



## **Public Health Institutes: The Michigan Experience**

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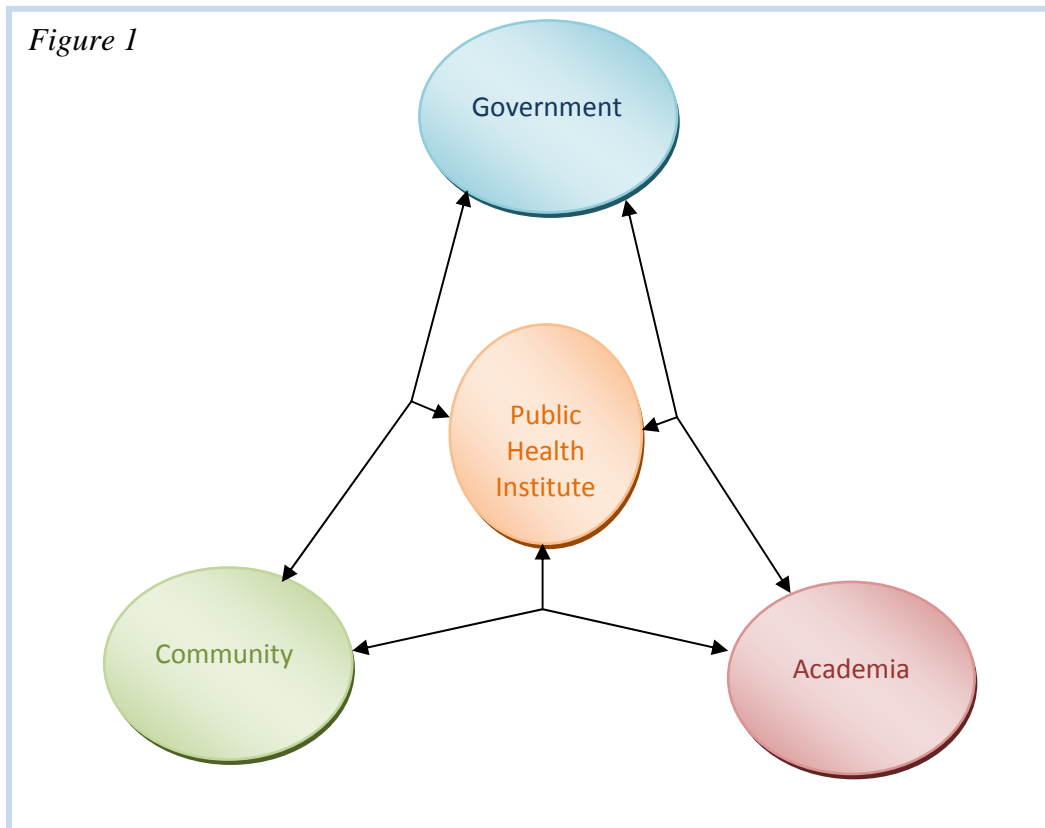
## **Abstract**

Public Health Institutes are generally non-profit organizations that rely upon multi-sectoral partnerships and collaborations to enhance the public's health and quality of life. It has been over fifty years since the "first wave" of institutes came into existence. Yet, they remain relatively novel public-private organizations that function as intermediaries or "fourth sectors" between government, community and academia. Although these organizations are diverse, they share characteristics that define them as public health institutes. The National Network of Public Health Institutes was developed in 2001 to facilitate mutual support and to advocate for the public health institute concept. There are now thirty two organization members of the national network in twenty seven states and Washington D.C. Much of this growth of institutes has occurred in the last decade. This success has not come without its challenges, as the institutes strive to find opportunities to thrive in changing times. The experience of the Michigan Public Health Institute is examined to illustrate one institute's evolution.

*Keywords – public health institute, network, servant leadership, public private partnerships*

## Public Health Institutes

Public health institutes connect government, academia and communities as well as promote collaboration. The public health system involves multiple organizations whose purpose is to assure conditions which promote a healthy population. These organizations can be broadly grouped into 3 sectors; governmental, academic, and community-based. These sectors often function independently despite regular interaction and a unified goal of improved population health. It has been stated that “achieving improvements in population health is inherently a multi-institutional endeavor” and that “no single organization can offer the full complement of information, resources, and expertise necessary for improvement on a population-wide basis.”<sup>1</sup> A “fourth sector” has been described; one that bridges the other 3 to create a multi-sector collaboration in order to maximize positive health conditions.<sup>2</sup> This fourth sector is the public health institute. (Figure 1) It is the purpose of this article to highlight PHI’s and their vital role in public health by elucidating some of their key characteristics and illustrating with one such story; the Michigan experience.



Source: Author



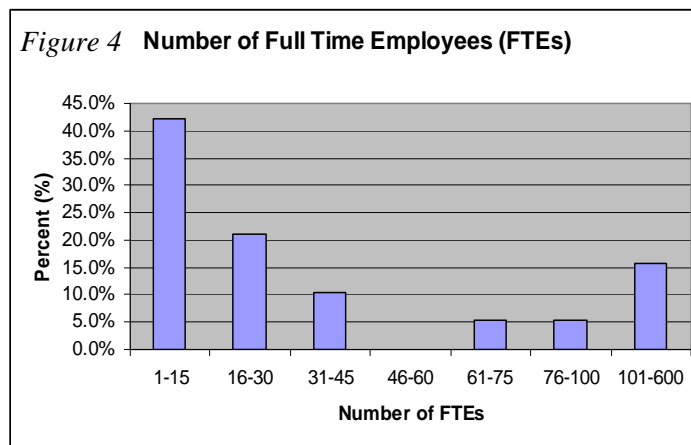
Figure 3

## NNPHI Membership Affiliation



Source: Author, developed from NNPHI data

A more recent survey of PHI's was conducted by NNPHI in 2007 to characterize its members.<sup>5</sup> The survey involved 24 of the then 28 member institutes. The organizations vary in staff size from one person to the hundreds, with the majority having less than forty five. (Figure 4)



Source: NNPHI 2007 survey

Annual funding ranges are shown with the percentage of dues paying members. (Table 1)

<i>Table 1</i> Funding Level	Percentage of dues paying members
\$0 to \$499,999	27%
\$500,000 to \$999,999	17%
\$1,000,000 to \$2,499,999	20%
\$2,500,000 to \$4,999,999	13%
\$5,000,000 and higher	23%

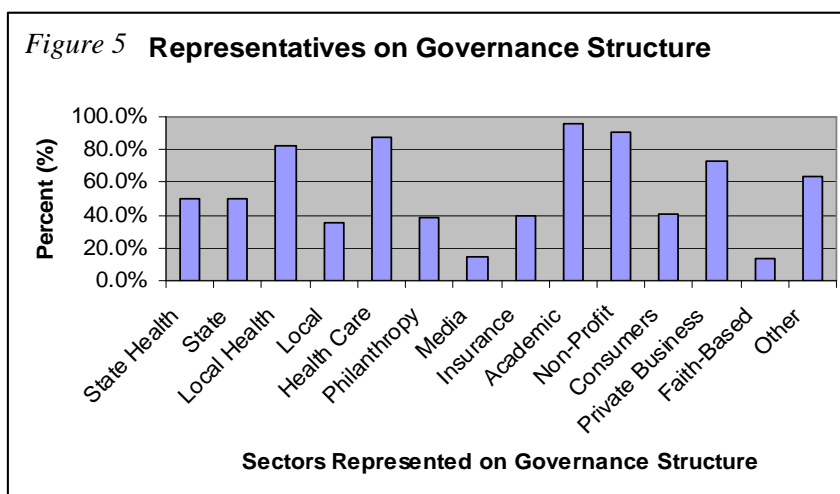
Source: NNPHI 2007 Survey

The top funding sources are shown by percentage of PHI's receiving revenue from the identified source. (Table 2)

<i>Table 2</i> Funding Source	(%)
National Foundations	83.3
State Source (Federal Pass Through)	79.2
Non-Government Organizations / Non-Profits	73.9
State Source (EXCLUDING Federal Pass Through)	73.9
Local foundations	70.8
Federal Sources (Direct)	60.9
State Foundations	59.1
Health Insurance Companies	56.5

Source: NNPHI 2007 Survey

The governing structures are likewise diverse with the majority of PHI's having 11-20 board members representing many different societal sectors. (Figure 5)



Source: NNPHI 2007 survey

## Public Health Institute Strengths and Challenges

Key competencies of PHI's were established by the MPHI 1999 survey, and are felt to still be representative today. They include; a) program management, b) evaluation, c) policy analysis, d) research, e) data management, f) communication, and g) networking.

Nevertheless, the aforementioned features and even the key competencies do not necessarily distinguish PHI's from other institutions. PHI's distinguish themselves with the following characteristics:<sup>6</sup>

- a) Public Health intermediaries – they serve as a platform to convene multi-sectoral stakeholders to forge collaborations and partnerships, which might not otherwise be possible. This engenders an approach to the public's health from a wider scope and a greater understanding but leaves a “soft footprint.” The intermediary roles have been classified as follows:<sup>6</sup>
  - i. Initiative Development – conceptual development and brainstorming to develop goals and methods.
  - ii. Convener – Bring various stakeholders together to facilitate processes, maintain relationships, and build trust around common goals.
  - iii. Technical Assistance – Provide resources and expertise where needed to support staff and maintain momentum.
  - iv. Re-grantor – facilitate the availability of foundation and state government funding to small community based organizations, consortiums, coalitions, networks and others.
  - v. Linkages – build bridges between various stakeholders in the community health system and broker communication.
  - vi. Evaluation and dissemination – perform evaluations, disseminate results/experience and assist stakeholder groups to translate findings into actions. The research is often published in peer reviewed journals and other publications.
- b) Non-partisan, neutral sources of information/knowledge based on evidence/research. This allows them to function as an “honest broker” of information and avoid the semblance of a “hired gun.” It has been pointed out though that this neutrality does not preclude advocacy on behalf of a wider public good.<sup>7</sup>
- c) Strategic management perspective – unlike most government agencies and universities with a bureaucratic hierarchy, PHI's link their environment, internal organizational design, capabilities, and strategies to position themselves to achieve their objectives. This allows the PHI's to be
  - i. Flexible regarding administration, types of funding sources and programs
  - ii. Responsive
  - iii. Economical
  - iv. Innovative
  - v. Timely, and
  - vi. Able to “get the job done”
- d) Programmatic breadth
- e) Technical depth



- f) Support State and Local Public Health Departments – PHI’s do not perceive themselves as competitors for or usurpers of the public health dollar. Rather, they are liaisons between the public and private sector with a mutual interest in population health.

Additionally, they are able to

- a) Generate fee-for-service income through specialized health service capabilities
- b) Patent, license and market various products

Despite the growth of PHI’s in the last two decades, keeping them operational is not without its difficulties. These problems have been delineated as follows;<sup>3</sup>

- a) Managing “start-up” activities – emerging PHI’s need to develop a board of directors, organizational plan and structure, as well as hiring initial staff.
- b) Surviving organizational growth – as a public health institute grows in size and revenue, its complexity does also. This is often the point in its evolution when it either becomes a mature sustainable organization or not.
- c) Establishing and sustaining a sound financial infrastructure – this is key to any business but particularly so for PHI’s. The majority operate on “soft money” generated through time limited grants and contracts. The indirect rate earned may be the only source of revenue to support central administration overhead, i.e. directorship, human resources, accounting/finance, marketing, and technology support.
- d) Recruiting, hiring and retaining high quality staff/professionals – creating and maintaining a “brain trust” is the heart of a PHI and without such it cannot survive.
- e) Establishing and maintaining effective partnerships – PHI’s not only develop and foster partnerships as part of their work, but also to establish relationships which may draw future funding opportunities.
- f) Isolation – up until 2001, the PHI’s did not have a peer network as a resource for assistance. They were “on their own” to create a path of success or failure.

Kimbrell has also indicated the increased distance from policy development that may result from being outside the government as another challenge, although it is also what allows PHI’s the freedom to address politically controversial issues.<sup>7</sup> Yet, despite the partnerships and collaboration, there is a tension between PHI’s and the collaborating organizations. The nature of the business is pursuing limited funds, many of which are based on the awarding of competitive grants and contracts. The PHI’s partners and collaborators are, therefore, also its competition. This can be true amongst the PHI’s as well since they compete for similar opportunities.

### **Development of a National PHI Network**

Due to the challenges PHI’s face, MPHI recommended ten years ago that a “more formal network of institutes” be developed.<sup>3</sup> Following this, a series of meetings occurred between October, 2000 and April, 2001 which culminated in the formal establishment of the National Network of Public Health Institutes (NNPHI). In June 2001, NNPHI was incorporated as a 501(c) 3 nonprofit organization.

The NNPHI is active in supporting its members and nurturing the development of additional PHI's. There have been six new members in the past year while technical assistance and mentorship has been provided to five emerging institute grantees as well as nine additional emerging institutes and interested parties. An annual conference is held in New Orleans and hosted by NNPHI to grow and strengthen the peer network; periodic educational teleconferences are held throughout the year. A sampling of some of the NNPHI initiatives includes the Public Health Leadership Society and the Multi-state Learning Collaborative: Lead States in Public Health Quality Improvement. A collaborative initiative with member PHI's is the Community Benefits Project with Public Health Institute of California. Nevertheless, just as the PHI's have challenges, so too does NNPHI. Many of these were addressed head-on at this year's annual conference themed, "Opportunities to Thrive in Changing Times."

### **Public Health Institutes' Purpose**

Ultimately, the success of the PHI's may be reasonably expected to translate into improved population health. The evidence for such, however, is lacking as was pointed out by MPHI in 1999, "there has been no effort to quantify the impact of public health institutes on the public's health within their states."<sup>3</sup> Similarly, in a paper prepared by the Georgia Health Policy Center for NNPHI, an evaluation of the impact of PHI's was believed necessary to demonstrate their health impact.<sup>8</sup> Regardless, it has been postulated that for alternative structures, such as PHI's, to be successful, they would need to move from collaboration to co-evolution: a state in which each of the sectors (community, government, universities and PHI's) are interdependent having adapted to each other and their environment.<sup>1</sup> Specifically, for any given project, each of the sectors may pursue it, but they will also consider the others as potential partners to proceed with it in a collaborative effort. This seemingly has occurred for some of the PHI's. Co-evolution appears to be the next stage for the NNPHI with each of its individual PHI members. The expected result would be to improve its stability and efficiency for an even greater impact on the public's health - a synergistic one.

There has been concern voiced regarding these alternate organizations. In a lament on the decline of the traditional public health infrastructure, Jacobson questioned the assumption that these public-private partnerships represent the best alternative.<sup>9</sup> He argued that the rush to create such partnerships was akin to placing form before function. This may be true and his questions and concerns remain valid today. It also appears that the states' divestiture of public health from its traditional portfolio of services continues as well, opening opportunities for other organizations to assume public health responsibilities. It is suggested that herein lies an opportunity for NNPHI and the PHI's to "thrive in changing times" by addressing the questions Jacobson posed and developing methodology to determine the public health outcome as a result of the PHI movement.

### **The Michigan Experience**

The Michigan Public Health Institute formally came into existence as a corporation in July, 1990 with the filing of Articles of Incorporation for establishment of a nonprofit corporation with the Michigan Department of Commerce.<sup>10</sup> The concept for this unique organization came decades earlier, but, not from the "first wave" of PHI's. Rather, MPHI's origins lie in the teachings of George W. Fairweather and his concept of an experimental social

innovation center.<sup>11, 12</sup> This innovation center was envisioned as being positioned “in-between” government, universities, and private industry. Characteristics of these four types of institutions relative to location of an innovation center were compared by Fairweather and shown in Table 3.<sup>12</sup>

*Table 3. Comparison of Characteristics of an Experimental Social Innovation Center (ESI) relative to location*

	Freedom of Inquiry	Longevity	Operational control of subsystems	Dissemination ability	Multidisciplinary orientation	Training opportunity
University	Excellent	Good to Excellent	Poor, no direct access to programs	Poor to Fair, no access again	Fair, disciplinary chauvinism	Excellent
Private Industry	Poor to Fair, necessary to maintain profits	Poor to Fair	Poor, contracting mechanism insufficient for control	Fair	Good to Excellent	Poor
Government	Varies, poor if research is "captive"	Excellent under civil service	Excellent, if located in operational dept, only Fair from legislature	Good, if located in dept, Poor to Fair elsewhere	Poor, if located in single dept, Good, if located in legislature	Poor
"In-between"	Good to Excellent	Good to Excellent	Good to Excellent	Good to Excellent	Good to Excellent	Good to Excellent

Source: Adapted from Fairweather GW, Tornatzky LG. *Experimental Methods for Social Policy Research*. New York: Pergamon Press; 1977, pg 392.

In the 1970’s, such an innovation center for public health was suggested to the Michigan Department of Public Health (MDPH) by a young civil servant and former student of Fairweather’s, Jeffrey R. Taylor, Ph.D. Little was thought of this suggestion then, but it arose again in the mid 1980’s. Dr. Gloria Smith, the State Health Director at MDPH, recognized the possible benefits of an “in-between” organization. Jean Chabut and other MDPH staff sent a “MINET” telecommunication in March 1986 to all state officers in the United States inquiring about whether any of them had an institution or foundation of this nature.<sup>13</sup> Indeed, some of them did (California, Maine, Massachusetts, New York, Ohio, and Texas responded affirmatively).

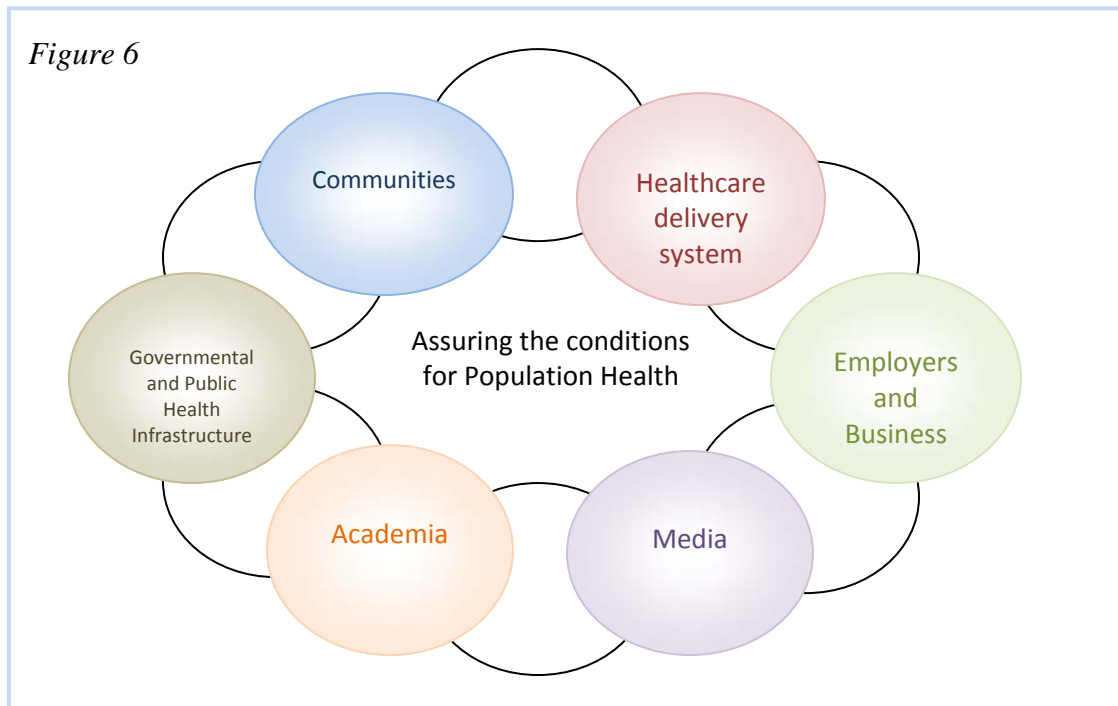
The MDPH staff then further researched and studied these “first wave” institutes as the model might apply in the State of Michigan. By January of 1987, a draft paper on policy options had been developed and released.<sup>13</sup> This was followed by Acting State Health Director Raj Wiener initiating a planning process for the formation of Michigan Public Health Institute in August, 1988.

This planning process included representatives from University of Michigan, Michigan State University, Wayne State University, the Michigan legislature, and the governor’s office. The “in-between” or “fourth sector” institute would soon be codified in Michigan’s Public Health Code. Representative Michael Bennane introduced House Bill 4841 on May 18<sup>th</sup>, 1989 which was unanimously passed by the House and Senate. It was signed into law December 24<sup>th</sup>, 1989 by Governor James J. Blanchard as Public Act 264 of 1989.

MPHI was initially housed within MDPH in Lansing, MI from June 1990 until July 1993 when the organization matured and moved to offices in Okemos, MI where it remains today. Its close ties with its parent and nurturing agency, the Michigan Department of Community Health (MDCH), remain; they function as “family”, although this does not preclude independence.

### Governance

The first organizational meeting was held in June 1990 and the Bylaws were adopted in September 1990. The original Board of Directors consisted of twelve members, six of whom were appointed by MDPH and two each from University of Michigan, Michigan State University and Wayne State University. The terms are for two years and are staggered. The Bylaws designated the Director of Michigan Dept. of Public Health as the MPHI Board president with a University representative as vice president and secretary/treasurer (but not from the same university). Also, one of the MDPH appointees was to be from local public health. Provisions in the Bylaws allowed for as many as fifteen members. In the Fall of 2005, membership was expanded to include a representative from business, media, and community based organizations. This change was based on the 2002 IOM report, *The Future of the Public’s Health in the 21<sup>st</sup> Century*, and its multi-sectoral approach to public health as illustrated in Figure 6.<sup>14</sup>



Source: Adapted from U.S. Institute of Medicine Committee on Assuring the Health of the Public in the 21<sup>st</sup> Century. *The Future of the Public's Health in the 21<sup>st</sup> Century*. Washington D.C.:National Academies Press; 2002.

The Board also appoints and evaluates the executive director. This initially proved to be difficult in that an interim executive director was not hired until 1993 and this only lasted for ~ 6 months. In February 1994, Jeffrey R. Taylor, Ph.D. became the full time executive director and remains in this capacity today.

As a nonprofit, MPHI is mission driven. The original mission was stated as;

*“to assist in developing and increasing the capacity of the Michigan Department of Public Health to prevent disease, prolong life, and promote public health through an organized program of policy development, planning, scientific research, service demonstrations, education, and training.”*

In keeping with continuing environmental changes, the mission is now;

*“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.”*

## **Funding and Growth**

Initial funding for MPHI was secured by Vernice Anthony Davis, the Board president and State Director of MDPH, from the W.K. Kellogg Foundation. This four year grant funded 2 projects begun in November 1992; the Rural Health Project – designed to gather and utilize input from local leaders to plan and implement new health service programs in five rural Michigan communities, and the Community Health Profiles Project – designed to provide population health assessments, as well as information on services and resources available in each of the states’ fifty one local health departments, for program and development purposes. By the end of 1992, MPHI had 3 funding sources, no employees, four new projects and an annual income of \$371,056. MPHI has grown considerably since its fledgling days, having built strong partnerships and a credible reputation. In 2008, MPHI had 37 funding sources, 251 employees, ~300 projects, and an annual income of ~\$33 million. MPHI is divided into 11 operational programs varying in size from 1 person to 55 as follows;<sup>15</sup>

- Health Promotion and Disease Prevention – focuses on chronic disease prevention and health promotion at the national, state and local level.

- Center for Data Management & Translational Research – is dedicated to conducting high quality public health research that can be integrated into practice and policy.
- Systems Reform Program – facilitates the reform of human services systems with the aim of increasing the effectiveness of services for children and families.
- Cancer Control Services – provides epidemiological and evaluation expertise to the State of Michigan’s cancer control programs.
- Child and Adolescent Health Program – provides technical assistance in the design, implementation and evaluation of innovative multidisciplinary programs aimed to improve the health, safety and well-being of children and families.
- Interactive Solutions Group – leverages technology and an experienced staff to develop solutions for public-sector agencies and health care organizations by creating efficient and effective ways to exchange information, automate business processes, manage change, communicate to partners, and deliver training.
- Education and Training – provides high quality education and training to the public health workforce.
- Center for Healthcare Excellence – works collaboratively with its partners to transform public health systems and improve the health of communities.
- Center for Nursing Workforce & Policy – supports nursing workforce policy efforts and health policy in general at the state and national levels.
- Center for Tobacco Use Prevention and Research – 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.
- MPHI Kresge Program Office – Provides the Kresge Foundation’s Health team with support in their health grantmaking.

### **Core Competencies**

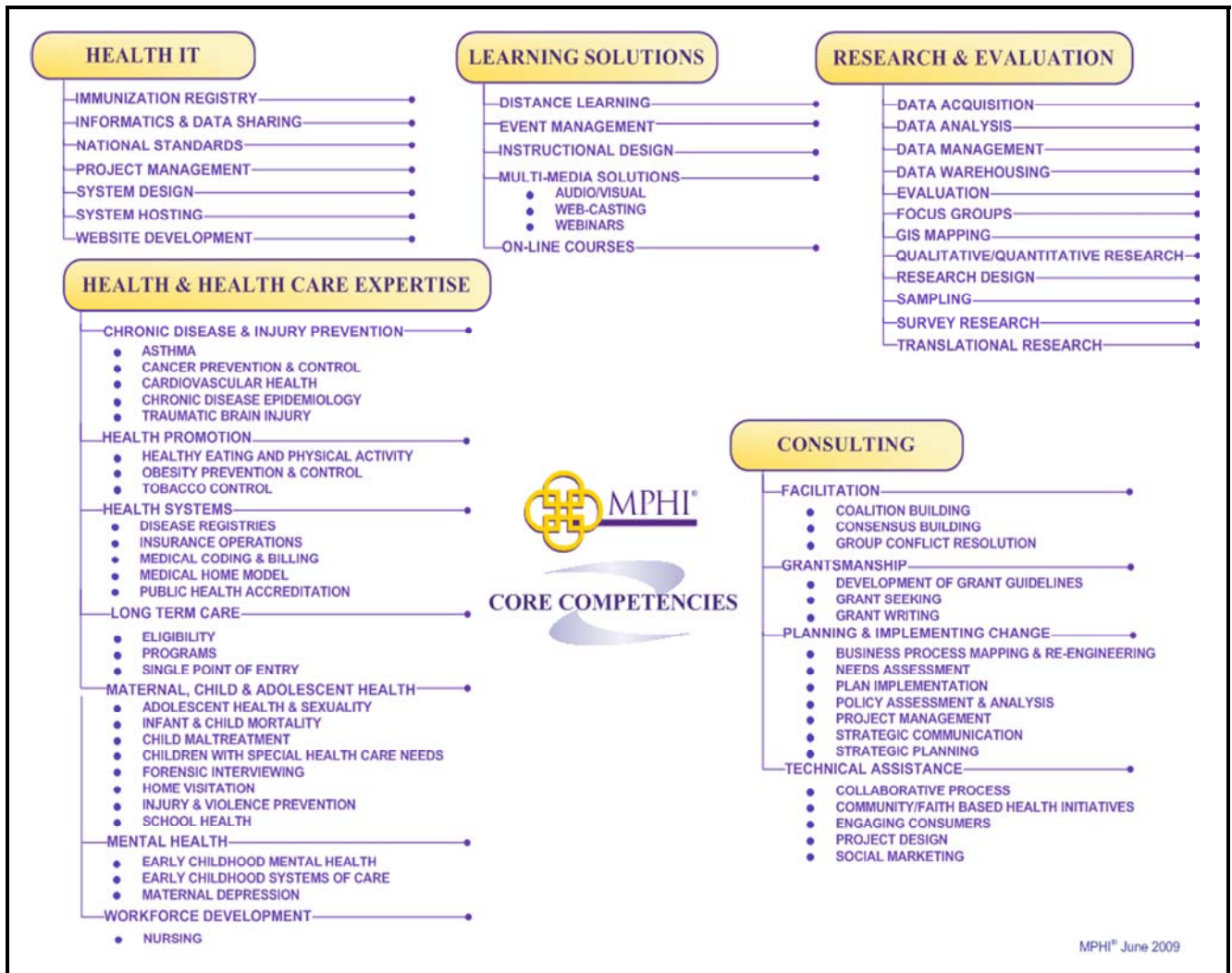
The core competencies at MPHI offer benefits to its partners. (Figure 7) The state health department gains access to:

- a) Additional sources of funding
- b) Scientific and technical expertise of MPHI and its partner universities
- c) Additional research, development, demonstration and training capabilities, and
- d) The flexibility of initiating and terminating projects readily

The three universities gain opportunities for:

- a) Internship and training
- b) Employment of graduates
- c) Access to specialized facilities
- d) Access to a broader talent pool for adjunct research and teaching appointments
- e) Partnership with other universities and cooperative research, and
- f) Translating their research into application

Figure 7 – MPHI Core Competencies



Source: Michigan Public Health Institute

Communities benefit from MPHI projects that are designed and implemented to assist communities in improving health care systems, surveillance systems, disaster preparedness, and communication of health care information. Training of community services staff and community toolkits are provided. *See the Case study for an example*

### Structure and Function

The capabilities of MPHI are all fostered and facilitated by the horizontal organizational structure and the culture which are decidedly non-corporate. Each of the programs functions semi-autonomously and has their own identity, which includes individual addresses and signs. Although, this may have initially promoted the programs to function in individual silos, this is no longer the case as they cooperate regularly in joint projects. This cooperation also allows MPHI

to take on larger projects. Central administration is not the pinnacle of the organization; rather, it is the operational support (Human resources, Finance and Accounting, Information Technology support, Administrative assistance) to each of the programs and is the connection that brings them all together as a unified institute.

This has been referred to as a “loose/tight” management style by the Executive Director. It is loose in that each program has independence which allows for professional entrepreneurship to seek opportunities based on their mission. This preserves a degree of *esprit de corps*. Certified project managers are employed to assure that the projects are run proficiently. Yet it is tight in its oversight, given that every project gets reviewed quarterly by the program directors and central administration.

This reflects the leadership style that directs MPHI which is based on the theory of leadership described by Robert Greenleaf in his book, *Servant Leadership*.<sup>16</sup> He believed that people “will freely respond only to individuals who are chosen as leaders because they are proven and trusted as servants.” Greenleaf summarized the theory with the phrase *primus inter pares*, first among equals. Ten characteristics which are essential to servant leaders have been defined by Larry Spears, former CEO of the Greenleaf Center for Servant Leadership, and are; listening, empathy, healing, persuasion, awareness, foresight, conceptualization, commitment to growth, stewardship, and focus on community.<sup>17</sup>

### **Current Challenges**

Strong leadership will be needed to maintain MPHI’s current capacity. Michigan has been in a “one state” recession since 2001, as the automobile manufacturing business has struggled. The 2008-2009 national recession has reinforced this poor economic situation. Consequently, Michigan’s government has planned for reorganization and “streamlining.” Once again, there have been reductions in funding for public health. Similar circumstances occurred in MPHI’s past, in January 1996. Michigan’s government reorganized; MPHI lived through, survived and thrived during the reorganization, despite being a less mature and stable organization at the time.<sup>18</sup> In many ways, it led to opportunities for MPHI to assume new roles and responsibilities leading to growth of the organization. It also supported the co-evolution of MPHI with its collaborating partners and in response to its environment. MPHI is poised to do the same today but now as a more mature and substantial organization. Changes and economic upheavals at the federal level will lead to similar opportunities for PHI’s nationally.



**Case Study** - Michigan Care Improvement Registry (MCIR): From collaboration to improved community health

In the mid 1990's, Michigan's childhood immunization rate was the lowest in the nation at 59% (April 1994 – Mar 1995, 4:3:1:3 series).<sup>19</sup> This did not go unnoticed and by 1997, Michigan Public Act 540 was passed establishing a childhood immunization registry within the Michigan Department of Community Health (MDCH) and originally known as the Michigan Childhood Immunization Registry (MCIR). By 1998, the fully functional MCIR was released combining records from both public and private providers for all children. Since MCIR's inception by MDCH, MPHI has worked in collaboration with MDCH and multiple partners including Vector Research – now Altarum, the Robert Wood Johnson Foundation, the Michigan Association of Local Public Health (MALPH), Michigan's local health departments, the U.S. Department of Commerce, and Medicaid in order to develop, implement and provide continuing support of this successful product. Most importantly, it has improved the childhood immunization rate in Michigan to 83% (July 2007 – June 2008, 4:3:1:3 series).<sup>20</sup>

There are now 5.1 million people in the system with 62 million shot records. There are 24,000 registered users and over 14,000 user log-ins every day. MCIR now also displays data on childhood lead screening, newborn genetic screening, newborn hearing results, and Early Periodic Screening Diagnostic Treatment (EPSDT), with future plans to track body mass index (BMI).

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