

MPHI™

2007 ANNUAL REPORT

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.

2007 Board of Directors

Pictured left to right:

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

Jacquelynne Borden-Conyers
The W.K. Kellogg Foundation

Rick Severson, PhD
Wayne State University

Karen Aldridge-Eason, MPA
Office of the Governor

David Beach Cotton, MD
Health Plan of Michigan, Inc.

Allen Goodman, PhD
Wayne State University

Ed Dore, JD, MPA
Michigan Department of Community Health

Front Row:
Denise Holmes, MS
MPHI Board Secretary/Treasurer
Michigan State University

Jean Chabut
MPHI Board President
Michigan Department of Community Health

Jim Giordano, MBA
CareTech Solutions, Inc.

Elaine Brock, MHSA, JD
University of Michigan

Not pictured:
Matthew L. Boulton, MD, MPH
MPHI Board Vice President
University of Michigan

Hiram Fitzgerald, PhD
Michigan State University

Sarah Mayberry, MPH
WDIV-TV

Phyllis Meadows, PhD, MSN, RN
Detroit Department of Health and Wellness Promotion

Angela G. Reyes, MPH
Detroit Hispanic Development Center

PRESIDENT'S LETTER

The end of an old year and the start of a new one is a time for each of us to reflect back on what we've accomplished and where we're headed. What successes and challenges have the past year brought? What dreams do we hope to bring into reality in the upcoming twelve months? And underlying all of these questions is the bigger one of who we are and what we stand for. It's no different for MPHI.

It's been almost two decades since the seeds for MPHI were planted by forward-thinking staff members of the state health department, state legislators, and leaders from the University of Michigan, Michigan State University, and Wayne State University. What they envisioned was not merely the state's first public health institute but a public trust: an institute committed to identifying gaps in public health and working collaboratively to find solutions.

The years since have brought amazing changes to our world that nobody could have imagined. Even our vocabularies have been revolutionized. Two decades ago, a server was someone who brought you dinner, breaking up meant the end of a relationship, and words like "ecommerce," "ipod" and "modem" would have been taken for typos. All of these changes in how the world communicates and conducts business have forced all organizations to evolve and MPHI has been no exception. In this annual report you'll learn more about some other new terms like "webcasting" and "food deserts." As that latter term suggests, new health issues have arisen as well, many of them just as unforeseeable as the way that the internet has changed the way we communicate.

What hasn't changed is how vulnerable all of us are to disease. And precisely because there has been so much change, the vision upon which MPHI was founded is more vital than ever. Now, more than ever, primary healthcare givers need support and guidance in the form of innovative ideas and creative problem-solving. Now, more than ever, there is an urgent need for fast and efficient methods of communicating those new threats and new solutions. And now, more than ever, there are gaps in access to public health that desperately need to be met.

As a result, now more than ever, it is apt to ask what MPHI stands for. Of course those letters still stand – will always stand – for the *Michigan Public Health Institute*. But as we move into a future that will bring new health challenges, those letters also represent much more. Here are my thoughts.

M will always stand for Michigan because of our unique commitment to this state, which is reinforced by our ties to its universities and public sector. But it also stands for Mission, a word that reminds us of the mission statement that shapes our vision and our shared sense of the importance of our work. And for Multi-Disciplinary, a term that nicely suggests bringing in ideas from many different quarters.

Maybe more than anything else, I like to think of the M standing for Marketplace. Marketing got a bad name in the twentieth century, as it became synonymous with the commercialization of relentless advertising. But it's important to remember that a market was originally something much simpler – a central place where farmers brought their goods to exchange, and where a sense of community was born. As we enter the twenty-first century, a marketplace is becoming just such a place again and we hear more and more talk about the marketplace of ideas. MPHI can have no higher calling than to become a marketplace for ideas about promoting better health.

The letter P also continues to stand for our stake in the public health and our mandate as a public trust. But it too represents many related ideals: the Partnerships that we seek to build and nurture, the Promotion of better health, our

forward-looking focus on Prevention by means of Proactive approaches, the imaginative new Policies that we help craft, the important Principles that underlie our work, and the Progress we have made. And most of all, we are always about People.

The H is simple – it will always stand for the fundamental concept of health. Did you know that the word health derives from an Old English word meaning hale or whole? That's something we try never to forget – to be healthy is to be whole. An organization, like any chain, is only as strong as its weakest link, and so too an organism is unhealthy if any of its parts is sick.

The letter I stands for a host of related concepts that support everything we do at MPHI. It symbolizes the Interchange of Information and the Intelligence that results. It represents the Independence that we all cherish. It stands for the Investment in the future embodied in each of our projects. It stands for Ideas and Ideals and for the spirit of Innovation that makes them possible. And it stands for our Involvement in the lives and well-being of the people of Michigan.

Standing for such principles and sharing a vision as a public trust is what has kept MPHI vital and relevant during two decades of extraordinary changes. As we look forward to the future, we know that it will bring more changes, many of them ones that none of us can foresee. But that won't stop us from doing everything possible to anticipate and alert primary healthcare givers to new challenges. And it won't change our commitment to doing whatever it takes to protect the public health of every resident of Michigan. That is what MPHI stands for.

Jean C. Chabut

Jean C. Chabut,
President, MPHI Board of Directors
Deputy Director, Public Health Administration,
Michigan Department of Community Health

PROGRAM DESCRIPTIONS

The **Health Promotion and Disease Prevention Program (HPDP)** focuses on chronic disease prevention and health promotion at the state, local, and national level. Its core efforts involve translating scientific research and evidence-based interventions into program development and evaluation, social marketing, coalition development, and applied research. Professional disciplines represented include dietitians/nutritionists, health educators, researchers, evaluators, professional counselors, public health administrators, communication and community development experts, and psychologists.

The **Center for Collaborative Research in Health Outcomes and Policy (CRHOP)** provides clients with technical expertise and training in program evaluation, policy analysis, survey research, research design, data acquisition, management and analysis, web hosting and website design, web-based data collection, development and programming, and information reporting.

The **Systems Reform Program** facilitates the reform of human services systems with the aim of increasing the effectiveness of services for children and families. Staff members participate in a variety of collaborative efforts that apply outcome-based strategic planning and evaluation to the fields of health, human services and education.

The **Cancer Control Services** program provides epidemiological and evaluation expertise to the State of Michigan's cancer control activities. It offers technical assistance in such areas as cancer prevention, screening, referral, tracking and follow-up; partnership and coalition development; quality assurance and improvement; professional and public education; surveillance; planning, and administration. Expertise is also provided in epidemiology, statistics, quality assurance, financial analysis, data analysis, and nursing.

The **Child and Adolescent Health Program (CAH)** provides technical assistance in the design, implementation and evaluation of innovative multidisciplinary and community-based programs aimed to improve the health, safety and well-being of children and families. CAH collaborates with national, state, and local partners on a wide range of programs that strengthen existing assets and reduce risks. Focus areas include child and infant mortality, abstinence promotion, antibiotic resistance, injury prevention, and home-based services for high-risk families.

The **Interactive Solutions Group (ISG)** helps healthcare organizations and public-sector agencies operate more efficiently by redesigning business processes and automating information exchange. Its project managers, business analysts, trainers, and technical staff are skilled at tailoring electronic data interchange (EDI), Internet technology, and learning management systems to clients' specific needs. Its comprehensive approach combines information technology, project management methodology, and training/outreach processes to help clients choose the right technological options.

The mission of **Education and Training** is to provide high-quality education and training to the public health workforce. Staff members work closely with a wide range of clients to produce conferences, large and small meetings, and e-learning methods that provide timely and effective training. Areas of specialization include needs assessment design and analysis, facilitation of planning committees, focus groups, logistical coordination, curriculum design and implementation, continuing education administration, on-site event staffing, and training material development and evaluation.

The **Center for Healthcare Excellence (CHE)** is a collaborative partner that provides scientific, methodological, issue-specific, and administrative expertise to program evaluation, outcomes studies and policy-oriented research. Specialties include training and technical assistance, conducting human service needs assessments and health research, evaluating health programs, analyzing health data, public health surveillance and coordinating multi-agency projects. The CHE has collaborated on projects that examine health disparities in such populations as racial and ethnic minorities, rural communities, American Indian communities, the uninsured, and the Medicaid population. It also has a Survey Research Unit with extensive experience in survey research methodology, as well as a full-service Geographic Information Systems (GIS) lab with broad capabilities.

WEBCASTING AT MPHI: AN EXCITING NEW WAY TO GET INFORMATION AND MOVE ON

by Peter Morris

"Customer service ain't what it used to be!" It's a common complaint today, especially when we find ourselves transferred from recorded message to recorded message in a vain attempt to find a human being who can answer a simple question. But the government agencies and private sector firms that we're fruitlessly trying to contact are often just as frustrated by the many obstacles that prevent them from providing those answers.

To begin with, the costs of having staff members on hand to answer questions that may come in at any time are daunting. Still more difficult is making sure that the staff will be able to provide accurate answers to the increasingly technical questions that they are fielding. Incoming questions frequently deal with recent procedural changes and updates and that raises another key concern – how to keep a staff informed about the many new issues that arise.

Finally, even if all of these hurdles are overcome and successful contact between a confused caller and a well-informed staff member is made, the conversation may not produce the desired outcome. All too often, the caller is too baffled to even be sure of what questions to ask, or is not able to describe what he or she is experiencing, which makes it difficult or impossible to give helpful answers. With neither party able to understand what the other one is seeing, both are liable to grow increasingly frustrated.

The underlying problem is that showing is always a more effective means of teaching than is telling. This is especially true when technical complexities are involved. As we all know, a procedure that can be easily picked up when shown to us seems much more complicated when written in an instruction manual. Phone calls all too often produce the same aggravating feeling that the problem could be rapidly resolved if both people could spend a few minutes in the customer's living room. But who makes house calls any more?

To solve this problem, an increasing number of public and private sector organizations are turning to the powerful new medium of webcasting. MPHI anticipated this trend by launching its own webcasting platform for public sector clients at its Interactive Learning Center (ILC) in July of 2006. The eighteen months since have proven that webcasting is an exciting way to address the communication needs of these clients by providing fast, anytime-anywhere access to up-to-date information and by showing concepts in a clear, comprehensible manner instead of trying to translate them into words.

As with any new technology, potential users are initially daunted by unfamiliarity with webcasting. Larry Doele, Account Executive for MPHI's Interactive Solutions Group (ISG), notes that many agency workers initially fear that they will have to redo a presentation repeatedly to avoid having misspoken words. "In reality, viewers don't care if a speaker stumbles over his words," he says, "they just want the information and to move on."

Doele's comments reveal one of the beauties of this new technology – rather than being a one-size-fits-all medium, webcasts can be specifically tailored to a client's needs. Webcasts have the potential to be integrated into an existing network of technology, if desired. Yet many of the ILC's customers don't need anything that sophisticated – like their clients, they want to address a specific communication need and then "to move on." No problem. The ILC offers customers the choice of do-it-yourself and full-service options in creating video recordings. Either way, a client has full access to many state-of-the-art technologies, including a teleprompter, that allow even a novice presenter to make a professional and polished recording.

For example, Teri Takai, Director of Michigan Department of Information Technology, had a very simple problem and a tight deadline. She had been invited to deliver the welcoming address to the Harvard Policy Group of the National Association of State Chief Information Officers but found herself unable to attend. So she turned to MPHI and was delighted at the speed and efficiency of the solution. She marveled, "MPHI was able to work with us to turn around this communication piece from start to finish in just an hour and a half so we were able to meet the conference's deadlines."

At the same time, webcasts can also be the perfect solution for clients with far more complex needs. MPHI's webcasts are created by Mediasite® by Sonic Foundry, a state-of-the-art platform that converts a recording into an interactive media-rich presentation that can immediately be viewed on the web. Mediasite's webcasts also feature comprehensive rich media content management, which makes it possible to integrate these webcasts into an existing technology network.

These capabilities proved ideal when the Michigan Department of Treasury was seeking an efficient means of communicating new tax law information to business owners and their financial partners. Treasury staff, in tandem with the experts in MPHI's Interactive Solutions Group, recorded a webcast that was made available on an on-demand basis immediately after the session ended. In addition, the presentation included links to PDF documents and an array of web-based reference materials. While only 14 people attended the live presentation, 768 viewers watched the recording in the next few days. As Treasury Tax Specialist Mike Martin put it, "Given our current economic restraints, this low-cost method to get our message out became a viable alternative to providing training in costly geographic areas. We were able to reach an audience that was otherwise unavailable to us."

This potential for far greater outreach at no additional cost makes it possible for webcasts to provide an impressive and almost immediate return on investment. Imagine the cost if it had been necessary to coordinate meetings in locations that were convenient to each of those 768 geographically dispersed webcast viewers. Using a conservative estimate of an $80 savings per viewer for the typical live or on-demand webcast, MPHI determined that the Michigan Department of Community Health recognized $420,400 in savings from the 19 webcasts it produced in 2007.

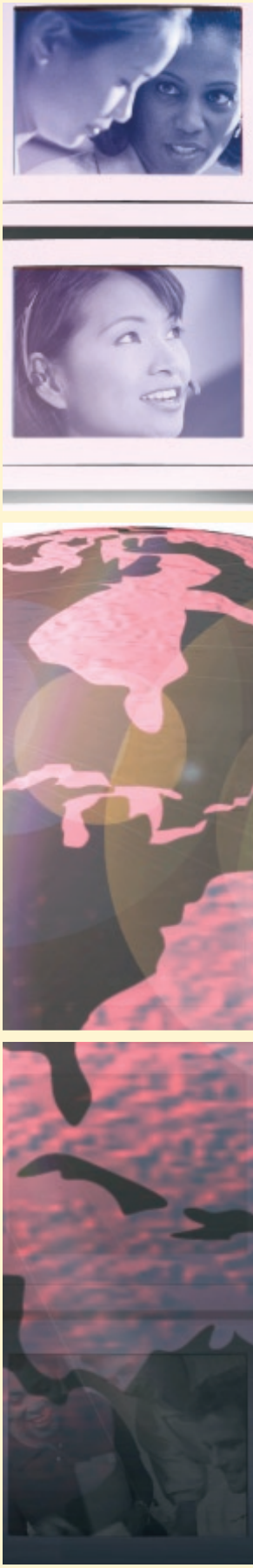
As is suggested by these impressive viewership figures, testimonials and return on investment numbers, webcasting at the ILC has already been a success. In 2007, the first full year of webcasting at MPHI, 130 webcasts were produced for clients such as the Michigan Departments of Education, Treasury, Information Technology, and Community Health, and they were watched by more than 20,000 viewers. This impressive performance was recognized when MPHI received the Rapid Return on Investment Award from Mediasite.

Just as importantly, all of the ingredients for future growth are in place. Client unfamiliarity with webcasting technology has quickly been replaced with enthusiasm about its potential. Doele reports that an increasing number of clients now appreciate the wide variety of applications for Mediasite's state-of-the-art webcasting technology and the ISG's expert technical support. In addition, the Mediasite system offers reporting capabilities that make it possible for agencies to track and survey viewers and thereby obtain indisputable proof of the value of webcasting.

Perhaps the best part of webcasting is that customers are pleased with the quality of the information being conveyed. Despite the unfamiliarity of many users with webcasts, around 90% expressed satisfaction with the quality of both the video and audio, and a similar percent said that they would consider watching the archive of the webcast again. Even more impressively, 96% said that they would recommend webcasting to a colleague.

As this suggests, webcasting is first and foremost a great teaching tool. Customers know that they are listening to someone authoritative on the specific topic on which they requested information. The visual tools further enhance learning, making the whole experience more personal and easier to understand. If a key point is missed, the webcast can be viewed again and again. Best of all, you are never transferred into someone's voice mail.

Peter Morris, Senior Research Associate, MPHI



THE SENTINEL CENTERS NETWORK: IMPROVING QUALITY OF CARE FOR PATIENTS AT COMMUNITY HEALTH CENTERS *by Christopher Wojcik, MPH*

The contributions that MPHI's Center for Collaborative Research in Health Outcomes and Policy (CRHOP) has made to the development of the Sentinel Centers Network is a classic example of MPHI playing a low-profile but crucial role in filling the gaps in the healthcare system.

Community health centers are an essential means of providing healthcare to overlooked, vulnerable populations. Their purpose is to provide quality primary health care to patients in a comprehensive and coordinated manner, regardless of the patient's ability to pay. Community health center patients are more likely to be minorities, less educated, have lower income levels, and uninsured than the overall population. In 2005, there were nearly 1,000 federally funded health centers located throughout the United States, serving nearly 15 million patients.

The isolated nature of community health centers, however, makes it difficult to measure and evaluate the quality of care provided to patients. As a result, the Bureau of Primary Health Care (BPHC) at the Health Resources and Services Administration (HRSA) began laying the groundwork for the Sentinel Centers Network in 1999. The intention of the network was to gather patient and encounter level data from a representative sample of health centers. The data would then be submitted to a central "data warehouse" for analysis of the types and severity of health conditions being treated and assessment of the services and treatment being provided. This would in turn enable HRSA to tailor its decision-making and policies to the specific needs of this underserved and vulnerable population.

The obstacles in creating such a data warehouse proved daunting. Community health centers used a wide variety of computer systems, software systems and electronic health records, and health care staffs possessed a range of technical knowledge. As a result, almost none of the participating health centers were able to submit data according to the requested specifications. While data collection began in 2002, no products or reports were released between 2002 and 2005, leading many participants to question the value of their participation. That was when CRHOP entered the picture.

In August of 2005, CRHOP was awarded the contract for overseeing all responsibilities related to implementing and improving the Sentinel Centers Network project. Although landing this relatively large federal contract was a major accomplishment, the project also came with a number of major hurdles to overcome.

The first challenge was to re-engage and re-energize participants. CRHOP staff members immediately began making personal contact with health center personnel to assure them of the need for their contributions. Once communication channels had been established, CRHOP created a monthly newsletter that provided network members with information and updates about project activities.

The next major challenge was to devise a HIPAA-compliant data collection process. To do so, individual Business Associate Agreement (BAA) contracts were entered into with each network member. Even before the BAA contracts were in place, project staff began creating HIPAA-compliant protocols for transferring and receiving privacy-sensitive data from the centers. A secure FTP server was set up so that data submitted by the health centers would automatically be encrypted at the beginning of the upload process and would only be decrypted after being safely transferred onto MPHI's secure network servers. A detailed instruction document explaining the data submission process was distributed to each participant.

The third challenge of the project was related to the data itself. To address the wide variations between health centers, CRHOP staff worked with each center on a one-on-one basis to extract whatever data elements were available and to develop data translation syntax files. This in turn made it possible to compile the data in a standardized format and build a yearly data file. The result was that at last it became possible to develop a representative

sample of such information as patient demographics, payment source, diagnoses, procedures, provider types and specialties, and selected clinical measures.

As data sets from participating health centers became available, the data were used as the basis for individual center reports. CRHOP developed a series of data analysis syntax files that produced the results for a standardized individual center report. Centers that submitted data received an individual report containing their data. These reports summarized the data submitted and gave health centers an opportunity to review their data before it was aggregated into the yearly data file.

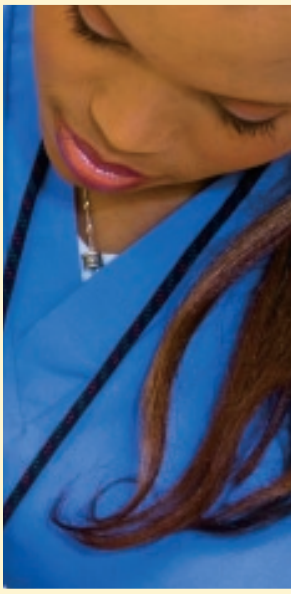
Once all of the individual center reports had been created and distributed, an annual aggregate report was produced. This report presented information about patient and encounter volume, selected patient and encounter demographics, most common diagnoses and chronic conditions, most common procedures performed on patients, and an indication of care for patients with diabetes. Annual aggregate reports have been produced for 2004 and 2005 and can be found at www.crhop.net/scn.

There are now 38 health center organizations in the Sentinel Centers Network, representing 64 individual health centers and comprising nearly 1.6 million patients. With more than 6.2 million patient encounters per year, this wealth of data makes it possible to do much-needed analysis of broader trends among this neglected and vulnerable population. In addition, the data were collected and stored in a manner that allows individual patients to be linked from year to year. This feature makes the data uniquely valuable because it makes it possible to conduct long-term trend analyses. For example, patients who are identified in 2004 with a particular health condition can be followed into future years to monitor their course of treatment.

Demonstrating the exciting potential for making use of this previously unavailable information, CRHOP has performed a number of ad hoc data analyses at the request of HRSA. These analyses have focused on such key health topics as lead screening and blood lead levels among children, numbers and rates of selected mental health conditions, numbers and types of various providers serving in health centers, and the numbers and rates of selected childhood immunizations.

With the key data collection obstacles now successfully surmounted, MPHI's involvement with data collection for the Sentinel Centers Network is coming to an end. CRHOP will, however, continue to work with HRSA through the 2008 fiscal year on a series of exploratory analyses that focus on the level and quality of care provided to patients of health centers.

Christopher Wojcik, MPH, is the project leader for the Sentinel Centers Network and provides data management and analysis services for various other projects at the MPHI Center for Collaborative Research in Health Outcomes and Policy.



REACHING OUT TO FOOD DESERTS AND PROMOTING HEALTHY MICHIGAN CONGREGATIONS *by Brandess C. Wallace, MPH and Stephanie K. Halfmann, MS, RD*

Have you ever heard of a "food desert"? Most of us take for granted being able to make a quick stop at a local supermarket to pick up a few key essentials for that evening's dinner. But "food deserts" are an overlooked crisis affecting thousands of Michigan residents.

A food desert is defined as an "area of relative exclusion where people experience physical and economic barriers to accessing healthy food." In recent years, the city of Detroit has become a virtual food desert, with no major supermarket within its city limits. The recent closing of the city's last two major supermarkets has resulted in a lack of variety, higher prices, and unhealthy, often sub-par food options for residents of Detroit. Many of these residents are low income and lack reliable transportation, which leaves them with no means of obtaining fresh fruits and vegetables and other key components of a healthy diet.

We all know that good nutrition is an essential component of good health. But how do you tell someone they need to eat better when they live in a food desert? It's like telling a man stranded in a desert that he needs to drink plenty of water. These food deserts create a vicious cycle in which the absence of places to get fresh fruits and vegetables can lead to unbalanced diets and an increase in health-related issues. None of these problems can be addressed unless nutritious food is made more available. In a community where many residents face transportation challenges, there is no easy solution to this problem.

A first key step was taken in 2005. Through a partnership between MPHI and an innovative program called Promoting Healthy Eating in Detroit (PHED), fruit and vegetable mini-markets were established in select neighborhoods of Southwest and East Detroit. Building on the success of the mini-markets created through PHED, area faith-based organizations were identified as an appropriate place to offer additional fresh fruit and vegetable mini-markets to reach more members of the community.

Though at the surface a seemingly unlikely pairing, at its heart the partnership between the public health and faith communities is a fitting one. Like public health, the church has been a pioneer of social services to communities, particularly the African-American community. Similarly, faith communities provide a wealth of expertise for delivering programs and have a tradition of community service and leadership. Accordingly, faith-based initiatives offer the potential to meet the needs of citizens in a comfortable and trustworthy environment where a strong network of social support already exists. Recognizing this potential, the Cardiovascular Health Nutrition and Physical Activity section has made a commitment to working with the faith community to connect with hard-to-reach populations.

Now in its third year, the Detroit Fruit and Vegetable Mini-Market project provides free regional trainings for faith organizations throughout the state of Michigan. With assistance from the American Cancer Society, trainings were held in Lansing, Grand Rapids, Flint, and Detroit. The training sessions provide an opportunity for churches to build capacity and attain the resources necessary to implement and sustain mini-markets. Mini-grants were awarded to 15 churches to help cover start-up expenses. A number of the trained churches plan to continue offering mini-markets in the coming year.

In order for health messages to be personally relevant, it is crucial to address barriers that make it difficult to meet the very basic needs of a community (as the Detroit Fruit and Vegetable Mini-Market Project does by providing access and availability of fresh fruits and vegetables). Once these needs have been addressed, only then can broader health issues such as cardiovascular health be seen as a priority.

Recent state data show that heart attack and stroke are, respectively, the #1 and #3 causes of death among Michigan residents. While it is known that a balanced diet and proper nutrition play important roles in maintaining a healthy heart and preventing heart attack and stroke, it is equally

important to recognize their signs and symptoms, especially among African Americans, who are disproportionately affected by both. The faith-based setting has been identified by the Michigan Cardiovascular Health Task Force as a venue where improvements can be made, with the following recommendations:

~ Prepare congregations for cardiovascular health emergencies
    - Educate citizens on heart attack and stroke warning signs and symptoms and appropriate use of EMS
    - Expand and promote CPR programs
    - Enhance availability of Automated External Defibrillators (AED)
~ Promote the appropriate use of the cardioprotective effects of aspirin
~ Target efforts to priority populations and/or high CVD incidence
~ Develop culturally relevant risk reduction messages and strategies

In order to equip church health ministries in Michigan with the necessary resources to communicate these messages, the Cardiovascular Health, Nutrition and Physical Activity section took the Task Force recommendations and created the Faith, Knowledge & Action=Health Social Marketing Campaign. A toolkit was designed to address the above recommendations.

With assistance from key partners from the Michigan Department of Community Health, The Michigan Faith-Based Health Association, The Institute for Black Family Development, and the Cardiovascular Health Task Force in marketing and promoting the toolkit, over 150 Michigan churches have ordered Faith, Knowledge & Action=Health. In addition, a request for proposals was released to churches statewide for AED placement and AED/CPR training. Fifteen churches were awarded Lifepak Express AEDs. Results of this project will guide development of state-wide faith-based wellness initiatives.

MPHI's partnership with the faith community has already shown the potential for providing much-needed outreach into areas that have been neglected. These new initiatives offer the promise of strengthening and expanding the availability of vital health care information to vulnerable communities.

For more information about faith and community-based initiatives contact Brandess C. Wallace at bwallace@mphi.org or Stephanie K. Halfmann at shalfma@mphi.org.

Brandess C. Wallace, MPH and Stephanie K. Halfmann, MS, RD, are Community Health Consultants in Cardiovascular Health, Nutrition and Physical Activity for MPHI.

REVEALING THE TRUE STORY BEHIND AN EPIDEMIC

by Peter Morris

During the 1950s Americans were alarmed and appalled to learn that the popularity of the cigarette was being linked to an epidemic of deaths from lung cancer and other tobacco-related diseases. Half a century later, the death toll continues to mount yet shock has given way to complacency and a disturbing tendency to blame the victims – the millions of people who smoke their first cigarette when they are still adolescents or even children and who soon become hopelessly dependent upon a product that is lethal, addictive and carefully engineered. Cigarette-related deaths have become not only one of the worst epidemics in human history, but one that is increasingly shrugged off and taken for granted. As Joseph Stalin infamously said, "A single death is a tragedy; a million deaths is a statistic."

MPHI's Center for Tobacco Prevention Use and Research was launched in 2000 with the mission of ensuring that each preventable tobacco-related death would again be looked at as a tragedy, not a statistic. To do that, over the past seven years an unparalleled on-line archive has been created that gives the general public access to a wealth of tobacco industry secrets. And this past year brought another signal achievement with the publication of an academic journal supplement devoted entirely to the findings made possible by this valuable new resource.

There has long been a wealth of documentation on the factors responsible for this epidemic. Lawsuits against the tobacco industry began in the late 1950s and continue to this day, resulting in the availability of millions of previously secret tobacco industry documents. Yet these documents were not easy to use for either public education or serious academic study. Problems included the facts that many of the documents are old and that the authorship of some are unknown. In addition, the context of these documents is frequently unclear, making it impossible to be sure of whether the views expressed were company policy and of whether they were carried out. Most daunting was the sheer volume of such documents. As a result of these factors, all too often the truth remained hidden, even when it was in plain view.

To address these problems, the Analysis of Tobacco Depositions and Trial Testimony project was based upon a unique premise. That premise was that the trial testimony and depositions taken from tobacco-related litigation could be used to improve our understanding of key issues. Specifically, the testimony was potentially more reliable (because it was taken under oath), easier to understand in proper context (because witnesses focused on the documents that they considered most important and answered questions about them), more contemporary (because they allow an exact sequence of events to be established), and more representative (because they included the views of a wider range of people affiliated with tobacco companies and those of expert witnesses).

Even though these documents possessed all of these advantages, it was still essential to provide additional tools to make it easier for users to understand their context. Toward this end, indexes of the many named people and organizations needed to be created for each transcript so that a reader does not become sidetracked by unfamiliar names. It was just as important to craft a carefully worded abstract that spells out the main themes of each document. Another requirement was a network of hyperlinks to make it possible to jump directly to a specifically named document or to an expert report compiled by the same witness. Finally, it would be necessary to have a dynamic search function so that users could quickly find testimony on a topic of special interest to them.

Moreover, it was essential not just to make this resource available, but also to demonstrate how it could be used to advance scientific understanding of many vital tobacco-related issues. In order to do this, research teams of distinguished authorities in their respective fields were formed to write articles about the applicability of the testimony to key subjects such as cigarette design, health consequences, addiction, advertising of tobacco products, economic analysis, cessation, youth initiation, and potentially reduced exposure products. The results would then be published in a peer-reviewed academic journal.

This was a most ambitious project that became all the more so as new challenges became evident. To begin

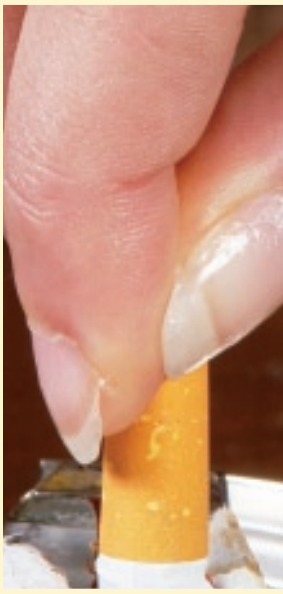
with, there was no comprehensive listing of relevant testimony or even of relevant litigation, so one had to be painstakingly compiled. Once transcripts began to come in, there was the new issue of converting a variety of file formats into one that could be readily and conveniently accessed.

But with the generous support of the National Cancer Institute and the American Legacy Foundation, and under the leadership of project principal investigator Ronald Davis, M.D., co-principal investigator Clifford Douglas and program director John Beasley, progress was steadily made. In the past year, several major milestones have been reached that attest to just how much has been accomplished. The project's primary website, http://tobaccodocuments.org/datta/, now contains more than 5,600 transcripts of an average length of about 180 pages. Indexing and abstracting of all of these transcripts has now been completed. This involved coding for more than 1,700 different witnesses, 4,500 different named organizations and 10,750 different named people, as well as 600 different subject areas. In all, some 300,000 coding, indexing or abstracting entries were made and more than 2,000 links created to ensure that users could fully appreciate the often stunning power of the admissions made in these documents. All of the transcripts have also been permanently archived at the American Legacy Foundation's on-line Tobacco Document Library at the University of California at San Francisco.

An equally important milestone was the publication this year of a special supplement of the peer-reviewed journal *Tobacco Control* consisting of fourteen articles written by the members of the expert research teams. Each article was based upon the material newly made available on the website and offered forceful illustrations of how this resource can be used to shed new light on crucial topics. In "Stay Away from Them until You're Old Enough to Make a Decision," youth smoking experts Melanie Wakefield, Kim McLeod and Cheryl L. Perry dissect the claims of the tobacco industry to be actively combating youth smoking. This lip service, they note, is belied by the disparity between the claims of substantial investments in youth smoking prevention programs and by the absence of substantive outcome evaluations of programs on actual youth smoking rates. In another article, epidemiologists John A. Francis, Amy K. Shea, and Jonathan M. Samet show that the industry has sought to refute damaging scientific studies on second-hand smoke by trying to create artificial standards of scientific proof. Indeed, they conclude that those standards are so impossibly high that using them would create the certainty of error, regardless of how well a study is designed. Similarly, in "Historians' Testimony on 'Common Knowledge' of the Risks of Tobacco Use," historian Louis M. Kyriakoudes finds a disturbing pattern in the industry's use of historians as expert witnesses. He shows that, while these historians have been used to establish the public's familiarity with the risks of smoking, they have done so by dubiously choosing to exclude from their research any records of the industry's efforts to promote smoking and to maintain that a "controversy" existed about the health effects of smoking. Eleven other articles offer similarly insightful and academically rigorous analysis of what these transcripts reveal about key components in the onset and continuation of this epidemic. Emblematic of what a critical public health issue this is, Ronald Davis, who in addition to serving as the project's principal investigator is now the president of the American Medical Association, is the co-author of no fewer than four of them. Together the supplement paints a compelling picture and points the way to exciting new avenues of research.

Although the Center for Tobacco Prevention Use and Research has now achieved these two key components of its initial mission, its work continues. While the archive now includes the vast majority of tobacco litigation transcripts, work continues on identifying additional cases and trying to obtain transcripts from them. Work on fine-tuning and enhancing the indexing tools is also ongoing. In addition, a vast quantity of trial exhibits has been acquired and work has begun on making these available and accessible. The epidemic of tobacco-related diseases and deaths isn't going away and neither is this project.

Peter Morris is a Senior Research Associate in MPHI's Center for Tobacco Use Prevention and Research.



MICHIGAN'S CHILD DEATH REVIEW: INNOVATION AND COLLABORATION

by Heidi Hilliard

The Michigan Child Death Review (CDR) program at MPHI supports multidisciplinary teams in all 83 counties. These teams, totaling roughly 1,200 professionals, meet regularly to review the circumstances surrounding the deaths of children in their communities. The purpose of this voluntary effort is to use the findings from these reviews to improve agency systems and to take action to prevent other deaths.

Most other state CDRs were established to review only child abuse deaths. Michigan opted for a broader process that would encourage reviews of at least all preventable deaths to children under age 19, using a public health model. Team coordinators consistently report that the CDR process does more to improve local interagency collaboration on children's issues than most other efforts in which they've been involved.

Michigan is recognized nationally as one of the premier CDR programs in the U.S. In 2002, MPHI was awarded the grant from HRSA's Maternal and Child Health Bureau to serve as the National Center for Child Death Review. That grant was renewed three years later, and is in the process of being renewed again.

The deaths of about 800 children are reviewed in Michigan each year. This constitutes roughly half of all child deaths in the state. More than 6,000 deaths have been reviewed since 1995. In 1998, Michigan CDR pioneered a web-based reporting system, which was eventually put into use in a number of other states. Starting in 2005, Michigan's CDR became part of a multi-state pilot project utilizing a new reporting tool developed by the National Center, with assistance from many professionals around the country. Analysis with this in-depth tool is providing an even clearer picture of how and why children die.

The Michigan Child Death State Advisory Team, mandated by PA 167 of 1997, represents a broad range of agencies and perspectives. It is mandated to produce an annual report on child deaths in Michigan. The report provides background information on the causes of child deaths, as well as comparisons of state mortality statistics to the aggregate CDR data. MPHI staff have authored this report each year and also coordinate its printing and distribution.

A sub-committee of the State Team also serves as Michigan's federally mandated Citizen Review Panel (CRP) on Child Fatalities. This sub-committee meets regularly to conduct case reviews of deaths to children whose families were involved in the child protection system, and to develop recommendations for improvements to that system. CDR staff facilitate the CRP process. The ninth annual report of CRP recommendations will be presented to DHS in January 2008. Through these efforts, Michigan is now better able to identify and understand the circumstances involved in fatal abuse and neglect cases.

In 2001, the U.S. Centers for Disease Control and Prevention (CDC) funded MPHI as one of five states to develop a model surveillance system for child maltreatment fatalities. With this grant, a workgroup convened by MPHI developed a model to more accurately count maltreatment deaths. Michigan was one of three states recently re-funded by the CDC to do further work in this area. CDR staff have managed both of these projects, successfully tying them in to the activities of the CRP.

Through contract with the Michigan Department of Human Services (DHS), MPHI continues to maintain the CDR program. Services include an annual training for team members, as well as statewide trainings on specific causes of death and child death investigation procedures. Annual regional meetings of local CDR team coordinators are held throughout the state. MPHI staff attend local CDR meetings regularly to provide technical assistance and encourage prevention efforts. Program support materials include resource guides for effective reviews, protocol manuals, investigative protocols, formatted local and state mortality data, prevention resources, and a program website. Staff provide ongoing technical assistance and support, including death identification, research on causes, county and cause-specific data analysis.

The Michigan CDR program has a successful track record of working with numerous diverse organizations throughout the state to promote child health and safety. The program also maintains a close relationship with DHS that has helped to spur several innovations within their system. These include the Birth Match Project, the Report of a Minor's Death Data System, tabulations of fatality data for the National Child Abuse and Neglect Data System, the Children's Trust Fund "Never Shake a Baby" Campaign, and the creation of new child safety brochures and waiting room materials. MPHI staff also manage the MDCH-funded Fetal and Infant Mortality Review Program (FIMR), which currently has 16 communities conducting intensive reviews of infant deaths. Michigan's collaboration of CDR and FIMR is also promoted as a national model.

Heidi Hilliard is the Project Coordinator for Michigan Child Death Review in the Child and Adolescent Health section at MPHI.

2007 MPHI PROJECT FUNDERS

American Legacy Foundation
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State of Michigan - Department of Agriculture
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U.S. Department of Health and Human Services - National Cancer Institute (NCI)
U.S. Department of Transportation - National Highway Traffic Safety Administration
University of Michigan
W.K. Kellogg Foundation
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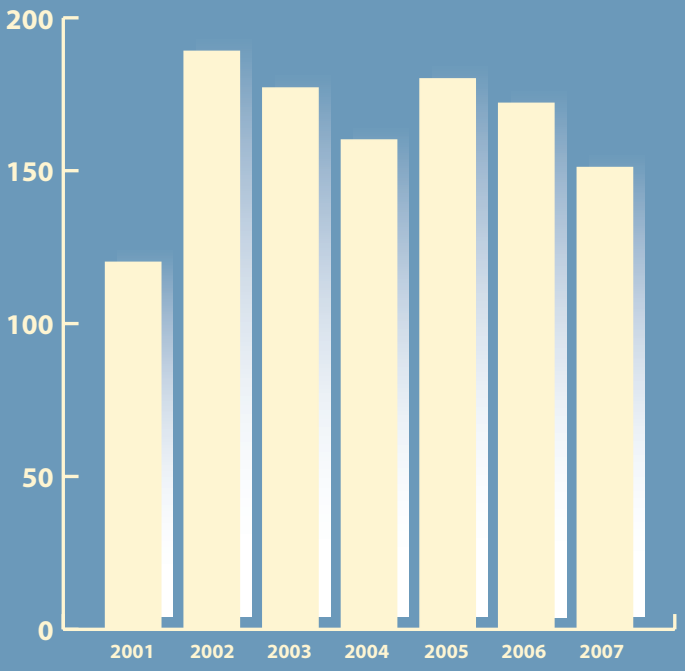
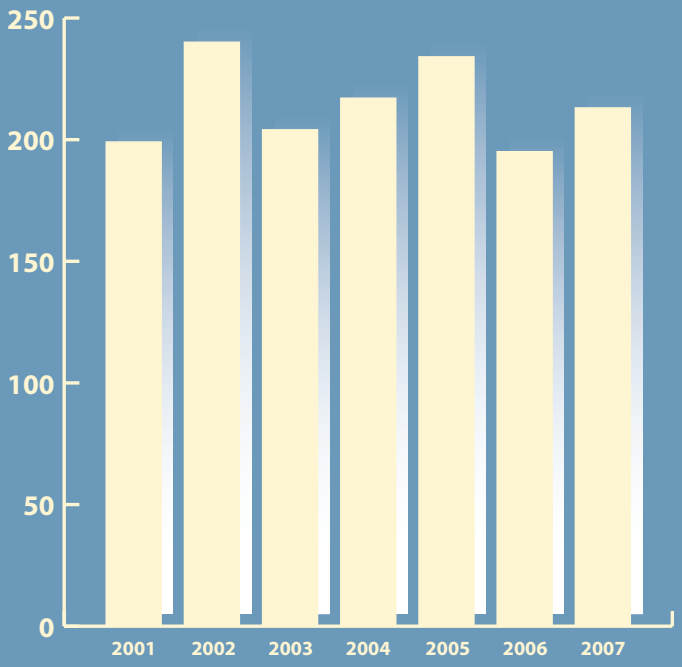
MPHI OPERATIONAL INDICATORS



NUMBER OF PROJECTS
UNDER MANAGEMENT



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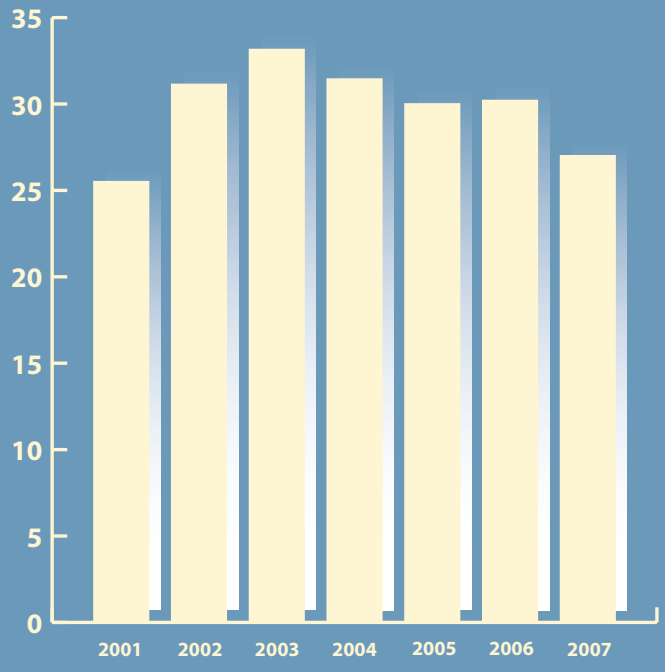
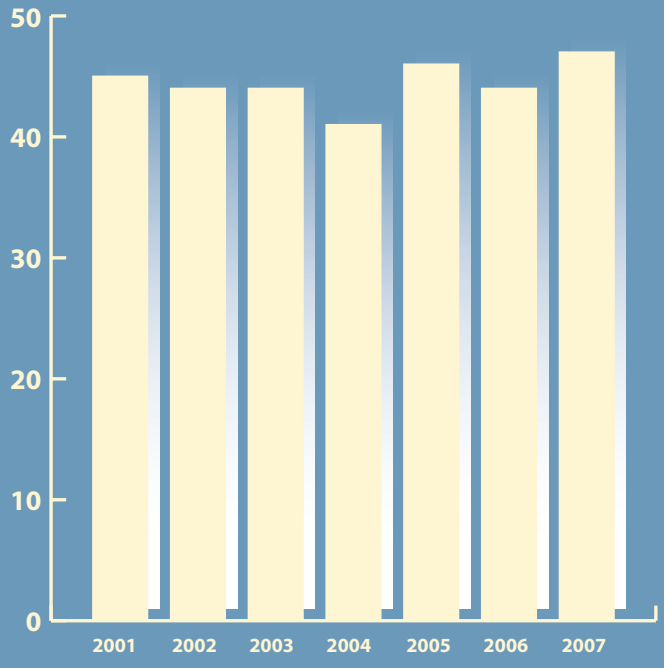


ANNUAL INCOME (in millions)



NUMBER OF FUNDING SOURCES

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