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.
Nearly two decades ago, key staff members of the state health department joined with state university leaders, state legislators, and other interested parties to lay the groundwork for the establishment of a closely aligned, nonprofit public health entity in Michigan. Although what they knew of the challenges that lay ahead for public health had convinced them of the need for such an entity, they could never have imagined to what extent the institute would develop and become such a crucial part of Michigan’s efforts to improve the health of its communities.

Since its establishment in 1990, that entity — the Michigan Public Health Institute — has grown and matured to become a recognized leader in public health work, a credible, neutral convener with an understanding of both the public and private arenas and the ability to bring together diverse community health stakeholders and lead them in collaborative efforts to identify their common problems and find innovative, far-reaching solutions for them.

In all its endeavors, MPHI has moved with integrity and a desire to empower communities as they seek to maximize positive health conditions for their citizens through collaboration, scientific inquiry, and applied expertise. MPHI stands today as a strong voice in the ongoing fight to improve the health of our communities and as a trusted, valued partner to all public health stakeholders, including local, state and federal agencies, academia, foundations, businesses, and community institutions and organizations. From the beginning, MPHI has focused on forming strong, collaborative partnerships and bringing tangible, added value to the table.

Historically, MPHI’s strongest contracting relationship has been with the Michigan Department of Community Health (MDCH). MPHI performs a variety of tasks for MDCH, and the two partners work together to enhance the capacity of both the State and its communities to improve health status and foster innovations in health systems. This working partnership is an important one for the citizens of Michigan, because it enables the State to extend its reach, capacities and resources. MPHI helps the State — and, indeed, all its partners — by:

- **Leveraging resources:** MPHI can give its collaborative partners access to new and diverse sources of funding. For instance, in some cases, foundation funds are available to 501(c)(3) corporations, but not to units of government. In others, federal or foundation funds are available only to statewide consortia, such as those convened through MPHI. MPHI’s track record shows it is extremely effective at leveraging State resources with funds from a variety of private and public sources at both the state and national levels. In fact, between November 1992 and November 2004, MPHI’s efforts added more than $50
millions in non-State resources to Michigan's efforts to improve community health. One prime example of this is Michigan's Electronic Immunization Registry which was developed with resources from the Robert Wood Johnson Foundation and the U.S. Commerce Department.

Similarly, MPHI can identify and organize in-kind resources to support State activities. Often, health-related entities, community organizations, and national groups are willing to provide staff expertise, plus other in-kind resources, to MPHI in its role as a neutral convener when they might otherwise hesitate to share them directly with other stakeholders. Such in-kind contributions leverage the resources of State agencies and enhance the success of projects aligned with State goals.

• **Building community capacity**: MPHI frequently is involved in projects that help communities develop and maintain capacities that can be used to improve the health of residents and the functioning of health care systems and health service programs. Over the years, MPHI-supported projects have provided capacity building, training, continuous quality improvement, surveillance data, and technical support to the majority of Michigan’s communities. The accreditation of all local health departments in the state is one key effort in this arena.

• **Extending the State’s capabilities**: MPHI’s staff of more than 165 professionals, the majority of which have earned master’s or doctoral degrees, includes researchers, data analysts, IT experts, project managers, and scientists trained in a broad array of health fields. State agencies benefit from that strength and breadth of expertise in a number of ways. They can use the resources at MPHI to comply with requirements associated with federal funding of programs and projects — requirements such as grant proposal and document preparation, program design, staffing and implementation, data gathering, and program evaluation; if funded projects are complex with short timeframes, MPHI can step in and help State agencies staff and operate those projects in a timely, cost-efficient manner — and terminate them in an equally timely manner once the work is completed.

State agencies also can utilize MPHI’s expertise and facilities to design and run computer-assisted telephone interviewing surveys and other health surveillance projects that will enable them to better monitor and understand the health behaviors, knowledge, and beliefs of Michigan residents — and then use that information to design more effective, cost-efficient programs and projects.

MPHI supports the State in a variety of other ways, too, such as with its specialized conferencing facilities that include an Internet-based video-conferencing system, satellite downlink equipment, and a three-room conference center that can be used for collaboration building, staff training, community outreach, and a number of other purposes.

• **Communicating knowledge and outcomes**: MPHI is proud of its efforts to disseminate state-of-the-science research findings that can advance community stakeholders’ capacity to improve health status and reduce disparities among population groups and geographic areas. Its collaborative projects often result in publications or even multi-media campaigns designed to educate the public and improve healthy behaviors or to inform health professionals about current health issues and trends and how to best address them.

Last May, MPHI published a report entitled *Michigan Public Health Institute: A 15 Year Retrospective*, which highlights the Institute’s more notable projects during its first decade and a half of service. That publication is available on our Web site at [www.mphi.org](http://www.mphi.org), and I invite all of you to review it. You may be surprised at the depth and variety of the collaborative projects we’ve undertaken … and the scope of their impact on our communities. Join with us as we work together for a healthier future.

**Ed Dore**
President, MPHI Board of Directors
& Chief Deputy Director, Michigan Department of Community Health
Bottom row on couch, left to right: Karen Aldridge-Eason, Ed Dore, James Randolph, Kim Horn

Second row, left to right: Michael Massanari, Gail Jenson, Toby Citrin, Jacquelynne Borden-Conyers, Jean Chabut

Third row, left to right: Hiram Fitzgerald, Michael Mortimore, Cynthia Cameron*, Amy Slonim*, Tracy Litzinger*

Fourth row, left to right: Jeff Taylor*, Hope Rollins*, Carrie Babcock*, Teri Covington*, Kimberly Westmoreland*

Last row, left to right: Mary Ann Gregor*, Lynn Breer*, Tom Lindsay*, Jeff Weihl*, Earl Sauers*, Richard Wimberley*

*MPHI staff members
**Health Promotion and Disease Prevention (HPDP)** focuses on the areas of asthma, nutrition, physical activity, obesity, dementia, diabetes, osteoporosis, cancer epidemiology and evaluation, managed care, and tobacco. Disciplines include researchers, evaluators, professional counselors, public health administrators, dietitians/nutritionists, health educators, communication experts, psychologists, epidemiologists, and international health/community development experts.

**Center for Collaborative Research in Health Outcomes and Policy (CRHOP)** offers clients a variety of skills and capacities related to program, evaluation, policy analysis, survey research, research design, data acquisition, management and analysis, web hosting and website design, web-based data collection design, development and programming, information reporting, and a wide range of training programs.

**Systems Reform** facilitates the reform of human services systems in order to increase the effectiveness of services for children and families. Systems Reform staff assist collaborative groups to use outcomes-based strategic planning, implementation of best practice strategies, and evaluation to drive their health, human services and education program.

**Cancer Control Services** provides technical assistance and support for the coordination of cancer control activities for the State of Michigan and its partners. Areas of focus include technical assistance and consultation on public health program matters relative to prevention, screening, referral, tracking and follow-up, partnership and coalition development, quality assurance and improvement, professional education, public education, surveillance, planning, administration, and evaluation. Disciplines include communication and technology experts, health educators, quality assurance specialists, financial analysts, data analysts, nurses, and public health consultants and administrators.

**Child and Adolescent Health (CAH)** provides technical assistance to state and local partners in the design, implementation and evaluation of innovative, multidisciplinary and community-based programs that strengthen assets and reduce risky behaviors, leading to improvements in the health, safety and well-being of children and their families. Current focus areas include child and infant mortality, abstinence promotion, antibiotic resistance, injury prevention and home based services for high risk families.

**Interactive Solutions Group (ISG)** helps healthcare organizations and public-sector agencies operate more efficiently and effectively by redesigning business processes and automating information exchange. Our project managers, business analysts, subject matter experts, and technical staff are skilled at leveraging electronic data interchange (EDI), internet/web technology, and learning management systems on behalf of our clients. Our comprehensive approach combines information technology, project management methodology, and training/outreach processes to help our clients manage change and more effectively interact with their business partners and constituents.

**Health Professional Recovery Program (HPRP)** is a confidential program established by the Legislature in 1993 that is available to the 27 disciplines of health care professionals who are licensed or registered pursuant to the Public Health Code. HPRP can be voluntary or regulatory (non-voluntary) and provides outreach, intake and monitoring to health care professionals who are at risk of losing or have lost their job due to alcohol and/or drug abuse or serious mental illness that impairs their ability to work. Professionals enter monitoring agreements that, if complied with, allow retention of their license/certification after a three-year period.

**Center for Advancing Community Health (CACH)** is an affiliated program for which MPHI provides management support services. The Center supports health care policy efforts at the community, regional and state levels.

**Center for Tobacco Prevention and Research** is an affiliated program for which MPHI provides management support services. This Center focuses on analyzing depositions and trial testimony from tobacco lawsuits to assess what they reveal in areas such as nicotine addiction and pharmacology, the health consequences of tobacco use, tobacco-product design and manufacturing, tobacco advertising and promotion, youth smoking initiation, and tobacco use cessation.
Michigan cancer patients will benefit from the results of a Michigan Cancer Consortium (MCC) project that promises to yield more accurate and consistent reporting of pathology samples among pathology labs operating within the state.

The project, which is referred to as the Michigan Standardized Cancer Pathology Lexicon Project, was launched by the Consortium in 2003 with support and assistance from the Michigan Department of Community Health and the MPHI Cancer Control Services Program, and an MCC Standardized Lexicon Advisory Committee was established to lead the effort.

Through the dedication and hard work of members of this expert advisory committee and the collaborative efforts of various MCC partner organizations, the project team has now met its goal of producing and implementing statewide field-tested basic pathology lexicon templates.

The implementation and use of these new templates will result in pathology reports that are more complete and uniform between facilities, and the resulting data will enable physicians to make more informed cancer treatment decisions and will provide healthcare policymakers and analysts with accurate information that can be used in determining the cost-effectiveness of various healthcare measures.

What Was Done

To meet their objectives, project team members gathered information, data and feedback from pathologists, clinicians, tumor registrars, and administrators of cancer treatment facilities throughout Michigan regarding the key elements currently in use for gross, microscopic and biochemical reporting of pathology exams on breast, colorectal and prostate cancers.

As one of the key steps in developing the templates, the project team solicited the input of pathologists who serve as directors of Michigan laboratories that routinely report more than 250 cancer cases per year, requesting from each a list of elements the laboratory typically includes in its anatomical pathology reports for breast, colorectal and prostate cancers.
After developing a format that they believed to be scientifically valid, clinically usable, and user-friendly, team members created basic pathology lexicon templates for breast, prostate, colorectal, cervix, and lung cancers and then expanded that work to create templates for all common cancer types.

After completion of the draft templates, the team began a pilot/evaluation phase, hosting regional meetings throughout Michigan to present the lexicon to pathologists and clinicians and to recruit pathologists and clinicians to use the draft templates in their facilities on a pilot basis.

Dozens of facilities agreed to do so and, at the end of the pilot testing, the team surveyed the participants for their opinions as to the completeness, efficiency, timeliness, and quality of the templates, as well as the likelihood the facility would use the templates and, if so, how the templates would be used.

Survey results showed that the majority of pathologists and health professionals who pilot tested the templates found them to be both functional and of immediate value in improving surgical pathology reporting practices in laboratory facilities. In fact, more than half (50.1 percent) of respondents said the templates would improve efficiency by being cost effective and lowering the margin of error in reporting; a majority (54.6 percent) of respondents said the checklists would improve the timeliness of the delivery of pathology reports; and three-quarters (75.1 percent) of respondents said the lexicon would improve the quality of pathology reports.

What’s Next
On Sept. 21, 2005, the MCC Board of Directors approved the field-tested templates, as well as a process for regularly reviewing and updating the templates. Next steps for this collaborative project will involve the dissemination and promotion of these templates, followed by the documentation of the change in Michigan pathology lab reporting practices.

The MCC is excited about the results of this project, and the Consortium recognized the efforts and success of the lexicon project team during its November 2005 Annual Meeting, when MCC officers presented the project with a Spirit of Collaboration Honorable Mention award. During the presentation, MCC officials noted that one of the award reviewers had referred to the lexicon project as an “excellent collaboration to achieve an important MCC priority!”

Other collaborators include:
- Michigan Society of Pathologists
- Participating member institutions of the MCC that provide pathology and oncology services (including the other Cancer Centers and their affiliates)
- College of American Pathologists
- American College of Surgeons
- Michigan Cancer Registry of the MDCH
- Michigan Cancer Registrars Association

Learn More
For more information about the MCC and its Michigan Standardized Pathology Lexicon Project, contact the MPHI Cancer Control Services Program at 2438 Woodlake Circle, Suite 240, Okemos, MI 48864 (517-324-7300) or visit www.michigancancer.org.

Richard Wimberley, MPA, is program director of the MPHI Cancer Control Services Program.
Michigan is one of five states selected to participate in an initiative to use performance standards to review and assess the work of individual state and local health departments, gather best practices, and produce models for action nationwide.

Michigan, Illinois, Missouri, North Carolina, and Washington were chosen from a field of 18 applicants to participate in the Multi-State Learning Collaborative for Performance and Capacity Assessment or Accreditation of Public Health Departments program (Multi-State Learning Collaborative for short). The initiative is being sponsored by the National Network of Public Health Institutes, the Public Health Leadership Society, and the Robert Wood Johnson Foundation (RWJF).

About the Collaborative
The Multi-State Learning Collaborative is designed to bring together states that are already conducting systematic performance and capacity assessments or accreditation programs of their public health agencies to: 1) further their current efforts, and 2) identify and disseminate best practices to the broader public health practice community. The long-term goal of the Multi-State Learning Collaborative is to maximize the effectiveness and accountability of governmental public health agencies.

The Robert Wood Johnson Foundation has awarded each of the five participating states a one-year grant of up to $150,000 to implement their portion of the program; the states will use the funds for technical assistance, sharing information about best practices and lessons learned, publications, meetings, evaluation, and the development of a fund to sustain the effort.

The Multi-State Learning Collaborative complements another project, called the Exploring Accreditation project, which is examining the implications and feasibility of establishing a national system for voluntary accreditation of state and local health departments. The Exploring Accreditation project is funded by RWJF and the Centers for Disease Control and Prevention and is being conducted by the National Association of County and City Health Officials and the Association of State and Territorial Health Officials.
Findings and recommendations from the Multi-State Learning Collaborative initiative will be shared with the National Steering Committee and workgroups of the Exploring Accreditation project in the hope of developing a framework for public health agency accreditation at the national level.

**Michigan’s Involvement**

The Michigan Local Public Health Accreditation Program is a collaborative effort between Michigan’s 45 local health departments; the Michigan Departments of Community Health, Agriculture and Environmental Quality; the Michigan Public Health Institute; and the Michigan Association for Local Public Health.

As a member of the Multi-State Learning Collaborative, Michigan’s stakeholders and partners in accreditation have established the following state-level objectives to support the national objectives.

- Assess opportunities for enhancement to the current approach (application of a gap analysis);
- Draft a voluntary component to enhance the current approach;
- Develop tools to enhance reviewer team and local health department interface;
- Develop a model for ongoing awareness, education and training of local governing entities;
- Establish an evolving digital library of Michigan accreditation information; and
- Develop a model to establish a best practices information exchange.

These improvements to accreditation will meet Michigan’s needs and also can be expanded to address national concerns as well.

For instance, the gap analysis will be useful for other public health entities (e.g., state/local public health, public health institutes, state/local boards of health, public health associations) that will face the same challenge of determining how/it to move to a model compatible with, or based upon, a common core of standards at the national level.

As the evolving digital library is developed, Michigan participants will work to ensure that it can be replicated and expanded as needed, and that the methodology used to determine items for inclusion can be shared. The digital library will be one vehicle to share documents and information locally, statewide, and to the broader public health community.

Likewise, the best practices information exchange will be designed to serve not only Michigan’s needs, but the needs of other stakeholders across the nation.

“I applaud this collaborative effort to enhance Michigan’s public health accreditation program,” Mary Kushion, health officer for the Central Michigan District Health Department, said. “Like many health officers in the state, I look forward to working with our state partners to incorporate the best practices of other states’ programs, as well as sharing Michigan’s expertise at a national level.”

**Learn More**

For more information about the Michigan Local Public Health Accreditation Program and Michigan’s participation in the Multi-State Learning Collaborative, contact the MPHI Center for Collaborative Research in Health Outcomes and Policy at 2440 Woodlake Circle, Suite 190, Okemos, MI 48864 (517-324-7389) or visit [www.crhop.net](http://www.crhop.net).

*Melody D. Parker, MM, MLIS* is a program coordinator in the MPHI Center for Collaborative Research in Health Outcomes and Policy.
With the assistance of a $900,000 grant from the U.S. Department of Health and Human Services, the Michigan Department of Community Health (MDCH) launched the Michigan State Planning Project for the Uninsured in January 2005 to develop a plan to eventually extend access to affordable healthcare insurance to thousands of citizens.

The project, which is scheduled to be completed in 2006, is designed to enable the State of Michigan to better identify the factors contributing to the rise in the number of uninsured citizens and to develop a plan to ensure that all residents have affordable access to healthcare insurance.

To set the groundwork for the project, MDCH created a broad-based governance structure, including a project advisory council, a steering committee, and several workgroups made up of key stakeholders, policymakers, and professionals who work with the uninsured.

The Access to Health Care Coalition (AHCC), which includes representatives from healthcare providers, purchasers, and consumer groups, was selected to serve as the Advisory Council for the project.

Three workgroups (Data Synthesis, Community Interface, and Models Development) were formed to assist in: designing data acquisition approaches and reviewing the information acquired; reviewing and assessing models; reviewing and assessing plan components as they are developed; and developing strategies to engage community stakeholders and build consensus.

Collecting the Data

Project team members and other stakeholders then worked to expand the current knowledge base regarding uninsurance issues through data collection activities designed to uncover unmet need, barriers to insurance coverage, and system changes needed to extend coverage to all Michigan citizens.

The Survey Research Unit (SRU) of the MPHI Center for Collaborative Research in Health Outcomes and Policy (CRHOP) collected data to identify the size and characteristics of the uninsured population.
in Michigan at the state and regional level. Unit staff gathered data using four collection methods, including:

- a random-digit-dialed household survey that targeted uninsured respondents in seven regions throughout Michigan;
- an employer survey that was mailed to 12,000 small and mid-size businesses in Michigan;
- focus groups of small/medium-size employers, uninsured consumers, and insurance brokers/agents that focused on existing state models and models for universal coverage; and
- key informant interviews with employers and policymakers to better understand attitudes toward universal coverage, as well as cost, regional variation, feasibility, and legislative implications.

With the help of the Community Interface Workgroup, MDCH also conducted public forums billed as Health Care Listening Tours at locations throughout the state and local organizations in several cities hosted town hall meetings on behalf of MDCH to gather citizen input.

**What’s Next**
Throughout the last year, the Models Development Workgroup has been reviewing and assessing existing state insurance coverage options and insurance models for their viability and acceptability in expanding health insurance coverage and also has been evaluating the impact of selected models on existing coverage and on the safety net system.

MDCH is working with members of the Data Synthesis and Models Development workgroups and other key project members to examine the quantitative and qualitative data that has been collected and to develop a set of recommendations and a strategic plan designed to provide all of Michigan’s citizens with access to affordable health insurance coverage.

Project leaders will provide state decision-makers with options that recognize the diversity of Michigan’s population and reflect the flexible nature of state and federal policy. They will present the project’s final report and recommendations to Governor Jennifer M. Granholm, the U.S. Department of Health and Human Services, and the health policy committees of the Michigan legislature.

**Learn More**
For more information about the Michigan State Planning Project for the Uninsured, contact the MPHI Center for Collaborative Research in Health Outcomes and Policy at 2440 Woodlake Circle, Suite 190, Okemos, MI 48864 (517-324-7389) or visit [www.crhop.net](http://www.crhop.net).

*Marti Kay Sherry, MBA,* is the director of the Survey Research Unit in the MPHI Center for Collaborative Research in Health Outcomes and Policy.
The National Center for Child Death Review, which was established at MPHI in 2002, received a second round of funding in 2005 that will support the National Center’s operations for at least three more years.

The Maternal and Child Health Bureau of the Health Resources and Services Administration awarded MPHI the grant for the Center in part based upon the Institute’s track record in managing the Michigan Child Death Review Program. The Michigan program is in its 10th year of operation, during which time local review teams throughout Michigan have developed partnerships for child death review that have led to more than 2,000 local child health and safety prevention programs, policies and services.

Working Collaboratively to Save Lives

A Child Death Review (CDR) team is a partnership of professionals that meets to review case information on children’s deaths in order to understand why the children died and to develop and implement strategies to prevent other deaths, injuries and illnesses. Team members at a community or state level typically include representatives of public health, social service, medical examiners, prosecuting attorneys, law enforcement, health care providers, mental health, education, and community leaders.

The National Center for Child Death Review provides technical assistance, training and coordination to teams in all states and the territories, as well as to the trust nations of the Pacific Basin. Forty states have received on-site assistance from the Center.

The Center also serves as a hub to help the state CDR programs partner with each other. The Center has held two national meetings of CDR program leaders, including one coordinated in partnership with the State of Missouri. This year, the Center supported five regional meetings for state CDR coordinators, one each in the Southwest, Northwest, Southeast, Midwest, and Northeast. These meetings have helped states improve their CDR programs, especially helping teams translate their reviews into actions that prevent deaths. By developing these partnerships with state CDR program leaders, the Center has also been able to capitalize on the expertise in states building Center resources.
Fourteen experts from 12 states worked with the Center over two years to author and publish the national Program Manual for Child Death Review. Another 18 experts from 14 states began working two years ago to design a national standardized reporting system for CDR; their work led to a reporting tool, data dictionary, and user manual. MPHI technical staff developed the software platform for the reporting system, and in 2005, launched this new web-based Multi-State CDR Case Reporting System as a pilot in 12 states.

The new multi-state database will enable local and state CDR experts across the nation to compile their findings in one place. Program and policy decision makers at the local, state and national levels can then use the aggregate findings to guide them in the formulation of child health and safety programs, services and legislation.

One of the primary functions of the Center is promoting the CDR process to both public and private stakeholders at the national level, including policymakers, federal agencies, foundations, national support resources, and member organizations.

Creating opportunities to connect these organizations with CDR programs will help build the capacity for CDR and help to translate CDR findings into policies and practices that prevent death. For example, the Center routinely receives requests for CDR data from national organizations, both public and private, and the Center has been able to use its network of state CDR programs to respond to these requests. In some cases, the data provided by the Center has led to national child safety initiatives.

For example, in 2004, the Center linked SAFE KIDS USA to 17 state CDR programs, which provided details on 496 drowning deaths to SAFE KIDS. The findings formed the basis of the 2004 SAFE KIDS national campaign on drowning prevention.

In 2005, the Maternal and Child Health Bureau (MCHB) was asked to provide evidence on circumstances related to infant sleep-related deaths for a national meeting. The MCHB looked for data from existing research, death scene reenactments, and any other available sources. They found the best data source to be that emerging from work by CDR teams, and that the CDR data provided much more extensive information about the deaths than was provided through death certificates. With only about three weeks lead time before the meeting, the Center linked MCHB to state CDR programs, and MCHB staff obtained data on 6,400 infant deaths from 12 states. The Bureau has since shared these data at national meetings and during web-based training sessions, and it is hoped that, ultimately, the data will be used as the basis for a national Safe Sleep for Infants Campaign.

What’s Next

In November 2005, the Center convened the National Center for Child Death Review Steering Committee. This steering committee, which includes representatives of national organizations, federal agencies, and state CDR programs, will help build capacity for CDR and work to formally translate CDR findings in national policy and practice.

The work of the Steering Committee members and, indeed, of everyone involved with the state and national partnerships being built through the National Center for Child Death Review, will translate CDR data into action and help foster positive changes throughout our communities that will help our children live healthier, safer lives.

Learn More

For more information about the national CDR program, contact the National Center for Child Death Review 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 the Michigan CDR program, Keeping Kids Alive, can be found at www.keepingkidsalive.org.

Theresa M. Covington, MPH, is senior program director of Child and Adolescent Health for MPHI and also serves as the director of the National Center for Child Death Review.

Sara K. Rich, MPA, is a community health consultant with the MPHI Child and Adolescent Health Program and also serves as associate director of the National Center for Child Death Review.
In 1999, a landmark U.S. Surgeon General’s report on mental health focused on the need for prevention and treatment of mental illnesses due to their substantial economic, morbidity, and mortality burdens.

Citing findings from the World Health Organization’s (WHO) *Global Burden of Disease* study, the report identified major depression and other mental illness as the second leading cause of disability in developed nations like the United States.

*Healthy People 2010* also described the significant public health impact of mental illness, noting:

- There is a higher prevalence of depression in vulnerable populations, such as persons who live in poverty and persons who have a physical health problem.
- Only 23 percent of adults diagnosed with depression received treatment in 1997, despite evidence that 80 percent of affected persons respond to appropriate medications and therapy.
- Untreated depression and other mental illness create formidable consequences. Along with increased morbidity and mortality, problems include unemployment, social isolation, substance abuse, incarceration, homelessness, and suicide.

In 2003, data from the national Behavioral Risk Factor Survey showed that Michigan ranked 4th among the 50 states in prevalence of poor mental health. Among those surveyed, 40 percent of Michigan residents reported at least one day of stress, depression, or emotional problems in the prior 30 days, compared with 34 percent of the U.S. population.

**Who Is Most at Risk for Depression**

Depression is a significant health problem that affects individuals across the lifespan. The following groups have been identified as populations of concern:

- **Prenatal to five years:** About 20 percent of pregnant women experience depressive symptoms, and 10 percent experience major depression. Women who suffer from depression during pregnancy are three to four times more likely to deliver pre-
term and low-birth-weight babies. They also are more likely to suffer complications during pregnancy and delivery. Children of depressed mothers are more likely than other children to have behavioral, cognitive, socio-emotional, health, and academic problems. Early mental health disorders among babies and toddlers have lasting effects and appear to be precursors of mental health problems in later life.

- **Children and adolescents, aged 5 through 18:** Untreated depression leaves youths at risk for developmental and social delays. Of those who experience childhood or adolescent depression, 70 percent will have another episode of depression by the time they reach adulthood.

- **Adults, aged 19 through 64:** Adult depression often is unrecognized and untreated. Persons suffering chronic illness have twice the rates of depression as the general population. Persons with co-morbid depression and chronic illness use healthcare services more often and incur greater costs due to increased physical symptoms and poor self-management. Recent research suggests that depression may compromise immune function and lead to development of chronic disease.

- **Older adults, aged 65 and older:** The prevalence of depression is higher among institutionalized (25 percent) and community-dwelling elderly (15 percent) individuals than among those persons in the general population (10 percent). Older adults are more likely to underreport their symptoms and are less likely to seek help. Depression causes excess symptom burden, disability, and healthcare utilization for older persons.

**What Michigan is Doing**

Traditionally, systems of care for physical and mental health disorders have been separate. The public health system provides population-based services that focus primarily on prevention and early detection, while the mental health system primarily concentrates on assessment and management of illness in individuals.

Growing evidence that physical health and mental health are linked has fueled efforts to enhance collaboration between physical and mental health systems.

In January 2005, the Michigan Department of Community Health (MDCH) Division of Chronic Disease and Injury Control initiated the development of a strategic statewide plan to address depression as a public health issue. The Division invited mental health partners and other stakeholders to work together to merge the public health and mental health perspectives into a continuum of essential services to prevent, identify and manage depression.

In its role as neutral convener, the MPHI Systems Reform Program worked with the Division to identify key stakeholders for each of the targeted age groups. The MPHI team surveyed the stakeholders and experts to solicit their input on unmet needs, available resources, and evidence-based interventions to prevent, identify and manage depression. This input was used to draft a preliminary work plan for each population of focus.

In August 2005, the MPHI team conducted a one-day retreat with more than 80 stakeholders to develop key strategies for a state depression plan and to discuss barriers to implementing the plan. The result was a draft of a strategic plan that focuses on the most important objectives and the most effective actions to accomplish them within the limitations of available resources.

The MPHI Systems Reform Program, in partnership with MDCH, Columbia University TeenScreen, and the School and Community Health Association of Michigan, was invited to submit an application to the Aetna Foundation to expand depression screening for screening adolescents utilizing school-based and school-linked health centers. If funded, this project will support depression screening in 21 health centers and will work to identify and resolve barriers to screening and treatment.

**Learn More**

For more information about collaborative efforts in Michigan to address depression as a public health issue, contact the MPHI Systems Reform Program at 2364 Woodlake Drive, Suite 180, Okemos, MI 48864 (517-381-8247).

*Cynthia A. Cameron, PhD,* is senior program director of the MPHI Systems Reform Program.
Licensed or registered health professionals who are at risk of losing — or who have already lost — their job due to substance abuse or chemical dependency problems or a mental health problem that impairs their ability to perform their responsibilities can work toward recovery through the Health Professional Recovery Program (HPRP).

The HPRP is designed as a confidential, non-disciplinary, treatment-oriented approach to address the public health and safety issues related to healthcare professionals practicing in an impaired condition due to the abuse of alcohol, improper use and/or diversion of drugs, and mental health disorders. HPRP services can be voluntary or regulatory (non-voluntary).

Healthcare professionals who successfully comply with the program requirements can retain their license/certification and return to work. Individuals who do not follow HPRP policies, procedures, and signed agreements are classified as non-compliant and are reported to the Michigan Department of Community Health (MDCH) for further action, as required by law.

**MPHI’s Involvement**

The HPRP was established by the Michigan legislature under Public Act 80 of 1993 and was operated under contract through the State of Michigan until December 2004, when MPHI began as the new contractor providing program services for the MDCH Bureau of Health Professions.

In its role of contractor, MPHI provides case management services for both non-disciplinary and disciplinary cases for all healthcare professionals licensed in the state of Michigan, with the exception of emergency medical services personnel, which are regulated under a different section of the Public Health Code. These services include intake, monitoring, and clinical consulting.

Intake involves gathering information and descriptions of the potential problem and consists of the interaction with the healthcare professional, their employer, treatment providers, and various related entities.
During the intake process, case managers assist the healthcare professional in evaluating their needs through appropriate referrals and ongoing discussions with the treatment team. Treatment is specific to the individual and generally involves a multi-disciplinary approach to treat the whole person. As the individual's situation is clarified, the case manager will develop a written monitoring agreement with the individual to guide and assist them in their recovery process. The agreement may include limitations on practice or employment, random drug screening, various monitoring and progress reports, meetings with self-help and/or peer support groups, evaluation and treatment.

Once the monitoring agreement has been completed, the case is referred to another HPRP case manager, who provides ongoing recovery monitoring services to the healthcare professional, including review of drug screens and treatment progress reports from the treating providers.

HPRP provides consulting services internally to the case managers, as well as externally to the treatment provider network, the MDCH Bureau of Health Professions, the Health Professional Recovery Committee (HPRC, the appointed policymakers for HPRP), and the healthcare community.

Through a staff of specialized physicians, professional counselors, and social workers, MPH also provides policy recommendations to the MDCH Bureau of Health Professions and the HPRC. In addition, HPRP provides evaluation and training of the provider network and outreach services to the healthcare community in concert with MDCH Bureau of Health Professions.

Michigan’s Health Professional Recovery Program is available to each of 30 healthcare professions and seven student categories that are regulated under Article 15 of the Public Health Code. Of the professions eligible for the voluntary program, all but three (registered dental assistants, trained attendants, and audiologists) have had participants in the program.

Healthcare professionals who are being monitored as part of their participation in HPRP are returned to work as soon as their impairing condition is stabilized and appropriate monitoring is in place. By providing healthcare professionals with the opportunity to enter treatment and recover from their impairments early in the disease process, the program helps minimize negative impacts on the professionals, their patients, their employers, their families, and their friends.

The program is achieving its goal of returning recovered healthcare professionals to professional practice as soon as feasible, and its success can be seen in its compliance rate. Overall, more than four-fifths (81.3 percent) of the 1,408 healthcare professionals involved with the HPRP over the last year have been compliant with the program requirements; 324 of those clients have met HPRP completion requirements and been successfully discharged from the program, returning to work as recovered professionals who can once again contribute to their communities.

Learn More

For more information about the Health Professional Recovery Program, call (800-453-3784) or visit www.hprp.org.

Tom Lindsay, M.B.A.-Management, is director of the Health Professional Recovery Program.
The Detroit Faith-Based Healthy Living Initiative was created as a collaborative of 22 faith partners in metro Detroit with the shared goal of promoting healthy eating and physical activity among African Americans involved in churches and faith-based organizations.

In partnership with the Michigan Department of Community Health (MDCH) and the Michigan Nutrition Network at Michigan State University Extension, Initiative leaders obtained funding to conduct a special project designed to increase capacity and provide resources for faith-based fruit and vegetable mini-marts at 22 churches in Detroit and the surrounding area.

The mini-mart model was created to counteract the lack of major grocery stores with fresh, affordable produce within the city and also to take advantage of the strong infrastructure of faith-based organizations, particularly African-American churches, and the role they can play in promoting and supporting health behaviors.

Project leaders provided the selected church sites with the trainings and materials necessary to conduct and sustain fruit and vegetable mini-marts in their neighborhoods. The churches received information on health and wellness programs, educational resources, project materials, and technical assistance throughout the eight-month project period. Staff provided support in troubleshooting and assisted in the coordination of health screenings and educational workshops for the churches.

In conjunction with the mini-mart project, MDCH conducted a wellness project called Body & Soul that was developed so African-American churches could empower their members to eat five to nine servings of fruits and vegetables each day.

The most beneficial outcomes of these joint efforts came as a result of church leaders and congregations understanding the importance of fruit and vegetable intake and implementing the fruit and vegetable mini-marts to offer low-income residents the ability to get low-cost, fresh produce in an easily accessible location.

Numerous partners played integral roles in the implementation of project activities. Their roles were diverse and included: the recruitment of churches and faith-based organizations for the mini-
mart sites; education and access to the selection and procurement of fresh produce from a wholesale distributor in the Detroit Eastern Market; promotion of project activities in community settings via flyers, targeted mailings, and posters displayed at health and human services offices; and securing funding to conduct project activities.

The partnerships that were formed not only contributed to the current success of the project, but also have helped to create an ongoing structure for future success of the initiative.

**Selected Highlights of the Project**

Ten churches implemented fruit and vegetable mini-marts, health screenings, education sessions, and point-of-service advertisements reaching more than 25,000 residents. Surveys of consumers showed positive change.

- More than 150 mini-marts were offered by 10 churches in metro Detroit.
- More than 50 faith leaders were trained regarding the implementation of health and wellness programs including the fruit and vegetable mini-marts.
- 8,500 consumers purchased produce at the fruit and vegetable mini-marts.
- Following implementation of the mini-marts and associated activities:
  - The proportion of church members eating two or more fruits per day increased from 60.3 percent to 82.8 percent.
  - The proportion of church members eating three or more vegetables per day increased from 39.1 percent to 63.9 percent.
  - The proportion of church members who reported exercising moderately four or more hours per week increased from 22.7 percent to 39.9 percent.
  - The proportion of church members who reported exercising vigorously four or more hours per week increased from 17.9 percent to 25.1 percent.

Church members shared a number of positive comments after participating in the project:

- “By increasing exercise and adding more fruit and vegetables to my diet, I have lost approximately 13 pounds.”
- “This program is excellent. It allows me to have vegetables and fruits readily available to me and at a great price, as well…I’m becoming more conscious about my health and eating habits…Thank you, and please don’t stop what you’re doing. It’s greatly appreciated.”
- “I think that the mini-market is a blessing for all participants because of the education it provides and the health benefits long term. I have changed my lifestyle as a result of some of the things I have learned in the mini-market workshops.”
- “This program is extremely important, and being knowledgeable about fruits and veggies made me more aware of their importance in daily consumption.”
- “This mini-market is a God-send, and they are fresh, and the price is really good.”

**Learn More**

For more information about the Detroit Faith-Based Healthy Living Initiative, contact the MPHI Health Promotion and Disease Prevention Program at 2438 Woodlake Circle, Suite 240, Okemos, MI 48864 (517-324-7305).

Quentin Moore, MPH, is a project coordinator for the MPHI Health Promotion and Disease Prevention Program.
Spreading the Word About Osteoporosis and Good Bone Health

By Judith Lyles
“The United Dairy Industry of Michigan appreciates the opportunity to support the Michigan Osteoporosis Project/Michigan Coalition for Bone Health over the past five years. It's heartening that the initiatives have decreased the osteoporosis risk factors of Michigan residents and achieved national recognition. United Dairy Industry of Michigan remains strongly committed to this vital program.”

— Karen Giles-Smith, MS, RD
United Dairy Industry of Michigan

Beginning in 2001 with support from the Michigan Department of Community Health and a grant from Procter and Gamble to develop an osteoporosis community education program, the Partnership for Better Bones (PBB) soon expanded to include the United Dairy Industry of Michigan and the Michigan State University Extension (MSUE).

The sustained public-private partnership between MPHI and its collaborators, who have generously contributed both expertise and financial support, has been the foundation for the success and continuation of this community education initiative.

The PBB focuses on professional training and community education and is designed to make health care professionals and the general public more aware of osteoporosis, its risk factors, and the healthy behaviors that reduce risk and increase bone health.

The centerpiece of the PBB is “Better Bones, Brighter Futures,” a 45-minute, up-to-date, easy-to-understand educational program available in two formats: Microsoft PowerPoint for large groups and flip chart for small groups and individual sessions.

Working with existing statewide educator networks, such as local public health departments, Office of Services to the Aging senior centers, MSUE, dietitians, and parish nurses, the PBB has conducted new educator training and refresher courses annually.

In 2005, more than 2,000 adults learned about osteoporosis through the more than 100 “Better Bones, Brighter Futures” programs conducted by educators supported and trained through the partnership.

Learn More
For more information about the Partnership for Better Bones, contact the MPHI Health Promotion and Disease Prevention program at 2438 Woodlake Circle, Suite 240, Okemos, MI 48864 (517-324-7397).

Judith Lyles, MS, PhD, is a senior project coordinator for the MPHI Health Promotion and Disease Prevention Program.
Working Together to Reduce Costs and Increase Efficiency for Healthcare Providers and Medicaid Beneficiaries

By Cindy Monarch
In March 2005, the Michigan Department of Community Health (MDCH), Blue Cross and Blue Shield of Michigan (BCBSM), and the MPHI Interactive Solutions Group formed a collaborative partnership to give Michigan healthcare providers a cost-effective way to validate Medicaid eligibility and benefits, resulting in reduced healthcare costs for providers and Michigan Medicaid beneficiaries.

Healthcare providers can now reduce their costs by validating before services are rendered that they will be paid by Michigan Medicaid. Medicaid beneficiaries benefit by being able to seek medical care when needed without incurring any additional cost.

**How the Partnership Works**

Prior to this partnership, BCBSM provided its participating healthcare providers with eligibility access at no additional cost through the BCBSM web-based application, web-DENIS. BCBSM providers validated eligibility and benefits for BCBSM-affiliated healthcare contracts (e.g., Blue Care Network, Blue Choice), NASCO, and Federal Employee Program (FEP) contracts.

MDCH, in turn, provided Medicaid beneficiary eligibility and benefit information to Michigan Medicaid providers via telephone or fax at no additional cost. Michigan Medicaid providers were also able to access Medicaid beneficiary eligibility and benefit information via an online environment via several eligibility service providers, but had to pay an additional cost to do so.

The enactment of this collaborative partnership between BCBSM, MDCH, and MPHI has given the mutually shared providers of BCBSM and MDCH the ability to validate eligibility quickly and easily via one online location. Michigan Medicaid providers can now validate a Medicaid beneficiary’s eligibility online at no additional cost using web-DENIS, the BCBSM internet-based application.

The MPHI Interactive Solutions Group (ISG) serves as a host/clearinghouse for the Michigan Medicaid eligibility information.

ISG receives proprietary eligibility data files from MDCH on a daily basis. The eligibility information is exchanged real-time between BCBSM and ISG using the HIPAA (Health Insurance Portability and Accountability Act) 270/271 standard transactions and a virtual private network (VPN) connection. This real-time environment enables the exchange of information to occur at a rate of three to five seconds per transaction, resulting in a fast and economical way for providers to validate Medicaid eligibility.

In October of 2005, ISG enhanced its partnership focus by offering MDCH program entities and contracted health plans the ability to validate Medicaid eligibility through the exchange of HIPAA 270/271 standard transactions or through utilization of the Michigan Healthplan Benefits web application. This gives other health plans and organizations the ability to integrate Medicaid eligibility into their system via a real-time operation or to access the information directly via an ISG web application. To date, the ISG host/clearinghouse for Michigan Medicaid eligibility is averaging 700,000 transactions per month.

This partnership of healthcare eligibility has not only enhanced the relationship between MDCH, BCBSM, and MPHI, it has also enhanced each partner’s relationship with Michigan’s healthcare providers. Technology and this continued partnership will continue to create additional opportunities to further the shared focus of reduced healthcare costs and increased administrative efficiency.

**Learn More**

For more information about this project, contact the MPHI Interactive Solutions Group at 2501 Jolly Road, Suite 180, Okemos, MI 48864 (517-324-6060).

_Cindy Monarch, CPC_, is a business analyst in the MPHI Interactive Solutions Group.
**MPHI Operational Indicators**

**2005 MPHI Project Funders**

- American Legacy Foundation
- American Lung Association of Michigan
- Arbor Circle Corporation
- Centerpoint Institute
- Centers for Disease Control (CDC)
- Centers for Medicare & Medicaid Services
- Children's Hospital of Michigan
- Children's Trust Fund
- Chronic Disease Directors
- Copper Country Mental Health Services
- Department of Education
- Department of Environmental Quality
- Department of Transportation / National Highway Traffic Safety Administration
- Emory University
- Family Independence Agency
- Health Research, Inc.
Health Resources & Services Administration (HRSA)
Karmanos Cancer Center
Kansas Health Institute
Kresge Eye Institute (Detroit Medical Center/Wayne State University)
McKing Consulting Corporation
Meridian
MI Society of Hematology & Oncology
Michigan Association of Centers for Independent Living
Michigan Association of Health Plans Foundation
Michigan Department of Community Health
Michigan Primary Care Association
Michigan State University
Muskegon Community Health Project
National Cancer Institute -- National Institutes of Health

National Network of Public Health Institutes
Native American Alliance Foundation
Netwerkes.com
Office of Highway Safety Planning
P&G Pharmaceuticals
Pfizer Inc.
PFS:KnowledgeTrek, LLC
Robert Wood Johnson Foundation
Ruth Mott Foundation
Shiawassee Regional Education Service District
Southeastern Michigan Health Association
Tomorrow's Child/Michigan SIDS
University Of Michigan
U.S. Department of Justice
W.K. Kellogg Foundation
Waksman Foundation for Microbiology