The amounts charged by my companies would be very similar to the ones currently being used by DPH, so the granting agencies should not have concerns regarding the amounts being charged to complete the activities in the grants.

A third concern was that subcontracting to a private company is only being done in order to cut staff numbers and would not benefit the State public health system. I feel that any strong option should address both the future goals as well as the present problems that DPH is experiencing. My proposal addresses not only how to maintain the current programs, but also focuses on how to build and strengthen our State public health infrastructure for the future.

A final concern brought up during the public forums was that "this has not been done before". That statement is not correct. Subcontracting through the University has been done for many years in the State of Wisconsin by DPH in order to hire staff for grant positions. As an employee, I also wrote a grant in 2003 that included a written MOA with a private, non-profit clinic in Minneapolis, Minnesota. All of these types of agreements were approved by both DPH and DHFS.

There are also several states that are currently using subcontracting to increase and strengthen their public health programs. New York has two major private non-profit programs that have been in existence since the 1950's. Both Ms. Ellen Rautenberg, President and CEO of the Medical and Health Research Association of New York City, Inc. and Michael Nazarko, Executive Director of Health Research, Inc, have flown from New York to describe how their partnerships have benefited both the City and State of New York. Our neighboring state of Michigan has also used subcontracting to provide services to its citizens. The Michigan Public Health Institute has also provided written testimony regarding how subcontracting with the State Public Health Department has benefited their state. The National Network for Public Health Institutes has also offered to provide technical assistance for my companies in order to make this public/private partnership a success.

In conclusion, I want to state that I am not asking for any special treatment or consideration in regard to my proposal. I am only asking for equal treatment and equal consideration, which I have not received. I feel that my option is the only comprehensive solution that addresses both the present issues and future goals for our State public health system in a way that would maintain our current level of services and infrastructure as well as strengthening and expanding them in the future.

My proposal to the State of Wisconsin is a very simple concept. By subcontracting using MOA's, the State could reduce the number of State employees without reducing the services and programs offered to the citizens of Wisconsin at no cost to the taxpayer. Implementation of this solution could be done in a relatively short time frame of a few months rather than several years. There would be assistance with grant matching funds, creation of pilot projects that will allow Wisconsin to be more competitive with grant applications, and a reduction of rent and other administrative costs. The State would also be able to continue and strengthen the public health infrastructure, maintain control and oversight of the grants in order to assure quality and timeliness of the grant activities, and promote writing for new public health grants.

I feel this public/private partnership would benefit not only the Division of Public Health, but would also benefit the Department of Health and Family Services and the State as a whole. By working together, we would be able to assist DPH to meet its objectives for Healthiest Wisconsin 2010 and Turning Point. This partnership would provide a positive opportunity for the State of Wisconsin and its citizens.

Sincerely,

Susan J. Garman

Susan J. Garman, CEO
Wisconsin Institute for Public Health
Public Health Service Corporation of Wisconsin
(608) 643-0686

The **Wisconsin Institute** for **Public Health**

Keeping Wisconsin Healthy

The **Public Health Service Corporation** of **Wisconsin**

Promoting Health and Prevention for Wisconsin

PHSCW The Public Health Service Corporation of Wisconsin

Promoting Health and Prevention for Wisconsin

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Mission

The mission of both the Wisconsin Institute for Public Health, Inc. and the Public Health Service Corporation of Wisconsin is to conduct research activities and publication of findings, provide health surveillance activities, development and distribution of educational programs and materials, and to promote the health of Wisconsin residents. Highly skilled staff members will not only maintain the current public health system and University of Wisconsin System research and health programs, but will expand the services and programs provided to the residents of Wisconsin.

Keys to Success

- Excellent quality and timely completion of activities outlined within the awarded federal grants.
- Writing competitive grant applications for current and future grant opportunities.
- Developing new partnerships with state, federal and private organizations for future projects, activities, or grant applications.

Structure

The public health model created was used in order to combine the best characteristics of two public health models currently found within the United States. The structural model of a for-profit and a non-profit company came from New Hampshire (The Community Health Institute and John Snow, Inc.). This structure would provide the State an additional competitive edge when writing grants. With a public, for profit, and non-profit relationship, funding agencies would be more likely to award grants to the partnership. Many grants now require these types of community based partnerships.

While the New Hampshire model had many good points, it does not incorporate the types of public health programs we would like to assist the State of Wisconsin with. The model that seemed to mirror more of the State of Wisconsin's programs was found in the Public Health Institute located in Berkley, California. Our goal was to combine the two models in order to create a new model which would incorporate the best components of both programs to meet the public health needs of Wisconsin citizens.

Purpose of this Partnership

Working in partnership with the State of Wisconsin, Department of Health and Family Services, Division of Public Health, the Wisconsin Institute for Public Health, Inc. (WIPH) and the Public Health Service Corporation of Wisconsin, Inc. (PHSCW) will provide quality public health services to the citizens of Wisconsin. Funding for these programs will be from federal grant money. Memorandums of Agreement (MOA's) will be written jointly by the State of Wisconsin, Department of Health and Family Services, Division of Public Health and WIPH/PHSCW to determine the amount of money to be provided to WIPH/PHSCW in order to hire staff and provide the services outlined by the federal grant.

The State of Wisconsin, Department of Health and Family Services, Division of Public Health is in the process of dramatically reducing their state employee staff numbers. With these staff reductions, there will not be enough people to complete the tasks of their currently awarded grants which puts the grants at risk of being lost and returned to the federal government. The companies would be able to complete the services the Division of Public Health cannot provide due to the staff reductions and in turn preserve the federal grants. Competent, qualified staff members will be hired, which may include current DPH staff being laid off, in order to complete all grant activities.

Information About the Companies

The Wisconsin Institute for Public Health, Inc. and the Public Health Service Corporation of Wisconsin, Inc. are companies which specialize in providing public health surveillance activities, development and distribution of educational programs and materials to promote the health of Wisconsin residents, and conducting public health research activities and publication of findings.

The Public Health Service Corporation of Wisconsin is a Wisconsin C-corporation based out of Sauk City located in southern Sauk County, owned by its principal operators.

The Wisconsin Institute for Public Health, Inc. is a 501(C)(3) Wisconsin non-profit C-corporation also based out of Sauk City located in southern Sauk County, owned by its principal operators.

Both the Wisconsin Institute for Public Health, Inc. and the Public Health Service Corporation of Wisconsin, Inc. are listed on the State of Wisconsin Vendor List. These companies are the only ones currently on the vendor list which are capable of performing the grant activities that are required by the DPH grants.

The **Wisconsin Institute** for **Public Health**

Keeping Wisconsin Healthy

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Strengthen Public Health Infrastructure

The partnership created for the State of Wisconsin with the Wisconsin Institute for Public Health, Inc. and the Public Health Service Corporation of Wisconsin, Inc. would continue to meet and expand upon the initiatives created in "Healthy People 2010" as well as Wisconsin specific public health initiatives in "Turning Point" and "Healthiest Wisconsin 2010". The focus of the Wisconsin Institute for Public Health, Inc. and the Public Health Service Corporation of Wisconsin, Inc. will be to address the issues outlined by the five infrastructure priorities and eleven health priorities described by "Healthiest Wisconsin 2010". The three overarching goals (promoting and protecting health for all, eliminating health disparities, and transforming Wisconsin's Public Health System) and the three core public health functions (assessment, policy development, and assurance) will also be an important focus for the Wisconsin Institute for Public Health and the Public Health Service Corporation of Wisconsin, Inc.

The goals of both companies are not only to maintain the current public health infrastructure in Wisconsin, but also to strengthen it. Focusing on new grants and new/expanding program initiatives to address areas of weakness in our public health structure will be of utmost importance in order to meet our statewide public health goals.

Benefit to DPH

The Division of Public Health (DPH) would benefit from the partnership created for the State of Wisconsin with the Wisconsin Institute for Public Health, Inc. and the Public Health Service Corporation of Wisconsin, Inc. in many ways. The partnership would:

- Maintain and strengthen the State public health infrastructure.
- Provide DPH a way to maintain control and oversight of the grants in order to assure quality and timeliness of the grant activities. By using memorandums of agreement (MOAs), there will be no risk of overcharging the grants because all charges would be clearly defined as well as all deadlines and activities to be performed. The corporations would be utilizing similar charges currently being used in grants written within DPH, so there would be a greater likelihood for support of the partnership from the grant funding sources.
- Allow DPH to be at an advantage when writing for their current as well as with future competitive grants because many grants are now asking for public/private partnerships in order to apply for the grants.
- Developing public health pilot projects. These pilot projects would provide a competitive edge when writing for grants by dramatically increasing our chances for new grant awards. Many funding sources are more likely to fund and expand programs that currently exist, even if they are very small in size, than to fund a program that has not been developed yet. These small programs would provide that competitive edge for our State. This option would also promote writing for new grants.
- Allow for greater ease to staff new and existing grant positions because the hiring freezes that periodically occur at the State level would not be an issue.
- Allow DPH to write for new grants. Currently, DPH is not allowed to compete for new grants if it may involve creating a new position.

Benefit to DHFS

This partnership between the State of Wisconsin with the Wisconsin Institute for Public Health, Inc. and the Public Health Service Corporation of Wisconsin, Inc. would provide many benefits for the Department of Health and Family Services. Some of those benefits would include:

- The ability to complete the activities outlined by the current public health grants.
- The ability to fulfill the three core public health functions for Wisconsin and would be able to increase the capacity for coordinating and delivering the twelve essential public health services as outlined in Healthiest Wisconsin 2010.
- A reduction of rent costs due to the overall reduction in employees being moved offsite.
- Assistance with grant matching funds. It is a goal of both companies to directly assist DHFS with public health grant matching funds.

Benefit to the State

A public/private partnership between the State of Wisconsin with the Wisconsin Institute for Public Health, Inc. and the Public Health Service Corporation of Wisconsin, Inc. would be a very beneficial venture. Some benefits to the State would include:

- Having absolutely no cost to the taxpayer to form this partnership
- Reducing the total number of state employees rather than shifting them from one state entity to another
- Creating well-paying jobs in the private sector with excellent benefits
- Being able to start in a relatively short time frame of a few months rather than up to a few years.


FORWARD

Mr. Chairman and Members of the Committee:

I am Kathy Munsey, the Health officer in Green Lake County and I have the privilege of representing nearly 100 Local Public Health Agencies as the Co-President of the Wisconsin Association of Local Health Departments and Boards (also known as WALHDAB). I would like to take this opportunity to thank the committee for allowing me to testify about the development of a Public Health Institute in Wisconsin.

The mission of the WI Association of Local Health Departments and Boards, which is a state-wide organization of board of health members and health department administrators, is to provide a unified forum for public health leadership development, advocacy, education, and forging of community partnerships for the improvement of public health at the local level.

WALHDAB believes that the development of a Public Health Institute can help ensure that public health workers are competent in providing essential public health services and demonstrating proficiency of the core public health functions related to their jobs.

WALHDAB would support a Public Health Institute that is consistent with the Institute of Medicine's: The Future of the Public's Health in the 21st Century (2003). This document stresses the need to reduce fragmentation of governmental services and improve communication and collaboration

The WI Public Health Association created the concept of a Public Health Incubator whose purpose would be to "grow" new ideas and opportunities to help WI be the healthiest state. This was included as one of six recommendations from the PHI committee which was formed to look at options for a PHI in Wisconsin.

Several states already have PHI's. The DHFS study committee, along with other WI public health professionals have looked at these institutes to see which "model" might fit us best. WPHA's incubator idea tells us we don't have to pick "a model" from another state. Rather, we can ask the questions, do the planning with partners and formulate an institute that fits WI. WALHDAB hopes to see an institute that could provide leadership, and support to public and private healthcare providers. A committee could be formed to look at ways to strengthen public health infrastructure via the PHI

as well as look at other gaps and challenges that need to be met to attain the vision of health people in healthy communities.

One caution WALHDAB members would provide about forming a PHI, is that current funding received by state and local health agencies NOT be utilized to fund the start-up of a PHI. This would further burden us at a time when adequate funding for public health services is already lacking.

The development of a PHI will be an evolving process. The public health institute may want to address such issues as integrating data and technology systems of public and private partners to improve the effectiveness of health interventions. It may want to explore funding sources available for health and wellness programs that government agencies are not able to capture. The possibilities are endless. This is why the "incubator idea' makes sense.

Finally, and most importantly, I think that we can all agree that the importance of public health cannot be understated. The development of a PHI can only strengthen the capacity of healthcare providers to meet the goals in Healthy People 2010 which is the national health plan. The WI Association of Local Health Departments and Boards supports the WI Idea

Public Health Incubator proposal and we hope your committee will give this idea careful consideration as we move forward to make WI the nation's healthiest state.

Thank you for the opportunity to testify today about this important topic. I would be happy to answer your questions.